NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 6 June 2023
Main Boardroom, Diana, Princess of Wales Hospital
Time – 9.00 am – 1.00 pm
For the purpose of transacting the business set out below

		Note / Approve / Receive & Confirm	Time	Ref
1.	**Introduction**			
1.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:00 Hrs	Verbal
1.2	**Apologies for Absence** Sean Lyons, Chair	Note		Verbal
1.3	**Patients' Story** Jo Loughborough, Senior Nurse – Patient Experience & Carolyn Phillips, Lead Medical Examiner Officer	Note		Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:20 hrs	Verbal
2.2	**To approve the minutes of the Public meeting held on Tuesday, 4 April 2023** Sean Lyons, Chair	Approve		NLG(23)090 Attached
2.3	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.4	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(23)091 Attached
2.5	**Chief Executive's Briefing** Dr Kate Wood, Chief Medical Officer (Acting Chief Executive)	Note	09:30 hrs	NLG(23)092 Attached
2.5.1	**Trust Priorities – End of Year Report** Shaun Stacey, Chief Operating Officer & Acting Chief Executive	Note		NLG(23)093 Attached
2.6	**Integrated Performance Report (IPR)**	Note		NLG(23)094 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Quality & Safety Report – Key Issues** Dr Kate Wood, Chief Medical Officer & Ellie Monkhouse, Chief Nurse	Note	09:45 hrs	NLG(23)094 Attached

3.2	**Maternity Oversight Report** Ellie Monkhouse, Chief Nurse & Nicky Foster, Associate Chief Nurse – Midwifery, Gynaecology and Breast Services	Note	10.00 hrs	NLG(23)095 Attached
3.3	**Annual Quality Account** Dr Kate Wood, Chief Medical Officer	Approve	10:10 hrs	NLG(23)096 Attached
3.4	**Quality & Safety Committee Highlight Report and Board Challenge including Self Assessment** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	Note / Approve	10:15 hrs	NLG(23)097 Attached
3.5	**Performance Report – Key Issues** Shaun Stacey, Chief Operating Officer	Note	10:20 hrs	NLG(23)094 Attached
3.6	**Finance & Performance Committee Highlight Report and Board Challenge – Performance including Self Assessment** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:30 hrs	NLG(23)098 Attached
BREAK – 10:35 hrs – 10:45 hrs				
4.	**Strategic Objective 2 – To Be a Good Employer and Strategic Objective 5 – To Provide Good Leadership**			
4.1	**Workforce Report – Key Issues** Simon Nearney, Interim Director of People	Note	10:45 hrs	NLG(23)094 Attached
4.2	**Freedom to Speak Up Guardian (FTSUG) Annual Report 2022/23** Liz Houchin, FTSUG	Approve	10:55 hrs	NLG(23)099 Attached
4.3	**Equality, Diversity & Inclusion Report & Strategy 2023 – 2027** Simon Nearney, Interim Director of People & Karl Portz, Equality & Diversity Lead	Approve	11:05 hrs	NLG(23)100 Attached
4.4	**Workforce Committee Highlight Report and Board Challenge including Self Assessment** Sue Liburd, Chair of the Workforce Committee and Non-Executive Director	Note	11:15 hrs	NLG(23)101 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Operational & Financial Plan** Lee Bond, Chief Financial Officer & Shaun Stacey, Chief Operating Officer	Note	11:20 hrs	NLG(23)102 Attached
5.2	**Finance – Month 01 – Key Issues** Lee Bond, Chief Financial Officer	Note	11:30 hrs	NLG(23)103 Attached
5.3	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note / Approve	11:40 hrs	NLG(23)104 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Strategic & Transformation Report – Key Issues** Ivan McConnell, Director of Strategic Development	Note	11:45 hrs	NLG(23)105 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge including Self Assessment** Gill Ponder, Non-Executive Director	Note	11:55 hrs	NLG(23)106 Attached

7.	**Governance**			
7.1	**Audit, Risk & Governance Committee Highlight Report and Board Challenge** Simon Parkes, Non-Executive Director and Chair of the Audit, Risk & Governance Committee	Note	12:00 hrs	NLG(23)107 Attached
7.2	**Board Assurance Framework (BAF) – Quarter Four** Helen Harris, Director of Corporate Governance	Note / Approve	12:05 hrs	NLG(23)108 Attached
7.3	**Strategic Development Committee – Disbanding of Committee** Helen Harris, Director of Corporate Governance	Approve	12:10 hrs	NLG(23)109 Attached
8.	**Approval (Other)**			
8.1	**Health & Safety Policy Statement** Jug Johal, Director of Estates & Facilities	Approve	12:20 hrs	NLG(23)111 Attached
9.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:40 hrs	
10.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
10.1	**Interim Chief Executive Cover Arrangements** Sean Lyons, Chair	Note		NLG(23)110 Attached
11.	**Questions from the Public**	Note		Verbal
12.	**Date and Time of Next meeting** **Board Development** Tuesday, 4 July 2023, 9.00 am **Public & Private Meeting** Tuesday, 1 August 2023, 9.00 am	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- In accordance with Standing Order 14.2 (2007), any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Chairman, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Chairman. Divisional Directors and Managers may also submit agenda items in this way.
- In accordance with Standing Order 14.3 (2007), urgent business may be raised provided the Director wishing to raise such business has given notice to the Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- **Members should contact the Chair** as soon as an actual or potential conflict is identified. **Definition of interests –** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.

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

APPENDIX A

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

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

9.	**Items for Information / To Note**	
	Committee Supporting Papers:	
	Finance & Performance Committee	
9.1	**Finance & Performance Committee Minutes – February & March 2023** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(23)114 Attached
9.2	**Health Tree Foundation Trustees' Committee Minutes – March 2023** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(23)115 Attached
	Quality & Safety Committee	
9.3	**Quality & Safety Committee Minutes – March & April 2023** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(23)116 Attached
9.4	**Nursing & Midwifery Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(23)117 Attached
	Workforce Committee	
9.5	**Workforce Committee Minutes – March 2023** Sue Liburd, Non-Executive Director & Chair of the Workforce Committee	NLG(23)118 Attached
9.6	**Guardian of Safe Working Hours Report – Quarter Four** Dr Liz Evans, Guardian of Safe Working Hours	NLG(23)119
	Audit, Risk & Governance Committee	
9.7	**Audit, Risk & Governance Committee Minutes – February 2023** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(23)120 Attached
	Other	
9.8	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(23)121 Attached
9.9	**Documents Signed Under Seal** Acting Chief Executive, Chief Executive	NLG(23)122 Attached
9.10	**Trust Board Reporting Framework** Helen Harris, Director of Corporate Governance	NLG(23)123 Attached

NLG(23)090

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (MEETING IN PUBLIC)

Minutes of the Public Meeting held on Tuesday, 4 April 2023 at 9.00 am
Ashbourne Hotel, Vicarage Lane, North Killingholme, Immingham

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Chair
Linda Jackson	Vice Chair
Lee Bond	Chief Financial Officer
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Chief Medical Officer
Fiona Osborne	Non-Executive Director
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director
Simon Parkes	Non-Executive Director

In Attendance:

Diana Barnes	Public Governor
Adrian Beddow	Associate Director of Communications
Rachel Farmer	NHS Liaison
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates & Facilities
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Simon Nearney	Interim Director of People
Ian Reekie	Lead Governor
Kate Truscott	Associate Non-Executive Director
Jane Warner	Associate Chief Nurse – Midwifery (for item 3.3)
Joanne Zamo	Nottingham University Hospitals NHS Trust
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Introduction

1.1 Chair's Opening Remarks

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

It was noted Ian Reekie, Lead Governor, Diana Barnes, Public Governor, Rachel Farmer, NHS Liaison and Joanne Zamo, Nottingham University Hospitals NHS Trust were in attendance.

Sean Lyons explained no Patient Story would be shared as part of the public meeting as a detailed Patient Story had been recently shared with the Trust Board at a private session held on the 7 March 2023.

Trust Board members were asked to take all reports as read and to ensure only highlights were shared during the meeting. It was noted the Trust currently faced challenges around finance, quality and workforce.

1.2 Apologies for Absence

Apologies for absence were received by Dr Peter Reading, represented by Ellie Monkhouse, Acting Chief Executive.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

2.1.2 Register of Interests – NLG(23)065

Helen Harris shared the report with the Trust Board and advised it was for noting. It was noted Dr Kate Wood's role should be amended to Chief Medical Officer. Dr Kate Wood queried whether individuals that held joint roles across Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospital NHS Trust (HUTH) should declare a declaration for this. Sean Lyons agreed this should be declared and confirmed some staff in those roles had already made those declarations. It was noted Linda Jackson's role should be changed to Vice Chair on page four of the report.

Fiona Osborne noted a declaration of a Trustee role for the Simon Clarke Charity and confirmed a declaration would be completed for this.

Simon Nearney declared working in a joint role with HUTH.

2.2 To approve the minutes of the Public Meeting held on Tuesday, 7 February 2023 – NLG(23)045

The minutes of the meeting held on the 7 February 2023 were accepted as a true and accurate record and would be duly signed by the Chair once the amendment below had been actioned.

- Lee Bond referred to page seven, Section 3.6, final paragraph. Additional wording should be added to state "Lee Bond felt mutual aid in terms of flow was very limited due to the number of patients on the NLAG waiting lists and the Trust capacity."

2.3 Urgent Matters Arising

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

2.4 Trust Board Action Log – Public by exception NLG(23)046

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

- Item 3.4, 4 October 2022 meeting – Bank Incentives. It was noted an update on this item was included within the Chief Executive Report. It was agreed this item would be closed.
- Item 2.2, 7 February 2023 meeting – Trust Management Board recommendation. Shauna McMahon advised a discussion with Dr Peter Reading was still due to take place, however, the Integrated Performance Report (IPR) had been circulated for comment on what additional information was required. Fiona Osborne advised this had related to the request to test IPR standard, it had been agreed to change to seven days relating to one particular target. It was agreed this item would be closed.
- Item 5.1, 7 February 2023 meeting - Finance Month 09. Shaun Stacey advised productivity was discussed and reviewed at the Finance & Performance Committee (F&PC) along with the Sub-Group of Operations. Theatre productivity had also been added to the IPR report. Work was now being undertaken on uncapped and capped activity and this would conclude within the next six weeks. This would again be discussed at the April 2023 F&PC meeting. It was agreed this item would be closed.

2.5 Chief Executive's Briefing – NLG(23)047

Ellie Monkhouse referred to the report and highlighted key points. It was noted the Junior Doctors Industrial action had been announced over a four-day period between the 11 and 14 April 2023, emergency preparedness had been put in place for this period. The new Emergency Department (ED) at Scunthorpe General Hospital (SGH) had opened on the 16 March 2023 and this had run seamlessly. Trust Board members were reminded of the Quality Improvement (QI) Conference due to be held on the 27 April 2023, this was due to be well attended as all places had been filled.

Fiona Osborne referred to the winter bank incentives and noted they had had a substantial impact on shift fill rate but not on agency spend. Sue Liburd queried what the likely impact would be on 78 week waits (ww) and the aspiration for 65 ww due to the industrial action. Shaun Stacey advised NLAG had nine patients on the 78 ww waiting list which were mutual aid patients, the strike action would not have any impact on those patients as these would be completed by the end of April

2023. It was expected there would be more impact around recovery and bed waits as there could be longer lengths of stay for patients due to delayed revies during this time. There were no cancellations on other services at the moment, however, this could change.

Sean Lyons noted the good performance in relation to 78 ww. Sean Lyons had been at SGH on the day of the ED opening and highlighted how well organised it had been. Shaun Stacey wanted to note thanks to the Medicine and Emergency Planning team for the co-ordination on opening of the ED as there had been a high number of attendees during this period. Thanks were also given to Shauna McMahon's team as all information technology (IT) systems had run smoothly over this time. It was recognised a number of teams had supported the smooth running of the opening of the ED at Scunthorpe so thanks were noted to everyone on behalf of the Trust Board.

2.5.1 Trust Priorities 2023 / 24 – NLG(23)048

Ellie Monkhouse shared the Trust Priorities with the board for 2023/24. It was noted the priorities could be changed or updated during the year if required. Gill Ponder referred to the priorities relating to deteriorating patients and queried whether it needed to specify 16 years plus. Dr Kate Wood advised this was due to paediatrics being carried out in a different way through Facing Future so would not be included. A query was raised as to whether this would be understood by members of the public. Sean Lyons queried whether further clarification could be included when other revisions were put in place. Stuart Hall queried whether the priorities should mention the Trust was an anchor institution, this was noted.

Simon Nearney advised the priorities that related to People would be monitored through the IPR. Linda Jackson advised the priorities also formed part of what Dr Peter Reading would continue to monitor with Executives. Anything required would also be included within the Committee workplan structure. Sean Lyons felt it would be helpful to share a one pager on how priorities were cascaded to be monitored. Sean Lyons agreed to discuss this with Dr Peter Reading.

Linda Jackson advised the normal process for monitoring priorities included Dr Peter Reading providing a six-monthly update to the board.

The Trust Board approved the Trust Priorities.

2.6 Integrated Performance Report (IPR) – NLG(23)049

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

3. Strategic Objective 1 – To Give Great Care

3.1 Quality & Safety - Key Issues - NLG(23)049

Dr Kate Wood referred to the report and highlight two points, one in relation to weight recording which remained a significant concern and Venous Thromboembolism (VTE) which had failed consistently. The issues with VTE was

due to the requirement of the parameters needing to be rebased as the performance had been above target, this change would be in place for the next report. Weight recording remained a challenge due to the numerous places it was recorded by teams, this was required for nutritional and cardiac reasons along with prescribing the correct medication. Recording of weight was being reviewed to enable this to be recorded in one place as this being noted in numerous places which meant this was not always undertaken correctly. A number of mitigations were in place along with awareness being raised to detect those patients with a weight of under 50 kilograms. Fiona Osborne advised this had been discussed at the Quality & Safety Committee (Q&SC) where Simon Priestly, Chief Pharmacist and Clinical Lead for Medicines Management was in attendance, it was noted the committee were assured at the moment due to the mitigations in place, however, a more robust system was required. Dr Kate Wood highlighted this was included in the Quality Priorities.

Ellie Monkhouse referred to the report and highlighted the significant improvement in compliance for complaint response times now at 85%. Patient Advice and Liaison (PALs) responses had also been consistent at around 63% to 64%. Concerns had been raised from the Patient Experience team as a Business Case submitted for additional staff had not been supported which would cause some challenge. It was confirmed the Trust had not met the target for Clostridium Difficile (C.Diff) as the number of cases was 23 for that year. Two additional cases had been confirmed the previous week. It was noted the Trust had done significantly well and remained in the top ten Trusts for performance.

Sean Lyons referred to the low response rate for Sepsis in Children and queried what this related to. Dr Kate Wood advised sepsis continued to be a focus area for the Trust and screening children was important, it was felt the position was better than was shown in the report. Unfortunately, the documentation did not feed through to the electronic format correctly so needed to be reviewed to link in better. Shauna McMahon explained the independent purchase of software had caused issues in the past as the integration of data was then not always possible, it was believed the recording of this data should not be an issue as this was available through Power BI. Dr Kate Wood explained the Trust needed to have in place the correct infrastructure for it to be recorded by clinicians. Shauna McMahon explained the processes would be in place, the shortfall of devices, however, did need to be addressed to ensure funds were available.

Ellie Monkhouse advised the relevant support was required to support staff on the wards when implementing new digital systems. A query was raised as to whether project teams should be in place to support changes in the future to ensure the required support was there.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(23)050

Fiona Osborne referred to the report and noted key highlights.

3.3 Maternity Oversight Report – NLG(23)051

Jane Warner shared the report and highlighted key points explaining this was in the new format. It was noted the Trust had welcomed four international educated nurses that were currently in "boot camp" preparing for examinations. NLAG was working with HUTH in respect of Midwifery Support Workers.

Sue Liburd queried whether there had been any progress on the recruitment of an Maternity Voices Partnership (MVP) Lead. Jane Warner advised NLAG had recruited to the role, however, the person had now left so recruitment had commenced once again. It was noted there was other forums where support could be accessed until an appointment was made.

Linda Jackson requested that future board reports were more refined as this had been quite a lengthy report for the Trust Board to read. It was noted there was a need for a detailed report for the Q&SC and this report had triangulated this well as the report provided was well written, however, only a brief summary of the report was required to provide the board with assurance. Ellie Monkhouse explained the report provided was what was expected from the national team and met all requirements from a Clinical Negligence Scheme for Trusts (CNST) and other external assurances required to support the Trust being removed from quality special measures. It had previously been raised that there was not enough information being provided, there was still concern being raised that Trust Boards did not have oversight of maternity services. Linda Jackson recognised the points made but felt in terms of a board report this should be more refined to highlight key points for board members. It was agreed further discussion on board content would be discussed outside of the meeting.

As this was Jane Warner's last board meeting due to retiring from the Trust, Ellie Monkhouse noted thanks for the support and contribution Jane Warner had made to NLAG.

Lee Bond referred to the midwife and birth ratio and queried whether this would reduce if recruitment was successful. Jane Warner advised NLAG were fortunate that it could maintain safety with the number of vacancies, however, filling those vacancies would provide additional assurance. Lee Bond queried whether one hospital had more risks than the other. Jane Warner confirmed risks were similar across both sites, however, Scunthorpe had a greater number of vacancies which was due to its locality.

3.4 Performance - Key Issues – NLG(23)049

Shaun Stacey advised the ED continued to be a challenge which impacted on a high number of patients remaining in the department for over 12 hours. Work continued to resolve those issues in respect of managing flow. Ambulance handovers remained a challenge due to activity. There had been an improvement in cancer with a small amount of improvement in elective care. Sean Lyons queried why the 52 ww patients had flat lined. Shaun Stacey advised the 52 ww patients were complex cases and some of those patients had been transferred through the mutual aid support. The high level of staff sickness had also impacted

on some waiting times. There were risks related to this as neighbouring Trusts had a high number of long waiters which would require support.

Stuart Hall queried what actions had been put in place in light of the pending strike action of junior doctors. Shaun Stacey advised no appointments had been stood and no electives had been cancelled at the moment, however, it may mean some cancellations on the day as the biggest risk would be to those patients in hospital beds. Strong leadership was in place over the strike period which included clinical leadership. Additional support was in place within ED to support minimising admissions. It was noted relevant communications were in place.

3.7 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(23)052

Gill Ponder referred to the report and noted key highlights.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Workforce - Key Issues - NLG(23)049

Simon Nearney referred to the IPR and noted key highlights. Monthly meetings continued between divisional teams and Human Resources (HR) Business Partners would continue to focus on recruitment and retention. Sickness remained a challenge within the Trust.

4.2 Staff Survey – NLG(23)053

Simon Nearney shared the presentation with Board members.

Jug Johal advised that feedback received from the Facilities team had meant it was more difficult to complete the survey online with the preferred option going forward would be to provide this in paper format. Simon Nearney advised it had been a local decision to complete this online. Shauna McMahon felt this would not make a difference to the number of surveys completed and that this should be kept online. The Trust could ensure devices were available for staff to complete the surveys in this way. It was concerning to see that Black, Asian and Minority Ethnic (BAME) staff still experienced bullying and it was felt this needed to be addressed going forward. Simon Nearney agreed with this point and felt there needed to be more understanding around what this related to.

Dr Kate Wood felt the reporting showed improvements had been made and this should be recognised and celebrated in a more positive way than it had been previously. Simon Nearney agreed, however, noted the comparison to the national average was required in terms of the people agenda. Dr Kate Wood felt staff needed to see the improvements made in light of the survey and Care Quality Commission (CQC) report to celebrate more.

Kate Truscott referred to the BAME performance and hoped that now the Trust was recruiting more international colleagues improvements would be made within those areas. Gill Ponder queried what the Trust was putting in place to learn from those organisations that were performing better. Simon Nearney confirmed the

Trust was sighted on what some of the other organisations had in place and this was being considered. Gill Ponder felt some of the issues related more to how the individual manager interacted with staff directly.

Simon Nearney advised an action plan was in place to show progress going forward. Discussion and oversight would continue through the Workforce Committee and Cultural Transformation Board to provide assurance to the board.

Sean Lyons referred to the results and felt this did not specifically relate to what the CQC report had stated during the recent inspection. Ellie Monkhouse felt one of the issues was the "label" a Trust carried whilst in special measures. There was a need to recognise how staff felt working in a special measures Trust for a long period of time. Sue Liburd advised a substantial deep dive had been undertaken at the Workforce Committee and actions would be put in place from this.

4.3 Workforce Committee Highlight Report & Board Challenge – NLG(23)054

Sue Liburd referred to the highlight report and noted key points.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 09 - NLG(23)055

Lee Bond referred to the report and noted key highlights. The Trust had achieved a £0.5 million surplus in February which had been £0.3 million ahead of plan. This brought the deficit to £1.3 million. Concerns to note had been included within the report. High spend continued on bank and agency staff with the highest amount being spent in Medicine and Surgery.

Linda Jackson queried when the rearranged Single Oversight Framework (SOF) Four meeting would be rearranged. Lee Bond confirmed current discussions were around signing off the Integrated Care Board (ICB) and Trust Financial Plan. There was an expectation that a further request of submission would be requested in April 2023. Discussion would then take place at a regional level as to whether the Trust would be released from special measures.

5.2 Executive Report – Estates and Facilities – NLG(23)056

Jug Johal referred to the report and drew the boards attention to the challenges around recruitment particularly soft services due to competitive pay rates, recruiting staff to those areas had not been an issue previously. Kate Truscott referred to accommodation and whether this had impacted on recruiting new staff. Jug Johal confirmed additional accommodation at alternative places had been sourced within the SGH area. Sue Liburd referred to staff parking and queried whether this would mean the Trust "breaking even". Jug Johal advised there would be a review on parking tariffs which would show an increase. This would be approved through the Trust Management Board (TMB). Shaun Stacey referred to capital projects noting this did not include the development of oxygen for the next year and queried whether this would be included. Jug Johal advised this was part of the plan, not all plans had been included within the report. Sean Lyons referred to the quality of accommodation at SGH and queried whether improvements had

been made. Jug Johal confirmed improvements had commenced and were on a rolling programme.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(23)057

Gill Ponder referred to the report and drew the boards attention to key highlights.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(23)058

Ivan McConnell referred to the report and advised the final Clinical Senate Report had been received for the Humber Acute Services Review which had provided reasonable assurance. Lee Bond queried when the board would receive the Business Case for the Community Diagnostic Centre (CDC), Ivan McConnell confirmed this would be during quarter one. Shaun Stacey highlighted the facility would need to be adequately staffed and trained for the service to run effectively. Ivan McConnell advised the workforce for the facility would be phased and those roles would report between the CDC and the acute site, this had already been agreed with the Divisions. One concern that needed to be addressed would be how to resource the demand that the centre would attract. Stuart Hall referred to page five of the report in respect of staff losing interest and enthusiasm due to legislation delays and queried how this would be mitigated against. Ivan McConnell advised an engagement plan had been put in place and the Trust would seek to address the risk.

6.2 Strategic Development Committee Highlight Report & Board Challenge – NLG(23)059

The Strategic Development Committee Highlight Report was noted.

6.3 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – NLG(23)060

Gill Ponder referred to the report and noted key highlights. It was noted the Terms of Reference for the committee had been discussed at the last meeting and the discrepancy of three Non-Executive Director (NEDs) attending had been discussed. It was agreed Neil Gammon as Independent Chair would count as the third NED which would be reflected in the Terms of Reference.

7. Governance

7.1 Audit, Risk & Governance Committee Highlight Report & Board Challenge – NLG(23)061

Simon Parkes referred to the report and drew the boards attention to assurance being provided in respect of the body storage issue previously raised. Sue Liburd referred to the Declarations of Interest (DOI) point and queried whether this related to declarations declared in meetings or the register itself. Simon Parkes advised all decision-making staff were required to complete a declaration and this currently

had low compliance and needed to be addressed. Sean Lyons queried who had oversight of this. Simon Parkes confirmed this was being addressed and oversight would be monitored by Helen Harris, however, it was an individuals and line managers responsibility for declarations to be completed. Shaun Stacey explained this had been discussed with Helen Harris in respect of operational staff and the issue was being addressed, it was noted there had been some improvements.

7.2 CQC Statement of Purpose - NLG(23)088

Dr Kate Wood referred to the report and advised it was a statutory duty for the board to approve this.

The Trust Board approved the CQC Statement of Purpose.

8. Approval (Other)

8.1 Health Tree Foundation Trustees' Committee Terms of Reference – NLG(23)062

Gill Ponder referred to the report and sought approval from board members.

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

8.2 Audit, Risk & Governance Committee Terms of Reference – NLG(23)063

Simon Parkes referred to the report and sought approval.

The Trust Board approved the updated Audit, Risk and Governance Committee Terms of Reference.

8.3 Division of Responsibilities between the Chair and Chief Executive – NLG(23)064

Helen Harris referred to the report and provided a brief update.

The Trust Board approved the Division of Responsibilities between the Chair and Chief Executive.

9. Items for Information

The following items were shared at the January 2023 meeting:

- F&PC Minutes – January 2023
- HTFTC Minutes – November 2022
- Q&SC Minutes – January & 1 March 2023
- Nursing & Midwifery Assurance Report
- Workforce Committee Minutes – January 2023
- Freedom to Speak Up Guardian Report – Quarter Three
- Guardian of Safe Working Hours Report – Quarter Three

- AR&GC Minutes – November 2022
- AR&GC Self-Assessment
- Communications Round-Up
- Documents Signed Under Seal
- Executive Director Statutory & Lead Roles
- Non-Executive Director Statutory Roles

11. Any Other Urgent Business

There were no items of any other business raised.

12. Questions from the Public

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

13. Date and Time of the next meeting

Board Development

Tuesday, 2 May 2023, Time: 9.00 am

Formal Trust Board Meeting

Tuesday, 6 June 2023, Time: 9.00 am

The Private Trust Board meeting was due to follow at 12:15 hours.

Sean Lyons closed the meeting at 12:10 hours.

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

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

NLG(23)091

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2023/2024

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting
2023/24

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
None										

Key:

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

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

Key:

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

Kindness · Courage · Respect

Page 3 of 3

NLG(23)092

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	6 June 2023	
Director Lead	Dr Kate Wood (acting CEO)	
Contact Officer/Author	Dr Kate Wood	
Title of the Report	**CEO Briefing**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a high level overview of work ongoing both across the Trust and wider health economy	
Background Information and/or Supporting Document(s) (if applicable)	Other Board documents provide more detailed information	
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.
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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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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

The past month has been very eventful for the Trust, with the final confirmation and announcement of the exit from NOF4 of the Recovery Support Programme. This is the culmination of 6 years hard work by all members of staff across the Trust and shows the dedication and commitment to the quality of care delivered, alongside better financial diligence. In the same week, was the announcement of the departure of Dr Peter Reading who has led the Trust through this journey, but he was able to lead the presentation at the RSP exit meeting to members of the NHS England national board, alongside the NHSE regional team and ICB colleagues. There will be some interim support for transition from NOF4 to NOF3 to help with sustainability and progress on some areas, and this financial package of support is being finalized.

Changes in senior executive roles continue, with Jug Johal becoming the new interim Director of Estates and Facilities across NLAG and HUTH. A new joint chief executive has been appointed, Jonathan Lofthouse, and is due to commence in post on 14 August.

Following Peter's departure, there are interim arrangements in place to cover the role of Chief Executive, with a process to be undertaken later in June to provide consistent interim CEO cover until Jonathan's arrival.

There have been many other things ongoing in the Trust in addition to the high profile announcements, which will be detailed below, but one of the many highlights include the QI conference which was held at Forest Pines, attended by some Board members and Governor representation; it was hugely successful with many staff members presenting their own Quality Improvement initiatives, which ultimately help underpin the improvements that we are making in the organisation. The conference was opened by Dr Yvette Oade, regional medical director, who stayed for the whole day and who has been very vocal on a regional scale about the vision and energy shown by NLAG colleagues.

External Visits:

Last month, we received Humber Fire & Rescue Service inspections at both Scunthorpe General Hospital and Diana, Princes of Wales Hospital in May. The outcome of these inspections was that we have a few minor advisory comments which are already being actioned.

There was also a repeat visit by the Faculty of Medical Leadership and Management, who continue to support the trust with the vision and enablement of the clinical leadership and engagement. A report has been produced by them which reflects the tangible improvements they have observed over the previous 3 years of the organisational affiliation.

Workforce:

The Trust will be paying the Agenda For Change national pay award to staff non-consolidated pay element for last year (22/23) and then the consolidated element for this year 23/24. This will be paid at the end of June.

Junior doctor strikes continue with the next round 14th to 17th June, 2023. Planning is ongoing to ensure services remain safe during this period, as well as maintaining appropriate performance. The consultants are also being balloted for industrial action, and the ballot closes on 27th June, 2023. RCN have not accepted the national pay offer and are balloting their members for IA, with the ballot closing on 23rd June. The Trust has agreed to work with trade unions regarding their campaign to pay HCA staff that work to the national band 3 job profile to receive the band 3 salary. This may incur a cost pressure.

Performance update

Against plans submitted to the ICS for 2023/24 we have achieved 117% Trust Core ERF Actual Percentage during April 2023; this currently stands at 94% for May 2023 but there will still be outstanding activity to be cashed up which will improve performance.

As part of the outpatient transformation programme we have plans to reduce non-value adding activity including patients being seen several times as outpatient follow ups when not required to do so. This capacity will be reinvested to see patients who need to be seen as a new patient following a GP referral. We are using best practice models of care including GIRFT and other benchmarks to reduce waste and improve efficiency in our Theatres, Outpatients and Inpatient care.

We have no patients waiting over 104 weeks and 78 weeks for treatment in NLAG. We occasionally do get a breach of the target waiting times through our robust validation process that we process quickly, with the assurance that all other patients receive care in a more timely way and that our Patient tracking systems are accurate. We are currently partway through reducing our treatment waiting times to 65 weeks by the end of 2023/24; the Trust currently has 43 patients waiting over 65 weeks.

NLAG is not consistently meetings Cancer targets and all 9 Cancer Targets in April 2023 were missed. We are focused on improved waiting times for treatment, of which faster access to diagnostics and reporting are important elements in the cancer pathway and associated waiting times for treatment. In addition clinician capacity in NLAG and our partner tertiary centre HUTH are also has affecting waiting times for treatment. We have detailed pathway level plans in to improve access and care provided. In the next few months we are increasing our diagnostic capacity through the addition of two MRI scanners and increased CT scanning capacity to support cancer and other pathways of care . In addition the Community Diagnostic Centre in Scunthorpe will support quicker access to diagnostics once it becomes operational in quarter 4 of 2023/24.

With regard to improving urgent care we have met the agreed ICS performance trajectory for four hour performance in April and May 2023. Several initiatives including developing community services and capacity, optimising length of stay of inpatients and ensuring we have enough acute beds in our hospitals, will reduce the congestion in A&E and create a ‘pull’ in the system for patients to move through the hospital, back into the community. This involves system level engagement and team work and NLAG are working collaboratively to achieve this.

Our efforts to improve ambulance handover times have resulted in a reduction of ambulance crews waiting over 60 mins from 674 in March 2023 to 234 in April 2023. A combined action plan owned by the Northern Lincolnshire system is providing the leverage required to improve this further over the next few weeks.

Community Diagnostic Centre (CDC):

As mentioned at previous Board meetings, the Scunthorpe CDC has been approved by the Secretary of State and is currently at the Planning and Procurement stage.

The business case for the Grimsby has been submitted to the Regional Team for approval, and the National team for review. The case is for a “Spoke” in Grimsby in the Town Centre and is currently planned to have a primary focus on ophthalmology, ultrasound and pathology/diagnostic testing. The National Timescales for final sign off are currently not clear and any scheme approved must be able to have some services available from 1 December 2023 and be open by 31 March 2024.

New Hospitals Programme:

The New Hospitals Programme aims to support the rebuilding or redevelopment of hospitals with significant infrastructure issues and is the main plank for the delivery of the Governments manifesto commitment to delivering 40 “New Hospitals” by 2030.

The Trust submitted an application for £470m of capital funding to invest in the redevelopment of both Scunthorpe and Diana Princess of Wales Hospitals as part of the New Hospitals Programme on 9th September 2021. 128 applications were made to be part of the scheme. On 25th May 2023 the Secretary of State announced that the “final five” schemes to be part of the original 40, with the remaining 123 rejected. All of the five schemes selected are RAAC hospitals which have air blown unsafe roof structures.

The Government Press Statement highlighted that no further applications will be invited for the scheme and that it is likely that the new Hospitals Programme will become part of a rolling programme of capital investment. Many of the schemes allocated funding to date have experienced delays in receiving business case approval, enabling works funding and some have forecast build dates in excess of the 2030 deadline.

NLaG continues to experience significant issues with the overarching condition of its estate and has an identified gap of £107m to bring the condition of its estate up to the required standard. The backlog is growing at c10% per annum and the Trust has only a small amount of capital it can fund internally from depreciation.

We decided not to wait on building our case for change since our initial Expression of Interest and over the past 18 months have developed an Outline Strategic Case in support of our proposed capital investment plans. We will now revisit the assumptions within that plan and look at how we can potentially break the capital schemes up into smaller blocks.

Significant issues with our backlog maintenance and our critical infrastructure continue.

Digital:

We are in the processes of finalizing Outline Business Cases for Enterprise Document/Content Management Solution (EDMS) and the Electronic Patient Record (EPR). The current priority is the EPR as we are driven by timelines that align with the NHS funding allocation schedule. We expect that OBC to be complete by end of

June. It will then need to be approved by Executives and with a target of Trust Board Approval August 2023. We are doing a lot of work capturing benefits and pulling an options appraisal together that has integrity. We expect our first draft of all information pulled together week of June 12th. The EDMS OBC is scheduled to complete by Mid July

Humber Acute Services Review:

The Humber Acute Services Review is reaching a critical stage in its development. Over the past 2 years we have worked collaboratively with clinical teams, commissioners and partners to develop a Pre Consultation Business Case in support of our proposed changes for Urgent and Emergency Care and Maternity, Neonatal and Paediatrics. Over that time we have engaged with over 12,000 people and have undergone multiple challenge and assurance reviews.

We are now in the final stage of the Programme and have post evaluation agreed the potential options we will take to consultation. These have been subject to a recent Clinical Senate Review and we have received “Reasonable Assurance” , their highest rating, on all areas reviewed. The Clinical Senate have highlighted that our current models of care are not sustainable and that the proposed models offer an opportunity to deliver longer term sustainability.

A Consultation Institute Review of our engagement work to date has been undertaken, with review of the scope, scale and depth of our activities and they have noted they have no areas of concern as we progress to Consultation.

We now need to undergo a number of formal reviews to allow us to proceed to Consultation:

- Approval of the Integrated Care Board of the Options, Consultation Document and Narrative in support of the Programme
- Approval from an NHSE England Gateway review we can progress to consultation – this has a focus on quality, safety, estate and importantly has the final sign off for capital finance and revenue savings set out in the Pre Consultation Business Case
- Approval of a Joint Health Overview and Scrutiny Committee of the Consultation Document and Consultation approach.

Assuming approval from each of these we would propose to go to Statutory Consultation by September 2023. That would be a twelve week consultation.

Upon completion of the consultation, we will analyse the findings and conclude upon a preferred option to implement which will be set out in a Decision Making Business Case. The Business Case will require ICB approval prior to implementation of any change.

It is important to note that at any stage of this process we could be referred to the Secretary of State for an Independent Reconfiguration Panel Review or indeed to a Judicial Review. If that happens we will need to stop all work and await the decision of that group prior to proceeding.

Summary:

As can be seen from this high level briefing, it is clear that there are a large number of significant change programmes occurring across the Trust being led by the executive colleagues, and across the evolving group structure, with impact across our Places and ICS. Focus is still maintained on our performance and quality of care delivery for our patients, and our staff will continue to need significant support over the next few months as we move towards a group operating model, to ensure that we continue our nationally recognized improving trajectory as we progress out of NOF 4 into NOF 3 with an aspiration to move towards NOF2.

I would like to thank all the executive colleagues for their support in pulling this briefing together, and also to thank Peter for his commitment to the Trust for the past 6 years and wish him all the best for the future.

NLG(23)093

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 6 June 2023	
Director Lead	Acting Chief Executive	
Contact Officer/Author	Acting Chief Executive	
Title of the Report	**Trust Priorities 2022-23 – End of Year Report on Performance**	
Purpose of the Report and Executive Summary (to include recommendations)	The report summarises how the Trust performed in 2022-23 against the Priorities agreed by the Trust Board. It is presented for discussion and noting.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Team
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	EDI and Health Inequalities are covered in the Report	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Priority		
1.	Our People	**We will further develop how we seek to attract and recruit new staff:** **Developing an overall Recruitment Plan to attract staff to a range of roles across the trust, including hard to fill clinical roles, resulting in less reliance on bank and agency staff** Recruitment continued across all staff groups at a further increased rate. 22/23 saw an increase of 15% in recruitment activity compared to the previous year with 1,960 headcount (1,046 WTE) starting compared to 1,700 headcount the previous year. Robust workforce plans were developed based upon workforce data which included current vacancy levels, leavers and talent in our local regional national and international pipeline for all clinical groups. Recruitment plans were then developed and implemented across all Divisions and services. In addition, a recruitment KPI dashboard was implemented for use at PRIMs and Workforce Committee to review performance against targets. An increase in establishment of 244 WTE in April 2022 impacted the vacancy position considerably. This primarily affected clinical roles, with increases in establishment for registered nursing (113 WTE), unregistered nursing (81 WTE), and medics (18 WTE). Although the vacancy position does not appear to have reduced in year because of these increases in establishment, there are significantly more substantive staff in post in March 23 in comparison to April 22. These include registered nurses (100 WTE more staff in post), unregistered nurses (122 WTE more staff in post), and medics (25 WTE more staff in post). This was achieved through various projects including: • International nurse recruitment – NHSE targets exceeded with 91 starting by December 2022 • Newly Qualified Nurse recruitment – internal target exceeded with 89 starting • Innovative recruitment process for HCA recruitment, including new to care candidates, recognised regionally and nationally as best practice – large numbers appointed on an ongoing basis to maintain a pool of candidates for quicker deployment **Reviewing our recruitment practices to ensure that they are fair, inclusive, responsive and provide a positive candidate experience.** • The establishment control process has been streamlined • Occupational Health clearance process improved with candidates cleared to work with immunisation and vaccination follow ups • Recruitment and Selection training strengthened to include further information on roles, responsibilities and bias • Communication of metrics and performance via IPR and KPI dashboard • Equality and diversity representatives implemented on interview

Priority		
		panels • Equality and values based recruitment questions included as standard in interview templates • Changes to recruitment paperwork • Significantly amended recruitment process for HCAs, recognised across region and nationally as good practice **Developing new roles (including nurse apprenticeships) to attract staff and support existing workforce shortages.** • Registered Nurse apprenticeships introduced alongside the nursing career pathway • Medical Specialist roles introduced • Medical Support Workers introduced with NHSEI support • Apprenticeship roles introduced within AHP areas **Increasing flexible and hybrid working opportunities clinically and non-clinically for our new starters.** • Reviewed the current flexible working (FW) policy to enable employees to request FW from day 1 of employment in line with NHS T&Cs and implemented August 2022 • Continued promotion of the current flexible working policy through information to managers and employees via Trust communications and line manager training. • Key Trust stakeholders have been engaged as part of the FW project group to enable continued homeworking post covid. • An online FW system has been developed that will provide FW baseline data as well as offer a better candidate and manager experience. Due to the current localisation and paper-based process, the Trust doesn't hold any FW data. As a result, the full impact will be evident in 2023/24. **We will develop and care for our own staff:** **Implementing a nursing career pathway which offers development opportunities for new and existing staff utilising our apprenticeship levy wherever possible** • The nursing / clinical career pathway has been developed and implementation began in 22/23, forming part of the information, advice and guidance provided at the newly introduced career clinics. • Nursing Apprenticeships launched and are now live recruiting through both internal and external campaigns • The pathway incorporates Level 2 Functional Skills in Maths and English at its base to ensure candidates are fully prepared for the requirements of the HCA apprenticeship standards (the beginning of the journey for many existing staff) • There are, then, a range of apprenticeship-based pathways to follow depending on career goals at different levels and in different clinical areas (i.e, nursing, AHP, ACP and clinical leadership). • At year end there were 171 active apprentices across the Trust in all areas.

Priority	
	Exploring opportunities with partners, to introduce new clinical roles that would enhance our clinical workforce. As per the above update re new roles **Reviewing our approach to flexible, hybrid and retire and return to meet individual needs in order to retain key staff wherever possible.** As per the above update re flexible working **Continuing to raise awareness of and expand access to health and wellbeing services for staff.** • Current internal well-being offer continues to support our people. Scoping is being carried out with Humber and North Yorkshire ICB regarding a regional coaching network led by OD Business Partner for Culture and Engagement. • Current internal well-being offer continues to support our people. Scoping is being carried out with Humber and North Yorkshire ICB regarding a regional coaching network led by OD Business Partner for Culture and Engagement. • Unions have joined the EDI/HWB leads in 2022/23 at a variety of engagement events (around 2 a month) including Men's Health Week, Pride flag raising and Grimsby Pride • Health and Wellbeing sessions have been developed and are included in both the People Leader Induction and Core Skills training and further work is awaited. • Swartz rounds have been developed and launched across the Trust for continuous support and development. • Significant engagement work has been carried out through a range of Wellbeing Hub Events and mobile Hub visits, with around 1000 conversations having taken place and soft intel used to respond to the challenges faced by staff i.e. – increased comms surrounding Menopause. • An engagement tracker has been developed and is in use to track numbers of individuals engaged and emerging themes. • Scunthorpe and Grimsby onsite counsellors have been introduced to give staff access to quick access support. • Maximus are now incorporated into the Trusts disability staff network enabling reasonable adjustments to be improved. **We will continue to improve our culture and staff engagement within the Trust:** **Conducting a culture diagnostic exercise to understand better what matters to our staff** Complete with support from Clever Together and NHSEI **Resulting actions included:** • Flexible working policy and hybrid working policy • Disability at work policy for accessibility and work adaptions • Promotion of our training and development offering and access to career pathways and apprenticeships • Monthly managers email communication newsletter • Branding across the Trust to highlight our Values

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	• Value based leadership and compassionate leadership development programme • Anti-Bullying and harassment training • Strong partnership with Trust trade unions These actions are now monitored via the Trust Culture Transformation Board **Further embed Just and Learning Culture (JLC) practices** • Comprehensive manager guidance and training launched and remains under review to develop best practice • Implemented the Just and Learning framework into line manager training • JLC has reduced the levels of formal case work by 93% • Significant reduction in time taken to deal with those cases that progress formally • Improved well-being - deal with incidents that focus on understanding, learning and improvement not blame, but ensuring accountability is maintained. **Designing and implementing a 3-strand Leadership Development Strategy** The “3 strand” or “3 tier” Leadership development strategy was implemented at the end of 2022 that focused on: • People leader induction: a series of workshops and online or face to face sessions that provides all the necessary skills to thrive in their first 90 days in the Trust. • People LIDA – individual assessment to highlight personalised development pathway leading to self-directed learning • People leader pathway – a blended programme of online and face to face courses for leaders to develop skills across all management and leadership competence • Access to leadership and management qualifications via apprenticeships: CMI, CMDA and SLMDA level 3/5/6/7. People leaders now have the opportunity to gain a nationally recognised qualification; maximising our apprenticeship levy. • Value based leadership development programme: procured and piloted Dec 22-April 23. The programme will continue throughout 2023 with 6 more cohorts with a full roll out at a rate of one cohort a month in 2024 onwards. **Strengthening our efforts to increase and celebrate the diversity of our workforce, developing strong staff networks to ensure an inclusive employee experience for all staff.** • **4 staff networks now established:** Black, Asian and Minority Ethnic (BAME) staff network, the Lesbian, Gay Bi-Sexual and Transgender + (LGBTQ+) staff network, the Disabled staff network and the Menopause staff network. • Internationally educated staff network established to explore cultural understanding

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		• Staff networks actively utilizing social media • EDI staff capacity increased in year to further support the development of staff networks and to understand and address challenges Commencement of a disability policy to support disabled individuals within the workplace
2.	**Quality and Safety**	We will improve safety on the following six Trust Quality Priorities: 1) Mortality Improvement - focusing on care at the end of life, we will reduce the number who die within 24 hours of admission and reduce emergency admissions for those in the last 3 months of life. a) Reduction in the number of patients dying within 24 hours of admission to hospital ✓ Statistically significant progress. The number of patients dying within 24 hours of admission to hospital has decreased year on year from 249 in 2020-21, to 201 in 2021-22 and 193 in 2022-23. b) Reduction in the number of emergency admissions for people in the last 3 months of life ↔ No statistically significant change. Common cause variation with 181 emergency admissions for people in the last 3 months of life in March 2023 compared to 208 in March 2022 and 202 in March 2021.Case reviews of patients who die within 24 hours of admission or who are admitted to hospital in the last 3 months of life have been undertaken alongside community and primary care partners to discuss the quality of care provided and identify gaps in provision of services or pathways that could have enabled patients to die in their preferred place. This work continues and requires further collaborative work with external partners to avoid admission, with end of life recognition and support requirements. c) Reduction in the out of hospital Standardised Hospital Mortality Indicator (SHMI) to 110 ↔ No statistically significant change. The out of hospital SHMI rolling 12 month position remains high at 140.1 in August 2022 compared to 138 in April 2022, 125 in April 2021 and 143 in April 2020. The proportion of patients having input from a Palliative Care Team is lower than other organisations, particularly in North East Lincolnshire (NEL), with continuing challenges with commissioners' trying to recruit suitable candidates. Other relevant SHMI data shows that we have 60% of our SHMI deaths taking place in hospital, 40% out of hospital. The England average is 70/30. Palliative care coding is another persistently lower than expected element, which could also be a factor in the numerator and denominator splits. This may also link to recognition in the community being low and is therefore out of our immediate control. Towards the end

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	of last year there were some reviews by NEL GPs auditing a sample of cases who were end of life and admitted, which they all felt were appropriate attendances. There is more work needed collaboratively to understand this aspect. Further to this, there is significant sustained improvement in the overall SHMI, with the latest data (12 month period up to December 2022) showing the Trust at 102.79, which is within the 'expected range' and at rank 51 of 121 acute NHS Trusts. The Trust continues to focus on improving End of Life (EOL) care, including a Quality Improvement Always Event in March 2023 which engaged frontline clinicians in articulating change ideas focused around: • The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care. • Appropriate use of the Last Days of Life pathway which underpins evidence-based care. • Timely recognition of EOL. • The themes and learning identified from this work will be carried forward and developed further in 2023/24 as part of the Trust's End of Life Quality Priority and on-going quality improvement projects. 2) Deteriorating Patient - in line with the CQUIN to improve safety, we will ensure we observe NEWS2, escalate when it is high, and respond with treatment. a) 90% of patient observations recorded on time (Adults). ✓ Target achieved for adult observations recorded on time with mean 90.55% and median 90.69%, monitored through the Deteriorating Patient and Sepsis working group. b) 90% of patient observations recorded on time (Paediatrics) ↔ No statistically significant change for Paediatric observations recorded on time. The target was met or exceeded for 6 out of 12 months and achieved 100% in August 2022. However, overall, no statistically significant difference, as remained below target with 75% recorded in March 2023 and April 2022. The mean value was 84.37% and the median was 86.62%. c) Escalation of NEWS in line with policy ↔ No statistically significant change with 3% in February 2023 compared to 0% in April 2022. The measurement of this metric includes 3 different criteria, timed to optimise escalation to relevant personnel and appropriately timed ongoing monitoring. The sample size is small and variable compliance is seen in all 3 elements, resulting in a very low overall

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	compliance. The Trust achieved the financially incentivised CQUIN CCG3 recording, escalation and response to NEWS2 for unplanned critical care admissions achieving over 80% in each quarter against a target range of 20 to 60%. d) 90% of patients have a clinical assessment undertaken within 15 minutes of arrival in ED ↔ Whilst the target was not met there was no statistically significant change with 47.4% recorded in March 2023 compared to 44% recorded in April 2022. 3) Sepsis - we will focus on improving sepsis six screening and the response within 1 hour. a) 90% of patients screened for Sepsis. ↔ Whilst the target was not met there was improvement from 40% of adults screened in April 2022 to 57.89% screened in February 2023. Similarly, an improvement in paediatric screening from 25.92% in April 2022 to 40% in March 2023. b) 90% of patients who had the Sepsis six completed within 1 hour for patients who have a red flag. ↔ 0% of adults had documented evidence of all the elements of Sepsis six being completed within 1 hour. Paediatric patients improved from 21.42% in April 2022 to 42.1% in March 2023. The Trust has a working group focused on Deteriorating patients and Sepsis. A series of educational activities and information provision have been introduced, to target the improvements needed. 4) Medication safety – we will improve the recording of patient weights, reduce medication omissions and improve appropriate antibiotic prescribing. a) Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA of WebV. ↔ No statistically significant change with common cause variations between 61.62% in April 2022 to 70% in March 2023 and peak of 78.57% in May 2022. b) Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV. ✓ Target achieved. Significant improvement from 13.13% in April 2022 to 56% in March 2023. c) Reduction in medication omissions without a valid reason for ward areas using EPMA.

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		✓ Target achieved. Sustained low percentage of omissions over the past 16 months and achieved reduction from 1.9% in April 2022 to 1.4% in March 2023 compared to 13% in August 2021. 5) Friends and Family Test and PALS - these are key to patient experience so we will aim to respond to 70% of PALS in 5 days by the end of the year and improve response rates in the Friends and Family test so we better understand what our patients want. a) 70% of PALS concerns are managed within timescale (5 working days). ↔ No statistically significant change. 62.85% of PALS concerns trust wide were closed within timescale in March 2023 compared to 62.5% in April 2022. b) To improve the Friends and Family response rates (Inpatient 40%, ECC 20%, OPD 4%, Community 5%, Day case 25%). ↔ Although the FFT response rates for the 5 areas has not increased in line with the ambitious target percentages identified, overall, the Trust FFT response rate has increased by 51% between September 2022 and February 2023. 6) Safety of Discharge - focusing on seamless safety across organisation boundaries, by improving the timeliness of discharge letters and helping ensure hospital beds are for those who need them by improving the speed of discharge once a patient is well. a) 86% of Discharge letters completed within 24 hours of discharge. ✓Target achieved with an annual mean of 89.42%. b) 50% Outpatient Clinic Summary to be sent to the patient's General Practitioner within 7 days of the appointment. ✓Target achieved in most recent months with 70% in March 2023 compared to 30.26% in April 2022. c) Improve the proportion of patients discharged before 12 noon to 30%. ↔ No statistically significant change with 16.56% in March 2023 compared to 18.01% in April 2022 and 16.56% in April 2021. d) Improving trend showing a 12%reduction in length of hospital stay 21 days. ↔ Fluctuating performance but overall below the national average and the Trust is one of the best performing trusts in the region. Lowest value 7.83% achieved in week commencing 20 June 2022. We will continue to implement and embed actions flowing from CQC inspection in 2019 and take all necessary action in response to any further inspection(s) in 2022-23.

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	The Trust was inspected by the CQC in July 2022, with a report provided to the Trust in December 2022. As a consequence of the inspection report recommendations, a new action plan has been developed with progress being taken forward through the action plan assurance processes. Historical action plan points have been through a compare and contrast exercise, with the 2019 and 2022 inspection reports, resulting in a consolidated action plan, with closure of several actions assured through positive feedback from inspectors. Internal Audit have provided a Significant Assurance rating on the CQC Action Plan Assurance process during Q4. We will improve safety by sharing key learning through multiple routes to enable the messages to become embedded. During 2022/23, a range of measures have been used to share learning, including learning forums, newsletters, safety bulletins, simulation, and sharing of learning through team meetings, various governance meetings, also feeding into quality improvement initiatives. As part of the implementation of the national Patient Safety Incident Response Framework, alignment of our Learning Response is being taken forward with the revised arrangements planned for introduction in the autumn of 2023. We will continue to participate in national audit and act on national and outlier alerts, and ensure we keep our services up to date by reviewing and changing practice based on best practice guidance from NICE. ✓Processes to monitor engagement of national audits are taken forward with the Clinical Audit Forward Plan. All relevant Audits that the Trust can contribute to have been undertaken and this is reported in full in the Quality Account. ✓There have not been any outlier alerts in 2022/23, with monitoring of historical alerts being reported quarterly. ↔ NICE gap analysis and compliance has an overall compliance rate of 88% against a target of 90%. We will continue to develop and implement our Trust-wide Quality Improvement (QI) collaborative approach, with a particular focus on the use of the discharge lounge, document reassessment of pain, the safe storage of medicines and the number of staff trained in QI methodology. ✓The use of the discharge lounges at DPOW and SGH has increased from 13% of discharged patients to 30%, with all ward teams, operations team and the Discharge Lounge teams, with leadership from senior nurses. ✓Pain assessment and reassessment can now be demonstrated through documentation on WebV, with rates of digital documentation moving from 32 per week, to an average of 557 per week. ✓Safe and secure storage of medicines audits show 84.49% compliance in March 2023. ✓656 staff have been trained in Quality Improvement, the majority of those, 377 accessing Applying QI, and 214 accessing Introduction to QI. The Medical and Dental staff group accessed the most

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		training, 327 of those being training doctors accessing across the ICB as well as NLAG trainees. We will meet the seven actions following the Ockenden Report Part 1 and new actions following the publication of the final report. ✓The Ockenden Part 1 action plan is complete ✓All immediate actions required from Ockenden Part 2. We will prepare the organisation for the changes to statutory Liberty Protection Safeguards (due summer 2022). The Liberty Protection Safeguards have not been implemented yet, with latest reports from the Department of Health and Social Care suggesting that this will be delayed beyond the life of this Parliament, therefore potentially beyond Autumn 2024. Despite this, there is a focus on formally assessing patients' Mental Capacity and appropriate assessment of best interest decisions, and where appropriate, applications to the Court of Protection are taken. We continue following the Deprivation of Liberty standards and applications are made as appropriate. We will continue to ensure compliance with Safe Staffing requirements in line with national workforce safeguards. The Chief Nurse establishment review has been undertaken for 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 have been held with ward and department managers to review the SNCT data and nurse sensitive indicators. Midwifery staffing is also monitored and reported through the Chief Nurse Office safe staffing processes, with escalation process embedded and OPEL status reporting for the service. The Guardian for Safe Working continues to engage with training doctors, offering support and linking with the Chief Medical Officer Office. We will continue to maintain the highest standards of Infection Prevention and Control. ✓The Trust has maintained better than average performance across all alert organisms, with top quartile performance on C-difficile and zero cases of MRSA bacteraemia.
3.	**Restoring Services**	• We will **increase the number of people we can diagnose, treat, and care for in a timely way** through doing things differently, accelerating partnership, and making effective use of the resources available to us, across health and social care. This will include offering our facilities to provide 'mutual aid' to neighbouring trusts if their waiting times are longer than ours.

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	The Trust has accepted 515 mutual aid referrals throughout 2022/23 and treated (clock stopped) 670 mutual aid patients, the discrepancy being the mutual aid patients referred prior to 1st April 2022 but treated within 2022/23. The Trust has also discharged 122,942 patients during 2022/23 which is 11,319 higher than 2021/22 when there were 111,623 discharges. During 2022/23 there was 159,975 Outpatient New Appointments and 327,169 Outpatient Follow Up Appointments carried out which is an increase from the 154,268 Outpatient New and 325,891 Outpatient Follow Up Appointments in 2021/22. • By keeping our patients safe, offering the right care, at the right time and in the right setting we will deliver **10% more activity** in 2022/23 when compared to levels of activity in 2019/20 ▪ Reduce the backlog of patients waiting for care in the Trust from 28,000 to 9,000 and reduce the number of patients waiting above 40 weeks to 400 by March 2023. In addition, **reduce long waits** for treatment by reducing patients waiting above 52 weeks to zero by June 2022. The Trust was well on target to deliver 65ww and reduce both 52 and 40ww. However, as NLaG increasingly work as a system, rather than a standalone Provider it is crucial that NLaG supported our Partner Trusts in the ICB to ensure that those patients waiting the longest are treated first. NLAG have treated more than 1,000 patients through the mutual aid scheme, which has had an impact on the trusts shorter waiters. Nonetheless, NLaG have managed to deliver the 78w target at the end of March, albeit for a handful of patents who were transferred in late February. The continuous pressure on the operational teams to treat long waiting patients and respond to emergency care, has had an impact on the ability to reduce NLaG's follow-up waiting list. However, the trust has still seen a reduction in the overall follow-up list when compared to the same time last year, and there has not been a significant rise during the COVID period. System changes in how NLaG manage the emergency patients is also impacting our follow-ups, which is masking some of the good work the teams are doing in reducing the traditional out-patient follow-ups. ▪ By March 2023, increase **Patient Initiated Follow-Ups** (PIFU), Advice and Guidance (A&G) services and support the reduction of unnecessary Follow Up appointments by 25% PIFU has now become an established suitable alterative to routine follow-up. Although we have not hit the % we set out to achieve at the beginning of the year, we have increased use to a healthy 2% in March 2023. This has been a steady increase month on month, demonstrating sustainable delivery. Progress is being seen across all relevant specialists, breast surgery is at 10%, Paediatric Epilepsy 7.6%, Upper GI and Paediatrics at 5%, Trauma and Orthopaedics 4.37%, Gastro

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		and Colorectal is circa 3%. The use of A&G has also seen a steady rise over the previous 12 month with requests increasing from 5.5% to 7.77%, which is reflective of the system approach being undertaken in primary care. Response times have also improved for both the 48 and 96 hr targets. Focus is now on the quality of requests and responses to increase usage further over the coming year. The use of a Referral Assessment Centre has seen a demonstrable increase in post referral advice, enabling NLAG to deliver on the system target of 16%. ▪ Improve performance against **cancer waiting times** standards ▪ 62-day performance – make a 3% improvement in each quarter from April 2022 The 62-day performance has remained relatively static throughout the year and this has been in large due to the capacity at both NLaG and HUTH. However, the 62-day backlog has improved from 126 patients in March 2022 to 103 in March 2023. The achievement of this internal standard has been impacted by several issues including the deterioration of backlog from May to September 2022; resulting in more than 200 patients waiting more than 62+ days sept/oct (75% of which were awaiting diagnosis). With the greatest volume of patients over 62+ days without diagnosis, this increases the probability of a breach with around 50% receiving a cancer diagnosis beyond Day 62. Current conversion rate to cancer is 5% meaning that around 5 patients over 62+ days without diagnosis are likely to have cancer. This cohort of patients beyond 62 days without diagnosis has been a major impact on the Trust ability to reduce breaches and improve performance. Increased oncology waiting times for consultant oncologist 1st appointments in all specialties are now waiting 4+ weeks for an appointment with the consultant oncologist to determine if oncology treatment is the most appropriate. This means that from diagnosis (even by Day 32) an additional wait of +28 days (to Day 60) results in increased breaches. Often staging scans need to be repeated before treatment can take place which further increases the waiting time. ▪ 31days performance and Faster Diagnosis Standard – meet the standard consistently by March 2023 The 31-day Diagnosis to First Treatment performance has been above 90% in all but one month of 2022/23 but has only met the standard on 4 occasions. This is

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		entirely due to capacity/patient compliance/cancellations. The 28-day Faster Diagnosis pathways has not met the standard of 75% during 2022/23 but has improved from 69.6% in March 2022 to 70.4% in March 2023. Compared to Apr 22 (by tumour site) there has been significant improvement and consistency of achievement. Colorectal/Upper GI were below 50% in May 22 and both achieved 63% in February 23 (March figures are still being validated). All tumour sites are now above 60% with Breast (82%), Lung (78%), and Urology (75.7%) achieving and Gynae (74.9%), close to achieving the standard. Colorectal and UGI have improved across the year following changes being made to the diagnostic pathway, e.g. introduction of STT (Colorectal) and Upper GI due to go live soon. ▪ Joint Clinical Director for cancer HUTH/NLAG to be recruited by July 2022, and single management structure in place by September 2022 The joint Clinical Director for Cancer has been appointed in January 2023. Work is ongoing to develop options for a single management structure and a further paper is due to go to Humber Cancer Board in April. The agreed position from February Humber Cancer Board is that work to achieve some consistency between the 2 Trusts will need to take place, the first step of which is the centralisation of the management of the Cancer Tracking Team at NLaG but this is dependent on the Cancer Service Manager post being made permanent – it is fixed term until September 2023. ▪ Join cancer services with HUTH by March 2023 for lung, upper gastro-intestinal, head and neck, skin, and oncology Although progress has been made in this area there is still work to be completed for joint cancer services in lung, upper gastrointestinal, head and neck, skin and oncology. **Lung** – the single MDT has been delayed due to workforce constraints (ability of radiology to support the single MDT). **Oncology** – there is a piece of work being undertaken by the Cancer Alliance to improve oncology with a dedicated project manager (hosted by the alliance). There is already, in essence, a single oncology service as the service is provided by HUTH. **Upper GI/Head & Neck –** there is joint work underway looking at the pathways starting in NLAG and being treated in HUTH. This is ongoing due to engagement issues with some clinicians. **Skin** – service transferred to HUTH Nov 22.

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		• Cease having any **patients waiting for 12-hours** or more in our emergency departments by March 2023. Not Achieved – There has been a rise in attendances for DPOW (18%) and SGH (10%) as per the SEDIT data when looking at the last 2 years. Both hospitals are outliers within the Integrated Care System as the attendances at all other hospitals within the region have remained static. A rise in attendances, patient flow issues and lack of community services support in the area NEL/NL for frailty, urgent care response and falls, that leads to increased attendances and more dependent patients not possible to turn around leading to longer stay and bed blocks. This has led to patients remaining within the ED department for more than 12 hours awaiting admission. Although we have patients staying in ED for more than 12 hours, senior review, diagnostics, nutrition, treatment, critical drugs and care is provided for these patients by ED and specialty teams as it would be in assessment areas. • Significantly improve the number of patients waiting to be admitted to wards from the emergency department within one hour. Not Achieved – As per the 12-hour waits, the rise in numbers and patient flow means that patients are remaining within ED for prolonged periods of time • Maintain utilisation of **Same Day Emergency Care** (SDEC) above national average and at 40% The Trust has continually maintained this target throughout 22/23, hitting a high of 54.01% in February 2023. The activity continues to increase through both the Same Day Emergency Care units, with over 2000 new patients being seen per month. The trust has embedded extended opening hours, adapted working models and implemented direct access pathways for GPs and EMAS, as well as electronic referrals from Single Point of Access. • Significantly reduce the time **ambulances** wait in our current emergency departments to **handover** care to achieve the following ▪ 65% of handovers in under 15 minutes ▪ 95% of handovers in under 30 minutes ▪ No handovers waiting more than an hour Not Achieved – As per the 12-hour waits, lack of patient flow has contributed to ambulance handover delays within both ED departments. Mean Ambulance Handover times have improved with the introduction of the RAT Model in the new ED at DPOW and it is believed that the same improvement will be mirrored in SGH now it is open.

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		The Ambulance Handover and Patient Flow Improvement Plan has been combined for 2023/24 to enable an "admission to discharge" view to be taken in relation to patient pathways. This also includes Community Services, Primary Care, Mental Health and Ambulance Services. A whole system partnership approach for 23/24 will support discharge and flow and will enable improvements in ED performance against targets. During 2022/23 the trust managed 25% of ambulance handovers within 15 mins and 53% within 30 minutes. • Open our **new Emergency Departments** in July 2022 for DPOW, and in early 2023 for SGH The new ED in Grimsby opened in October 2022 and this has been followed by the opening of the new ED in Scunthorpe during March 2023. The old ED at Grimsby has had its renovations started for the new IAAU/SDEC area and at Scunthorpe the surveys of the area have begun. o Improve the responsiveness and increase the capacity of **community care** to support timely hospital discharge ▪ Achieve full geographic coverage urgent community response - 8am to 8pm, 7 days a week and cover all 9 clinical conditions or needs of the national 2-hour guidance Community Services are fully achieving full geographic coverage for the urgent community response - 8am to 8pm, 7 days a week and cover all 9 clinical conditions or needs of the national 2-hour supported by our community response GP and unscheduled care team ▪ Improve productivity and reach more patients under 2 hours to exceed the minimum 70% threshold of people seen within 2 hours by December 2022 Community Services are reaching more patients under 2 hours to exceeding the 70% threshold with an average of 95% of patients reached within 2 hours which has been sustained for over 12 months ▪ Complete the comprehensive development of virtual wards (including hospital at home) towards a national ambition of 40-50 virtual beds per 100,000 population by December 2022 Comprehensive development of virtual wards taken place with both Frailty & Acute Respiratory Illness virtual wards live and operating at 95% occupancy
4.	**Reducing Health Inequalities**	• We will work at system level to reduce pre-pandemic and pandemic related Health Inequalities, using related waiting list data that is

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		embedded within performance frameworks to measure access, outcomes, and experience for Black Asian and Minority Ethnic **(BAME) populations and those in the bottom 20% of IMD (Index of Multiple Deprivation)** scores. • NLAG elective waiting lists have been analysed and current average waits of patients who are BAME show no variation of wait against those that are not BAME. • The split of ethnicity in the population against the waiting list is similar, however data sources for ethnicity are less reliable due to old census data. • Our patient services team are working on improving data quality to improve the quantity and quality of data collected on BAME patients seeking and receiving the services we provide. • We will improve the length of stay for patients who have **alcohol dependency** from North-East Lincolnshire (identified as an area of additional need) and provide support to manage and improve their health in the long term. • Provided 7-day services for patients in North east Lincolnshire. • Recruited a Care Navigator to support the team and therefore, increased the clinical time available to patients • **We will provide additional support and treatment to tobacco dependent inpatients, high risk outpatients, and pregnant women under our care by providing tailored behavioural change support and access to Nicotine Replacement Therapy in a smokefree environment.** • We provide vaping starter kits to patients accessing our services who have opted for 'Swap and Stop' support. This is incorporated into the government's ambition to provide one million smokers with starter kits to accelerate the 2030 target of reduce smoking prevalence to 5% or below. New marketing resources will be developed to promote our services and our smokefree status in media formats that will appeal to the most deprived part of our smoking population. • Tobacco dependency treatment services to support patients admitted to our hospital sites via wards and assessment centres are now fully established. • A enhanced staff offer to support to Northern Lincolnshire and Goole NHS Foundation Trust staff who want support to quit smoking has been implemented across the Trust hospital sites as a pilot and will run until March 31st 2024. This staff offer provides Nicotine Replacement Therapy, Vaping Starter Kits and Behavioural support from trained Smoking Cessation Advisors. The emphasis of the staff offer is on routine and manual staff, but

		referrals are also taken from all staff groups. This includes an offer of support to all new starters via occupational health. • Our **maternity services** will prioritise those women most likely to experience poorer outcomes, including women from Black Asian and Minority Ethnic (BAME) backgrounds and women from the most deprived areas, by developing and implementing targeted incentive schemes supported by the Humber and North Yorkshire Integrated Care Board (ICB) Tobacco Dependency Group. • Continuity of Carer teams continued in Northeast Lincolnshire centring on women living in most deprived areas who are likely to have poorest outcomes. Plan to continue to roll out teams as midwifery staffing allows. • Humber & North Yorkshire Equity and Equality plan shared across Local Maternity and Neonatal Systems (LMNS) footprint • Tobacco Dependence Advisors working well within Maternity services – North East Lincs at Diana Princess of Wales Hospital and are rolling out these services across North Lincolnshire (Scunthorpe General Hospital) and East Riding (Goole Hospital) • Positive initial data with downward smoking trend amongst pregnant smokers. NRT now available for advisors to provide. Funding from The NHS Plan has been made available with incentives to stop smoking being explored. • The 'Healthy Lifestyle' service has been rolled out across all sites with weight management provided for pregnant women. • A regional incentives plan has been completed to support pregnant smokers from Black Asian and Ethnic Minorities and local areas of deprivation. If approved by the Integrated Care Board (ICB), it is anticipated that the NLaG Maternity Tobacco Dependency Treatment Services will lead a pilot with £240k requested to support the project. • Re-commenced work with Lincolnshire Local Maternity and Neonatal Systems– focusing on reducing smoking / increasing breastfeeding rates. • We will focus on ensuring that **patients with learning disabilities or autism** suffer no additional disadvantages in accessing care. • For patients with learning disabilities or autism, we have identified no additional disadvantages in accessing care that we provide. • We currently flag with patients with LD or autism on our Clinical and administrative systems; currently this is a manual process when a patient attends a service. Discussions are underway with our PLACE teams to support receiving this information from GP held LD registers to allow us to be proactive in our approach to caring for these patients both as inpatients and outpatients.

Priority		
		• Inpatients with a flag are identified from Web each morning and visited on the wards to ensure all the correct documentation and reasonable adjustments are in place for the patients • Vulnerabilities ward rounds take place twice weekly to identify patients who haven't got a flag on WebV to ensure all patients receive the appropriate care and adjustments • Complex patients coming for elective procedures are referred to the learning disability liaison nurse to facilitate reasonable adjustments prior to admission and ensure a smooth patient journey. • The team work closely with partners in both North and North East Lincolnshire teams to ensure that processes in NLaG aligns well with the strategies and plans progressing in the wider health and Social care community.

5.	**Collaborative and System Working**	• We will develop and implement plans to align further our organisations and services with those of Hull University Teaching Hospitals (HUTH). This will include the Humber Acute Services Review (HASR).
		
		• Programme 1 – Interim Clinical Plan transferring to Humber Clinical Collaboration Programme from April 2023:
		  • 4 strategies developed (neurology, haematology, oncology, ophthalmology)
		
		  • Stocktake review and clinical engagement programme commenced April 23 to reflect potential changes as part of group structure
		• Programme 2 – Core Service Design:
		  • Evaluation of the proposed models of care for U&EC, Maternity, Paediatrics and Neonatal completed, pending financial validation
		  • Draft Pre-Consultation Business Case in process of being finalised for ICB approval
		  • Pre-consultation engagement continues internally and externally
		  • Clinical Senate final review complete
		  • The Consultation Institute engagement process commenced
		  • Overview and Scrutiny Committee briefings undertaken
		  • Alignment and engagement with Out of Hospital programmes
		
		• We will play a full part in the work of the **Humber and North Yorkshire Health and Care Partnership**, including the Humber Partnership Board, the Acute Collaborative, the Community Collaborative, the three Place-based partnerships of North and North East Lincolnshire, and the East Riding of Yorkshire, and associated clinical and professional networks.

Priority		
		• Continuous, full involvement in all these parts of the HNY HCP, except the Humber Partnership Board, which no longer exists. • We will play a full part in other **national and regional networks**, including professional, service delivery and improvement (e.g. GIRFT), and operational. • NLaG is actively engaged across the North Yorkshire and Humber ICB as well as with both the regional and national GIRFT teams to progress GIRFT agenda including High Volume Low Complexity (HVLC), theatre utilisation, pre-assessment, Anaesthetic Assessment, outpatient GIRFT and Right Place Right Procedure (RPRP). The Trust is involved in a clinically led manner with the work led by Professor Tim Briggs across the system. There is representation from the GIRFT regional team in the regular NLaG GIRFT steering Group. • We will work together with partners across the integrated care system (ICS) to develop our approach to **population health management and prevention**. This will allow our population to play a more proactive role in promoting good health, targeting interventions at those groups most at risk, supporting health prevention and treatment. • Aligning with HAS programme and future Planned Care framework
6.	**Strategic Service Development and Improvement**	With partners in the **Humber Acute Services Review**, we will: • Submit a **Pre-Consultation Business Case** (PCBC) to NHS England in May 2022 for the delivery of new models of care for Urgent & Emergency Care, Maternity, Neonates & Paediatrics, and Planned Care & Diagnostics; • PCBC draft completed • Timescales for submission changed at instigation of the HNY Integrated Care Board – due for submission to ICB Board Q1 2023/24 • Monthly NHSE assurance reviews continue • Gain approval to launch a **Statutory Public Consultation** during Quarters 2 & 3 of 2022-23; • As per ICB timescale change (above), Statutory Public Consultation revised to Q2/3 2023/24. • Deliver a **Decision-Making Business Case** based upon Consultation Outcomes by Dec. 2022; • As per ICB timescale change, Decision-Making Business Case revised to Q4 2023/24. • Commence implementation of the **planned models of care** in Q4

Priority		
		2022/23. • Interim clinical plan transitioning to Humber Clinical Collaboration Programme as part of Group structure with HUTH. • Aligning to the development of the H&NY Planned Care Strategy framework, building upon elective recovery and operational planning submissions for future opportunities.
7.	**Finance**	We will achieve the Trust's 22/23 Financial Plan The Trust achieved its Financial Plan for 2022/23, reporting an adjusted surplus on its SOCI of £0.043m. The Trust marginally underspent on its Capital limit in year with additions totalling £44.5m. We will achieve the 22/23 HNY ICB system financial control total The ICB position has not yet been published, however it is believed that the ICB has achieved its revenue and capital spend targets. We will leave Financial Special Measures The Trust continued to make good progress towards exiting Financial Special Measures (Recovery Support Programme), with exit being formally confirmed by NHS England on 17 May 2023, following approval of both the Trust's and the ICB's financial and operational plans for 2023-24. The completion of the HFMA Internal Control checklist provided a good level of assurance over the level and rigour of internal controls in place within the organisation. Two areas identified for further improvements were: i. ensuring that the budgetary control system is deployed to the lowest levels of the organisation (not held at divisional level) ii. ensuring that the "tone from the top" is the right one and that the Board of Directors and senior management within the Trust set the correct tone with regards to the restoration of financial discipline as part of a balanced approach to quality, access, people and finance.
8.	**Capital Investment**	We will invest **c.£100 million in estates and equipment**, including new Emergency Departments, Same Day Emergency Care and Acute Assessment Units at both DPOW and SGH, and Ward 25 (Scunthorpe) refurbishment. Projects delivered in 2022/23 include: • Completion of the new Emergency Departments at both DPoW & SGH, which are now operational, offering significant improvements to the urgent and emergency care facilities at both sites. Work is now

Priority		
		ongoing to convert the old A&E areas into AAU/SDECs [c.£63m overall] • Full refurbishment of Ward 25 at SGH, creating a fully modernised single room ward environment improving the patient experience whilst having medical treatment, in line with improved infection control guidance [c.£2.7m]. • Completion of the replacement of the failing Fire Alarm System at DPoW, providing a safer environment for patients and staff throughout the entire hospital [c.£4.5m] • Installation of a new Gamma Camera suite at DPoW, improving the diagnostic capabilities available at the Grimsby site [c.£1.7m incl. equipment] • Refurbishment of Theatres 7 & 8 at DPoW and Theatre A at SGH, enabled by TIF funding, and upgrades to the electrical critical infrastructure serving the SGH Theatres, enabling increased capacity to address the backlog in elective surgery [c.£6.8m overall incl. the electrical works]. • Critical Water Infrastructure Works to address the concerns over the condition of the fresh water reservoir at the Scunthorpe site [c.£730k overall] • Fire Door Surveys and the commencement of fire door replacement work at SGH, improving the fire safety of the site [c.£350k]. • Refurbishment of the Maxillo Facial Rooms at SGH [c.£300k]; • Refurbishment and installation of new equipment into the Fluoroscopy facility at SGH [c.£630k incl. equipment]. • Improvements to the Mammography facilities at DPoW [c.£800k incl. HTF funding] • Completion of the final phase of oxygen replacement works at DPoW, concluding the major multi-year project to improve oxygen flow rates and resilience at the DPoW site [overall value c£1.9m] • Installation of additional refrigerated body storage in the mortuaries at SGH and DPoW, along with replacement of floor finishes, to meet HTA requirements [c.£600k] • Provision of a fully accessible 'Changing Places' toilet facility at SGH [c.£200k], in conjunction with North Lincolnshire Council. Changing Places are toilet facilities fitted with specialist equipment including a hoist and changing bench, for use by children, young people and adults with profound or multiple disabilities. They also provide sufficient space for carers to assist. • Chiller replacement works at SGH and DPoW, including the replacement of the Endoscopy chiller at SGH [c.£190k] • Replacement of the Fire Alarm system at the Scunthorpe site has also commenced, a £5.5m

Priority		
		project which is due to continue into 24/25 Financial Year. • Overall delivery in full of the Capital Allocation for 22/23. • We will continue to pursue (with Hull University Teaching Hospitals) our £720m Expression of Interest to be part of the **National Hospitals Programme**, including Strategic Outline Case and Outline Business Case, if we are shortlisted for this Programme. Our proposal includes the long-term development of a new hospital for Scunthorpe and redevelopment of DPOW. • National Hospital Programme delayed and decision date unknown • Work undertaken to identify potential options for Strategic capital investment
9.	**Digital**	We will implement the second phase ofour **Digital Strategy**, including: Project and programme governance for implementing the Digital Srategy has been strengthened. An interim benefits lead has been appointed to create the required statement of planned benefits for the Digital Transformation programme and to ensure appropriate digital projects clearly define the benefits during development. Benefit Realisation plans will ensure that projects deliver on the improvements and returns agreed in their business cases. The benefits lead will link in with their HUTH counterpart ensuring processes are aligned. • 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. • Lorenzo PAS migration project is in full flight, with a planned completion date of September 23. The Data Warehouse upgrade to data as a service has a planned completion date for the primary data feeds which are linked to the PAS go live date. Secondary data feeds are being delivered in a phased approach to delivery. The first RPA process automation is due to go-live in early May 23 followed by the remainder of the initial 4 processes in Q1/Q2 2023.. Prioritisation of requests for automations is underway to agree the next processes to be automated after these initial 4. Single Sign-On is being implemented throughout the last 2 weeks of April and due to complete in May 23. WebV has delivered a number of enhancements and a project is starting to upgrade the Trust from WebV version 2 to version 3 which brings improved functionality across the entire platform. A pilot of the electronic meal ordering from WebV is just starting up. • 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).

Priority		
		• A draft business case for Enterprise Content Management has been created and the trust is working with a partner to finalise the return on investment case. A supplier is providing expertise to assess the detail around health records services across both NLaG/HUTH and reviewing/updating the financial/economic elements of the business case. • 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). • ICS Maternity system project underway with delivery dates planned to complete in February 24. A project manager is in place working with key HUTH and NLaG stakeholders to build the OBC for the ICS EPR. Discussions around how this might look across the 4 Trusts continue, with a plan for procurement to complete towards the end of 2023. Digital is continuing to support development and planning work for CDC's and a business case is being written for an Ophthalmology diagnostic hub by Q3 23/24 with input from technical leads. NHSE Eye-ERS system implementation for Community Optometrist referrals to HUTH/NLG is progressing with agreement on the model to take forward. This is done with partners in the ICS. The model is agreed but developers resource needs to be identified and we are still waiting for the ICB programme support. • 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. Demographic data and discharge summaries are available on YHCR, Lorenzo PAS alignment between HUTH and NLaG significantly improves the joint management of patient pathways with a single management system. In Ophthalmology, consideration is being given as to the potential for using a shared Ophthalmology EPR, aligning around a common system for both HUTH/NLaG which is in business case stage. • 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. • There are plans to start using the NHS England Digital Literacy assessment tool, its live, coordination with the education team to get it set up is in progress.
10	**The NHS Green Agenda**	• We will promote, develop and embed the **NHS Green agenda** into the Trust, specifically, procurement policies, staff energy champions, Net Zero Heroes, travel, waste and recycling, including continuing to move towards the removal of single use plastics where clinically possible and energy reduction.

Priority		
		• At Scunthorpe General Hospital we will explore funding to provide **energy conservation** schemes to include a new energy centre. • At DPoW we will continue to work with North East Lincolnshire council to explore and develop a **district heating network** across the locality, including a new energy centre coupled with energy conservation measures such as LED lighting. The Trust approved the NLaG Green Plan and Travel Plan 2022 – 2025. We will continuously strive to challenge every member of Trust staff, our partners, suppliers, and wider stakeholders to play their part in the Net Zero Carbon and Green agenda. We have embedded our Green and Travel Plan into sector speciality action plans to ensure we deliver upon the Net Zero Challenge To assist our progress against the Green objectives, we will develop reporting principles to directly track carbon impacting activity We will reduce the carbon impact of all Trust Car Scheme vehicles to achieve compliance with zero and low emission vehicle categories by 2027 We are committed to the Clean Van Commitment; our internal Van fleet will shift to full Electric or Hybrid by 2027. We have a current van fleet of 37% Electric for internal logistics. Our shuttle service has avoided 375,660 miles of business mileage. This equates to a saving of 145tCO2e Our entire pool fleet will be 60% Electric or Hybrid by 2024 Our Park & Ride service will utilise full electric transport during 2023 We will continue to invest in Electric Vehicle charge facilities We are a Zero waste to landfill organisation We are committed to the single use plastic pledge Our total tonnage of recycled waste has increased by over 10% since 2022. Almost 400 tonnes has been redirected to recycling We have prevented £30k of replacement furniture costs by repairing and reusing items marked for disposal Our non-recyclable waste has generated 316,000 kwh via waste to energy We have sent 11 tonnes of redundant medical consumables and equipment to charitable organisations • At Scunthorpe General Hospital we will explore funding to provide **energy conservation** schemes to include a new energy centre.

Priority		
		We have continued to explore funding to replace the energy centre at SGH unfortunately no funding has been secured. • At DPoW we will continue to work with North East Lincolnshire council to explore and develop a **district heating network** across the locality, including a new energy centre coupled with energy conservation measures such as LED lighting. Working with North East Lincolnshire Council we have: • Appointed an external project management consultant to lead the design of the scheme • Produced detailed design specifications and tendered the design works • Appointed a design consultant to produce a heat network detailed project development plan which is to complete by December 2023

NLG(23)094

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	**Tuesday 6th June**
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Chief Medical Officer Simon Nearney, Director of People
Contact Officer/Author	Shauna McMahon, Chief Information Officer
Title of the Report	**Integrated Performance Report (IPR)**
Purpose of the Report and Executive Summary (to include recommendations)	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page 4. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page 6. **4. Workforce** The executive summary of the Workforce section is provided over on page 8. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR Quality and Safety – IPR Workforce – IPR
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.

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

*Board Assurance Framework (BAF) Descriptions:

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

IPR EXECUTIVE SUMMARY	Date: May 2023

1. ACCESS & FLOW – Shaun Stacey

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

- Ambulance Handover Delays 60+ Minutes
- Number of Patients Waiting Over 12Hrs From Decision to Admit to Ward Admission
- Percentage of Patients Discharged Same Day as Admission (excluding daycase)

Lowlights: (share 3 areas of challenge/struggle)

- Cancer – Two Week Wait
- % Inpatient Discharges Before 12:00 (Golden Discharges)
-

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Cancer – Two Week Wait	Aim to reduce colorectal 2ww to <72 hours since introduction of CNS 2ww STT service. Continued monitoring and improvement as part of action plan.	Monitoring and improvement this month is expected to increase performance again back above target.
% Inpatient Discharges Before 12:00 (Golden Discharges)	Expansion of Virtual Wards planned.	Increase in virtual wards will increase opportunities to discharge patients earlier in the day.
Emergency Department Waiting Times (4 Hour Performance)	Ambulance Handover and Patient Flow Improvement Plan has been presented to partnership agencies for approval and implementation.	Improved Hospital Flow should free up more space in ED for patients to be seen quicker.

2. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- The Trust achieved a KPI of 86% for complaints closed within timescale
- The total number of falls reported has decreased for the fifth consecutive month
- The trust declared one mix sex breach which involved two patients who were not fit for the ward.
- 100% of national patient safety alerts were actioned and closed by the deadline dates.
- The new 'weight' button that has been added to EPMA to enable easier access to the weight recording page within the system has improved compliance with the highest value recorded to date, 56% for the percentage of patients admitted to IAAU with an actual weight recorded on EPMA or WebV.
- Electronic primary sepsis screening has been introduced in ED leading to a significant improvement in compliance at DPoW (51.9% in May 2023 compared to 14.4% in March 2023).

Lowlights: (share 6 areas of challenge/struggle)

- The Trust had a C.difficile infection (CDI) target of no more than 21 cases and ended the year on 24. There were no significant lapses in practice/care detected from the post infection reviews undertaken.
- The Trust reported a MRSA Bacteraemia case after having no case for over 26 months. A post infection review is being completed.
- The number of acute pressure ulcer category 2 incidents has increased slightly with a decrease in the numbers category 3 and unstageable pressure ulcers. This would indicate that appropriate measures have been implemented to prevent deterioration.
- There were two Duty of Candour breaches relating to Pressure Ulcer Serious Incidents. Duty of Candour was undertaken but occurred just outside the 10-working day requirement. The Chief Nurse Directorate have recently commenced a new process for Pressure Ulcer incident review that should also enable more timely completion of the Duty of Candour letters by divisions.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
The Trust declared 24 C.difficile infection against a target of no more than 21.	There were no significant lapses in practice/care detected and the Trust performed very well for CDI rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.	To await the trajectory/target for 2023/24
The Trust reported a MRSA Bacteraemia case after having no case for over 26 months.	A post infection review is being completed.	To await the outcome of the review.
There were two Duty of Candour breaches relating to Pressure Ulcer Serious Incidents.	Duty of Candour was undertaken but occurred just outside the 10-working day requirement. The Chief Nurse Directorate have recently commenced a new process for Pressure Ulcer incident review.	More timely completion of the Duty of Candour letters by divisions.

3. WORKFORCE – Simon Nearney

Highlights:

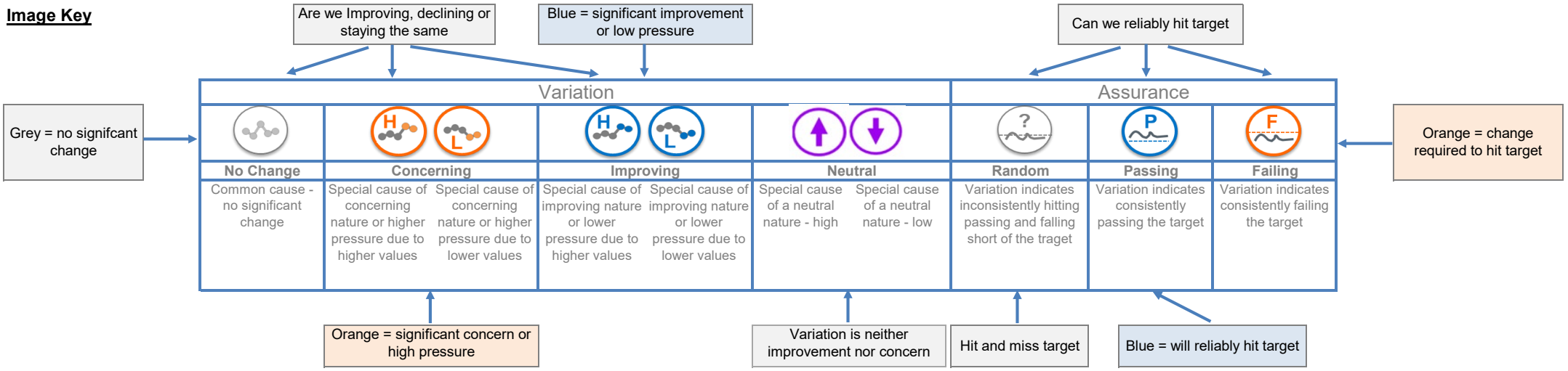
- The Medical vacancies position has reduced in month and is now at 11.09% this continues to be below target of 15%
- The Unregistered Nursing vacancy rate has reduced consecutively for the last 9 months and has now fallen in the expected range but remains above target at 10.25%. This is on a reducing trend seeing a decrease of vacancy position of 8% from July 22
- Registered Nursing vacancy positions continues to be high at 10.2% against a target of 8%, however this is on a reducing trend seeing a decrease of vacancy position of 5% over the last 7 months
- Trust wide Vacancy position is now at 9.7%, this is on a reducing trend seeing a decrease of Trust wide vacancy position of 3% since August 22
- Role Specific Mandatory Training has seen an increase over the last three months at 77.80% as a direct result of a Resus training and Moving & Handling initiative in, improving compliance.
- The Sickness position has now decreased for four consecutive months, this is now at 5.01% and the lowest it has been since recording via the IPR

Lowlights:

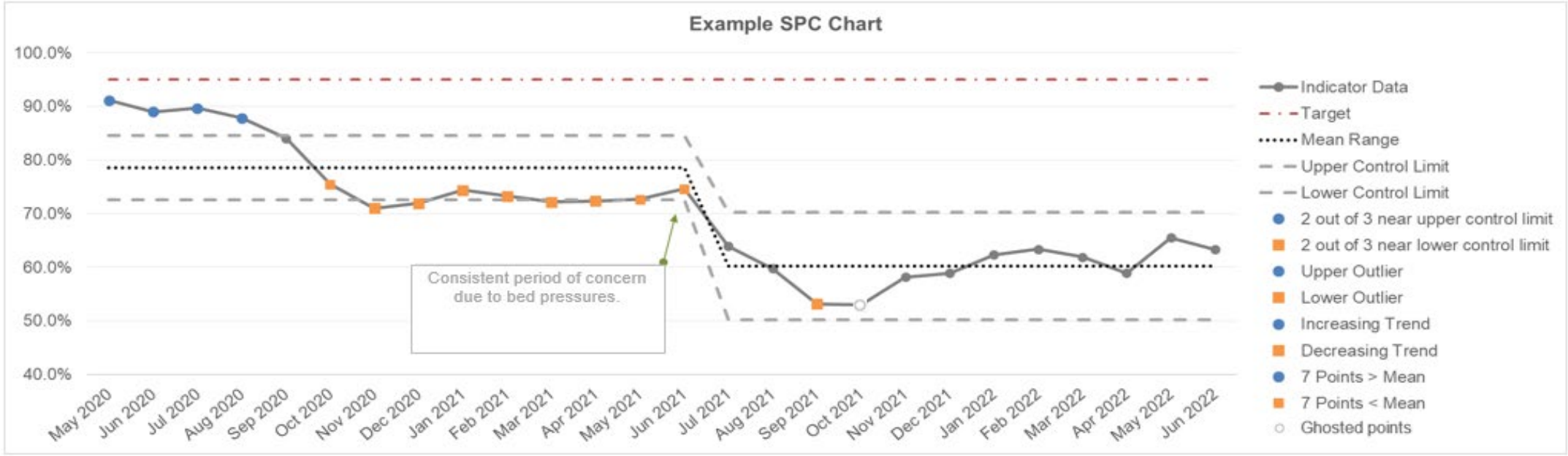
- The Core Mandatory Training position overall currently stands at 89% which is currently above the target, however the target has only just recently changed to 85% in line with normal target review processes.
- PADR compliance remains the same for the last 5 months at 83% which is just below the target of 85%

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Core and Role Specific Training - Only two core mandatory training programmes remain significantly below the target of 85%; Fire Safety at 75.13% and Advanced Prevent Awareness at 46.72%. **PADR Compliance -** The PADR compliance rate has remained steady for the past 5 months following a period of improvement, though it still remains 2% below target.	**Core and Role Specific Training -** Fire Safety has seen a significant improvement since the last report through targeted communication to individuals out of compliance. The withdrawal/DNA rate also continues to improve month on month, now at 36% (3% improvement since last report), again through targeted communication to individuals. The decline in compliance for Advanced Prevent Awareness has resulted from changes in requirements for specific staff groups. **PADR Compliance -** The Training and Development (T&D) administration team have continued with targeted communication to managers for out of compliance PADRs and have supported with uploading completed documents to ESR.	**Core and Role Specific Training -** The T&D administration team are communicating directly with staff that are now required to complete this competency and will continue to monitor compliance closely. This temporary decline was expected, and plans are in place to minimise the length of time that compliance will be impacted **PADR Compliance –** From 1.5.23, this support and monitoring will be moved to the ESR team who will also be providing targeted support to fully utilise manager self-serve for recording of PADRs. New guidance and bespoke Hub page have been designed to support Managers with the PADR process which will be lunched in the Manager newsletter this month.

Image Key



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



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

Notes on Process Limits Re-Calculation

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

This might be shown as:-

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

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

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

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

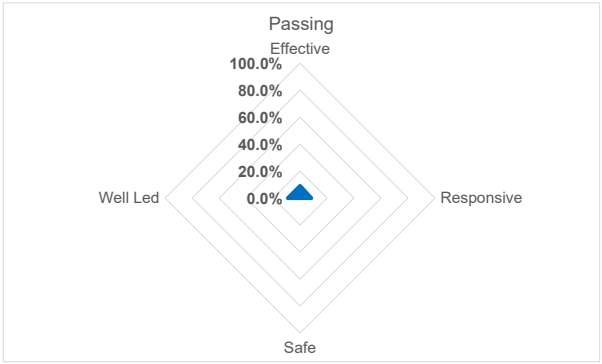
Radar

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

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

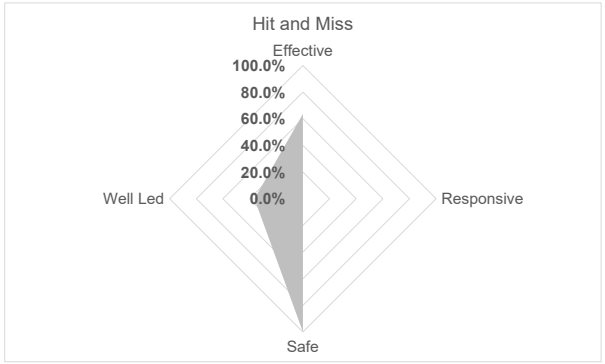
Total: 3



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

Hit and Miss

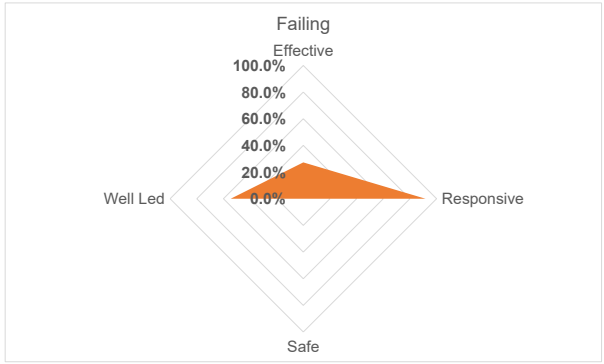
Total: 14



% Discharge Letters Completed Within 24 Hours of Discharge
% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Medical Staff PADR Rate
Mixed Sex Accommodation Breaches
Venous Thromboembolism (VTE) Risk Assessment Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Complaints Responded to on time
Registered Nurse Vacancy Rate
Medical Vacancy Rate
Sickness Rate

Consistently Failing

Total: 20



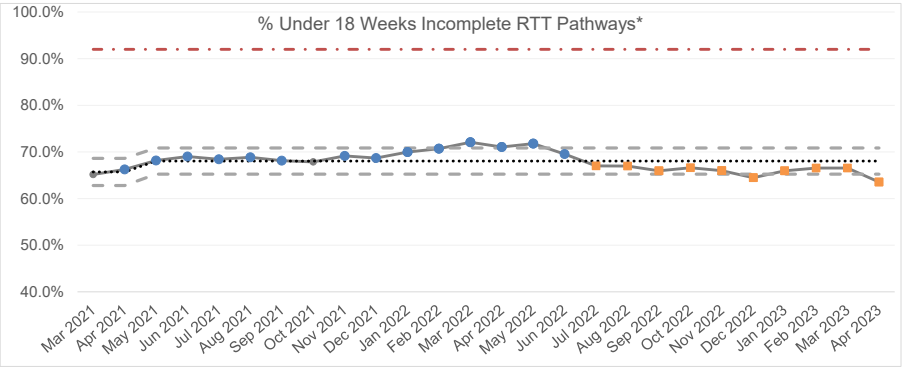
% Inpatient Discharges Before 12:00 (Golden Discharges)
Ambulance Handover Delays - Number 60+ Minutes
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Emergency Department Waiting Times (% 4 Hour Performance)
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
Outpatient Did Not Attend (DNA) Rate
PADR Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Role Specific Mandatory Training Compliance Rate
Turnover Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Unregistered Nurse Vacancy Rate
Trustwide Vacancy 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
Cancer Request To Test In 7 Days*

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H		% Patients Discharged On The Same Day As Admission (excluding daycase) Inpatient Non Elective Average Length Of Stay	Outpatient Did Not Attend (DNA) Rate PADR Rate
		L		Venous Thromboembolism (VTE) Risk Assessment Rate Medical Staff PADR Rate Registered Nurse Vacancy Rate	Combined AfC and Medical Staff PADR Rate Unregistered Nurse Vacancy Rate
	Common Cause			Bed Occupancy Rate (G&A) % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay Complaints Responded to on time Mixed Sex Accommodation Breaches Medical Vacancy Rate Sickness Rate	% Inpatient Discharges Before 12:00 (Golden Discharges) Ambulance Handover Delays - Number 60+ Minutes Cancer Waiting Times - 104+ Days Backlog* Cancer Waiting Times - 62 Day GP Referral* Emergency Department Waiting Times (% 4 Hour Performance) Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38* Cancer Request To Test In 7 Days* Turnover Rate Role Specific Mandatory Training Compliance Rate Trustwide Vacancy Rate
	Special Cause Concern	H	% Outpatient Non Face To Face Attendances Total Inpatient Waiting List Size	% Discharge Letters Completed Within 24 Hours of Discharge Duty of Candour Rate	Number of Overdue Follow Up Appointments (Non RTT) Number of Incomplete RTT pathways 52 weeks*
		L	Core Mandatory Training Compliance Rate		Percentage Under 18 Weeks Incomplete RTT Pathways* Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge

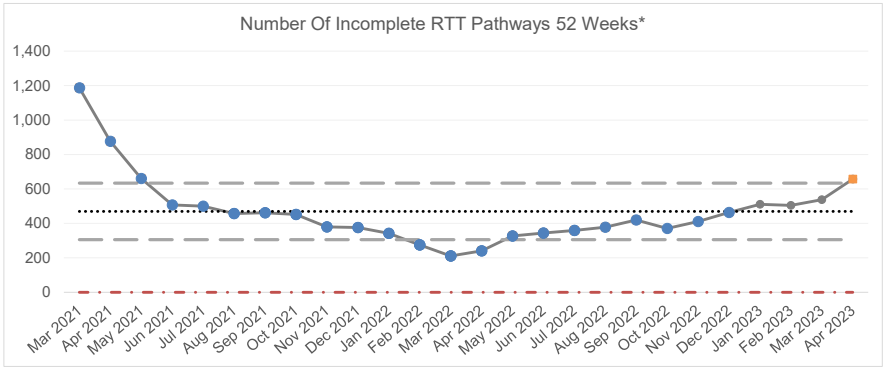
Scorecard - Access and Flow

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

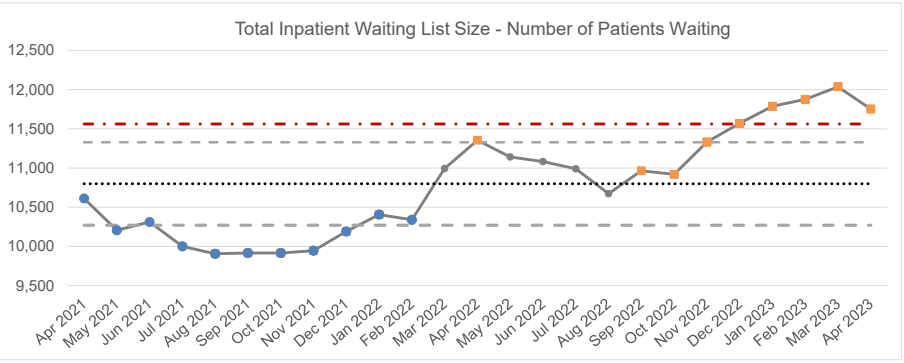
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Apr 2023	63.5%	92.0%	Alert	L	F
	Number of Incomplete RTT pathways 52 weeks*	Apr 2023	657	0	Alert	H	F
	Total Inpatient Waiting List Size	Apr 2023	11,753	11,563	Alert	H	P
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Apr 2023	38.6%	1.0%	Alert		F
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Apr 2023	32,450	9,000	Alert	H	F
	Outpatient Did Not Attend (DNA) Rate	Apr 2023	6.3%	5.00%	Alert	L	F
	% Outpatient Non Face To Face Attendances	Apr 2023	24.0%	25.00%	Alert	L	P
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Apr 2023	51.1%	85.0%	Alert		F
	Cancer Waiting Times - 104+ Days Backlog*	Apr 2023	28	0	Alert		F
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Apr 2023	25.0%	75.0%	Alert		F
	Cancer - Request To Test In 7 Days*	Apr 2023	54.9%	100.0%	Alert		F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Apr 2023	61.4%	95.0%	Alert		F
	Number Of Emergency Department Attendances	Apr 2023	13,133	No Target			n/a
	Ambulance Handover Delays - Number 60+ Minutes	Apr 2023	237	0	Alert		F
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Apr 2023	454	0	Alert		F
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Apr 2023	340	0	Alert	H	F
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Apr 2023	42.3%	40.0%		H	?
	% of Extended Stay Patients 21+ days	Apr 2023	10.9%	12.0%			?
	Inpatient Elective Average Length Of Stay	Apr 2023	2.2	2.5			?
	Inpatient Non Elective Average Length Of Stay	Apr 2023	3.6	3.9		L	?
	Number of Medical Patients Occupying Non-Medical Wards	Apr 2023	225	No Target			n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Apr 2023	83.6%	90.0%	Alert	L	?
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Apr 2023	16.1%	30.0%	Alert		F
	Bed Occupancy Rate (G&A)	Apr 2023	90.0%	92.0%			?
COVID	Number of COVID patients in ICU beds (Monthly)	Apr 2023	3	No Target		L	n/a
	Number of COVID patients in other beds (Monthly)	Apr 2023	195	No Target			n/a
	% COVID staff absences (Monthly)	Apr 2023	11.1%	No Target			n/a



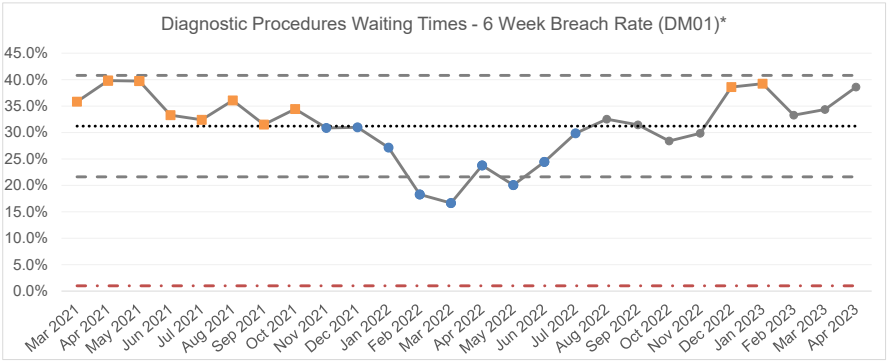
Apr 2023	Target	Variance	Assurance
63.5%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target



Apr 2023	Target	Variance	Assurance
657	0	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target



Apr 2023	Target	Variance	Assurance
11,753	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently passing the target



Apr 2023	Target	Variance	Assurance
38.6%	1.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:
Under 18 weeks incomplete*: Following a period of improvement, the trend is showing special cause concern for the last 10 months. Current data indicates that the target will not be met without action, planned actions outlined below.
Incomplete 52 weeks*: The number of 52 week waits has gradually increased over the past year, and is now showing a special cause concern for April 23. 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 last 8 months is showing special cause concern, with the last 5 months breaching the national target. The indicator can reliably be expected to meet the target.
Diagnostics 6 Week Wait (DM01)*: Performance remains within the expected range, with the last 5 months' data sitting between the mean and the upper process limit. Data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
- Acceptance of Mutual Aid
- Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted
- Significant pressures in anaesthetic assessment capacity due to Mutual Aid creating a bottle neck in the pathway
- Delivery of additional £13m - activity needs to increase to support delivery
- MRI capacity remains a concern, insufficient capacity to meet demand, deteriorating DM01 position
- Ageing diagnostic equipment poses a risk to service delivery
- Endoscopy procedures under GA impacting on DM01 performance
- Increasing demands from unplanned care and cancer targets impacting on ability to deliver routine activity
- Medical sickness

Key Risks:
- Site flow and bed capacity
- 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
- Nurse staffing vacancy, retention and high sickness rates - ODP vacancy
- Workforce risks: recruitment and retention
- Audiology service review
- Unreported position: internal diagnostic reporting capacity does not match demand, limited external capacity available

Actions:
- Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position (ongoing)
- Continue to utilise St Hugh's for new patients for Ophthalmology and General Surgery when waiting lists allow (ongoing)
- Robust recruitment plan for theatres with external company, agreed with recruitment plan being progressed for ODP (ongoing)
- Continual management of medical workforce, backfilling of vacancies with agency locum and immediate progress on any vacancies to reduce vacant positions (ongoing)
- Funding secured for 2x mobile vans to clear diagnostic backlog and reduce capacity v demand gap (ongoing)
- Recruitment of Radiologists (ongoing)
- Establish additional sessions to support delivery of Divisional activity plans (May 2023)

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 treatment
- Locum staff in place where able to secure
- Risk escalation and management in place
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
- Clinical risk stratifiation to ensure allocation of appointments, including pre-anaesthetic assessment is led by clinical priority of patients
- Activity plans reviewed weekly

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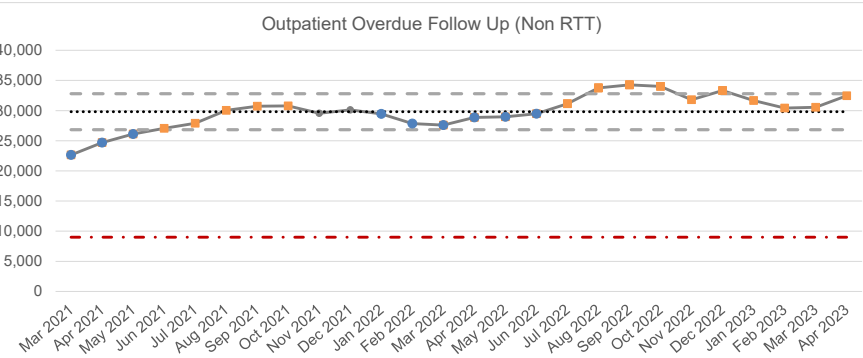
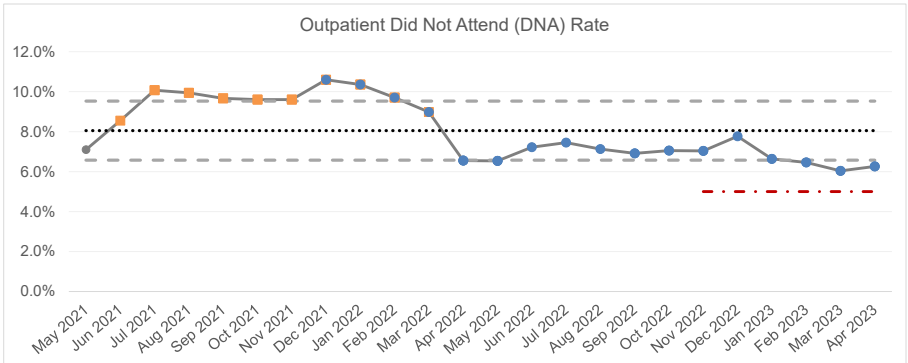
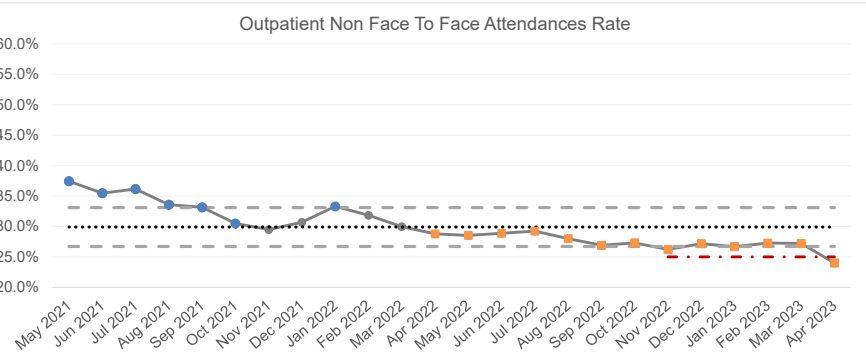


Apr 2023	Target	Variance	Assurance
32,450	9,000	H — Special cause of concerning nature or higher pressure due to higher values	F — Consistently falling short of the target



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



Apr 2023	Target	Variance	Assurance
24.0%	25.0%	L — Special cause of concerning nature or higher pressure due to lower values	P — Consistently passing the target

Data Analysis:

Outpatient Overdue follow up: Performance has recorded concern for the past 10 months. For the last 2 years the indicator has consistently failed the target of 9,000 by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.

Outpatient DNA rate: 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: The figure has consistently fallen below the mean for over 12 months, registering special cause concern. However, performance is reliably achieving the ICS target with the exception of April 23. Local target was 32% by end March 2023.

Challenges:

- Balancing delivery within capacity to ensure reduction in overdue follow ups and achieve the requirement to reduce the number follow ups by 25%
- The number of patients put on a Patient Initiated Follow Up (PIFU), remains under the 5% national target
- System financing models are not conducive to system working. Funding arrangements for the Connected Health Networks Model (CHN) model post 2022-23 fiscal year is a challenge with no designated funding identified

Key Risks:

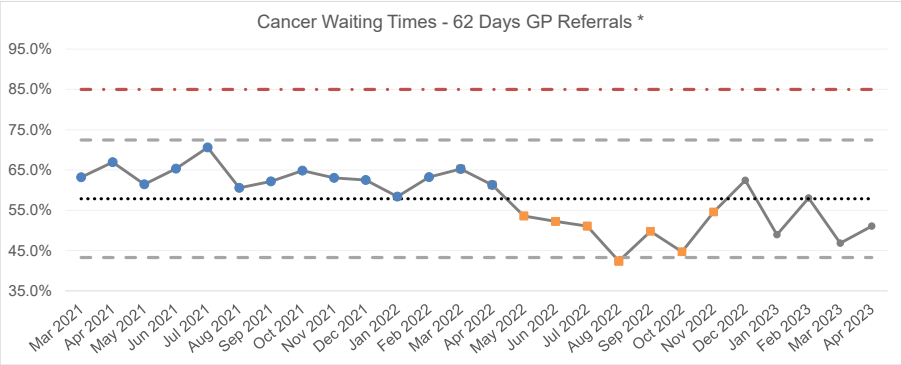
- Clinical buy-in across some specialities to embed PIFU as standard clinical practice
- There is significant risk to delivering a reduction in the follow up backlog unless there is significant focus on changing traditional models.
- Impact on operational delivery due to ongoing industrial action

Actions:

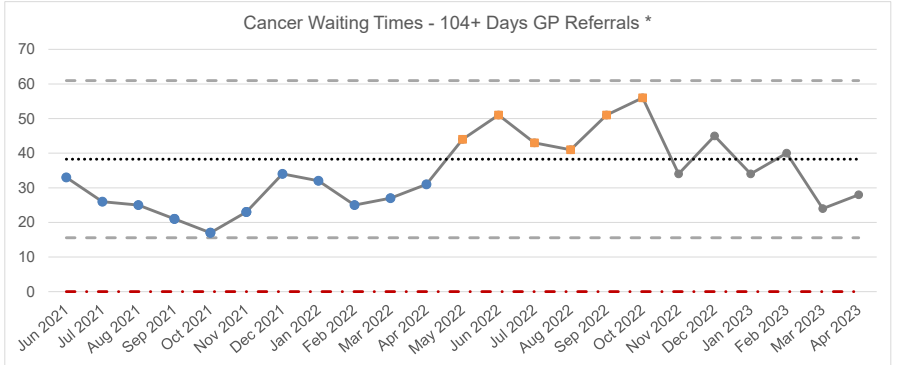
- Working with Clinical Leads and speciality leads to consider PIFU in pathways where clinically appropriate as part of GIRFT recommendations action planning (May/June 2023)
- Deep dive into Do Not Attend (DNA) - Analysis of patients underway who persistently DNA/Cancel their appointment (June/July 23)
- Getting It Right First Time (GIRFT) Clinically led Outpatient Guidance is being evaluated against recommended specialities and action plan developed. When evaluation is complete, gaps will be identified, and speciality plans developed (June/July 2023)
- Discussions on CHN future finance model in progress wiht NLAG and ICB finance leads (May/June 2023)
- Further collaborative work with Primary Care Networks (June 2023)
- Heart Failure at home being trialled as part of Patient Knows Best in Cardiology (June 2023)
- Develop and implement activity plans for 2023/24 which take account of transformational programmes in place (June 2023)
- Develop activity plans for 2023/24 which take account of transformational programmes in place (June 2023)

Mitigations:

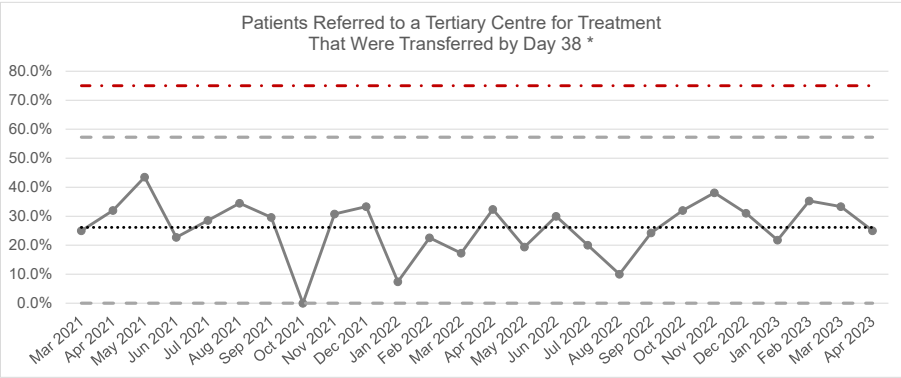
- Clinicians engaged in following the access policy appropriately managing patients who DNA
- Director of PLACE at North Lincolnshire is co-ordinating a group to try and secure funding to support the CHN Model from March 2023 onwards
- Specialty level trajectories in place within the activity plans for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



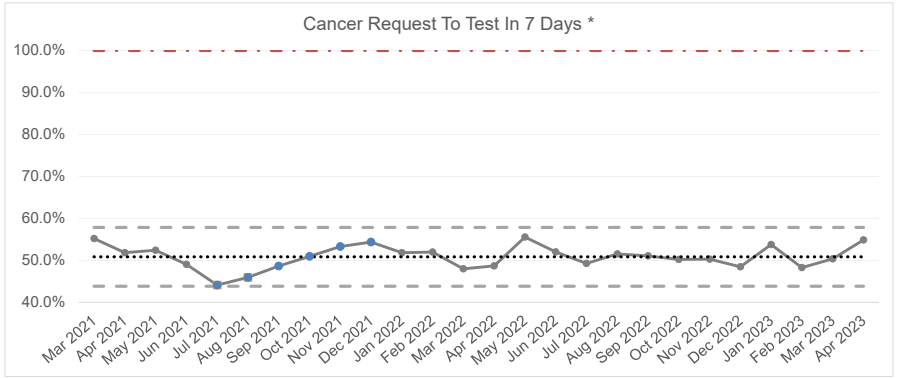
Apr 2023	Target	Variance	Assurance
51.1%	85.0%	Common cause - no significant change	Consistently falling short of the target



Apr 2023	Target	Variance	Assurance
28	0	Common cause - no significant change	Consistently falling short of the target



Apr 2023	Target	Variance	Assurance
25.0%	75.0%	Common cause - no significant change	Consistently falling short of the target



Apr 2023	Target	Variance	Assurance
54.9%	100.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:

62 days GP referral*: Performance has shown a broadly decreasing trend for the last year, sitting below the mean for 10 of those months. This target has not been achieved over the last 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.

104+ days GP referrals*: Performance has varied within the process limits for the last 2 years. The indicator is consistently failing the target and current data indicates that the target will not be met without action, planned actions outlined below.

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

Request to test 7 days*: Performance is stable and as expected based on the data. The target of 100% has not been achieved for more than 2 years. The data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

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

Key Risks:

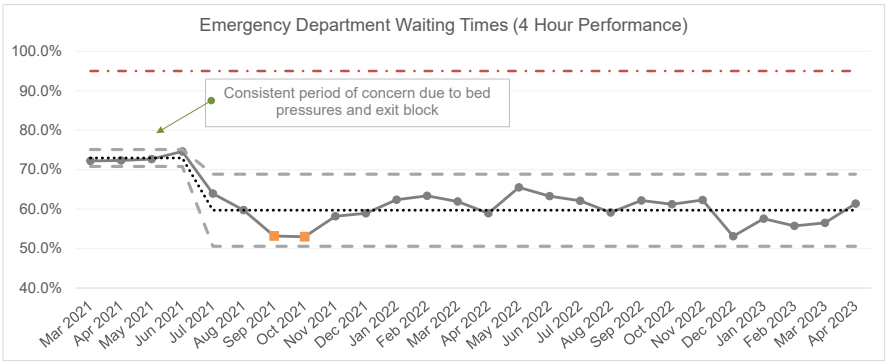
- For Upper GI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
- Lack of Oncology Capacity for 1st appointments - now booking 6 weeks from point of referral
- One Clinician at SGH running STT UGI service - manageable as small numbers but during leave and sickness 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
- HUTH Urology no longer providing visiting consultant clinics due to cons vacancies
- Request to Test (14 days) requires reduction to 7 calendar days to meet 28-day Faster Diagnosis Standard
- 1 x wte Consultant vacancy in Respiratory (Lung Cancer) - 2nd re-advertisement is out May 2023

Actions:

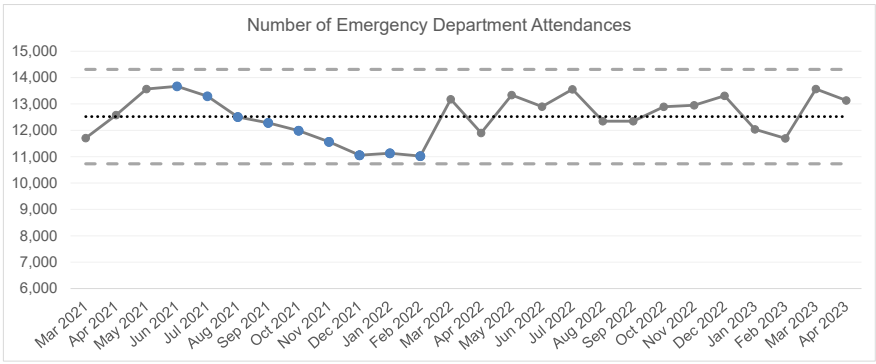
- Meeting with HUTH and regional leads to discuss IPT patients for radical prosatectomy/radiotherpy, any PA/AA appointments not able to be booked within 7 days are escalated to specialty tri for resolution (ongoing)
- Single Lung MDT with HUTH and NLaG will now not progress until later in 2023-24 - date TBC
- Second EBUS List to commence - May 2023

Mitigations:

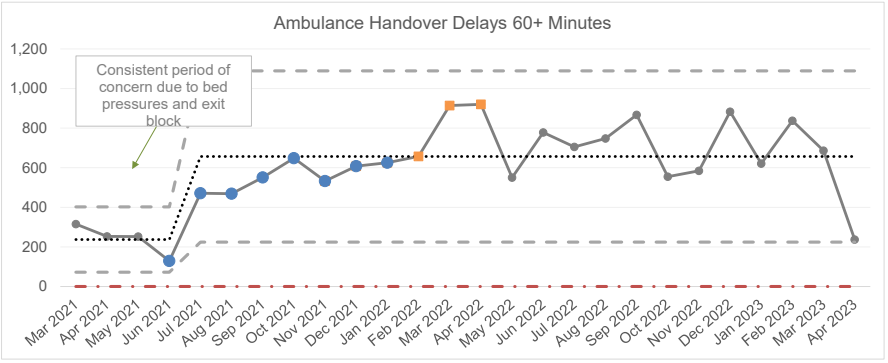
- Increase RDC capacity to work alongside STT to streamline service in Colorectal - managing numbers albeit increased
- Funding approved to recruit to Band 3 and Band 2 admin support
- 62 day performance is being reviewed and managed weekly - along with the 28 day performance. The GI RDC pathway is up and running and CN's contact with all 2 WW referals within 48 hours.
- Urology agency consultant currently in post to support the cancer work until cancer consultant fully returned.
- Cancer Improvement Plans developed for each cancer tumour site
- Micro-management of the completion of cancer packs with any incomplete after 5 working days is now being overseen at senior divisional level



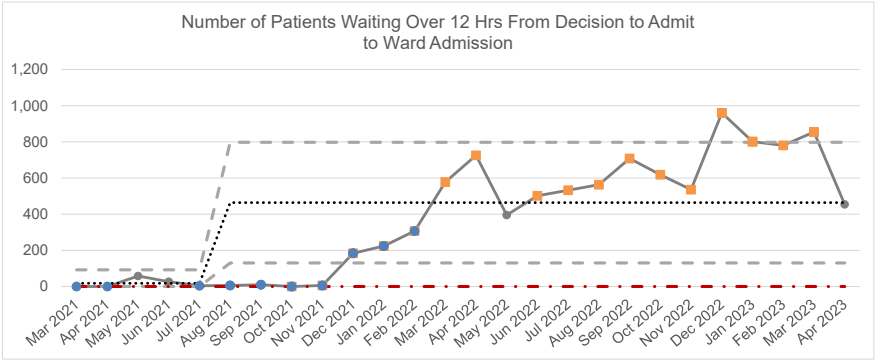
Apr 2023	61.4%
Target	95.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Apr 2023	13,133
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target therefore target assurance is not relevant



Apr 2023	237
Target	0
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Apr 2023	454
Target	0
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target

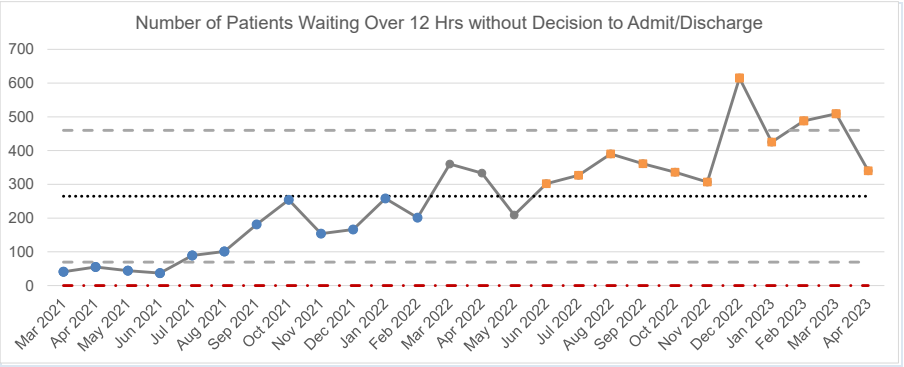
Data Analysis:
ED 4 hour waiting: Following the significant deterioration in the summer of 2021, performance has been stable and within the recalculated expected range. Current data indicates that the target will not be met without action, planned actions outlined below.
ED Attendances: Following performance moving closer to the upper range of the data in 2022 due to an increased number of attendances, 2023 data has varied around the mean.
Ambulance handover 60+ minutes: Process limits re-calculated from July 21. Performance remains within the expected range of the data, dipping more than half to the lower process limit for April 23. 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. Following a year-long period of concern, April 23 records a return to the mean. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
- Pressure created within the community due to demand for ambulances which may be held up in hospital handover process
- Elevated level of acuity resulting in pressures within Resus and delays for walk in patients
- Same Day Emergency Care (SDEC) regularly running at full capacity
- Plan to increase the Urgent Care Service to 24-hours a day and how this will be funded
- Demand on services impacts on hospital flow and delays in admission resulting in regular declaration of OPEL 4 status

Key Risks:
- Gaps in both medical and nurse staffing resulting in high levels of agency and locum staff
- Challenge to achieve Ambulance Handover targets due to lack of flow within the hospital
- Inability to meet waiting times in Emergency department due to demand
- Staff burnout and maintaining morale through ongoing pressures - impacting on recruiting and retention
- The current substantive SDEC staffing establishment does not meet the the increased service hours in place to support operational activity.

Actions:
- Review of all Urgent Care Services across Northern Lincolnshire continues and another meeting is booked in for May 2023. New model to be implemented (Oct 2023)
- Expansion of the Virtual ward services (May 2023)
- Ambulance Handover and Patient Flow Improvement Plan has been presented to partnership agencies for approval and implementation (June 23)
- QI project is in place to improve the flow within the department (October 23)
- Work carried out on the SAS 2021 doctors rota and the 30 day consultation has began to improve capacity versus demand with the aim to reduce locum spending and improve 4 hour performance (Jul 2023)
- Process improvement has been carried out in relation to Ambulance Handover to ensure achievement of 30 minute Mean time (Jun 2023)
- Plan agreed to create a dedicated OPAT nursing team that will provide a hybrid model between both O/P & Home delivery (Sept 2023)

Mitigations:
- Senior clinician reviews taking place in ambulances when delays to offloading occur
- New structure in place within ED with senior decision makers identified daily for EPIC, Resus/Majors, Initial Assessment and Ambulance Triage
- Tier system is in place to ensure that escalation is taking place where appropriate to support patient flow to ensure a swift resolution to issues
- Fast track paediatric process in place and working well
- Increased staffing in place within ED
- 2-hourly board rounds with EPIC and Clinical Coordinator with nursing care needs monitored through care round document
- SDEC nurse-in-charge attends 08:00am board round to support identification of patients suitable for SDEC
- Funding now approved for SDEC nurse staffing establishment, recruitment ongoing
- Direct electronic referrals to SDEC for GP/EMAS via SPA now in place to support alternative pathways and direct SDEC access.
- Virtual ward, Outpatient Parenteral Antimicrobial Therapy (OPAT) and Home first now implemented



Apr 2023
340
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target

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Data Analysis:

Patients waiting over 12 hrs without decision: This indicator continues to record high, increasing levels triggering concern, with 3 of the last 5 months' datapoints exceeding the upper process limit. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Number of patients with a Decision to admit (D2A) continues to rise - impacting on the ability to move patients from Emergency Department to Integrated Acute Assessment Unit (IAAU)
- Regularly running at capacity in SDEC, impacting Patient Flow within the department
- Use of urgent care service (UCS) rooms overnight to bed patients down resulting in a lack of rooms to see patients the following day

Key Risks:

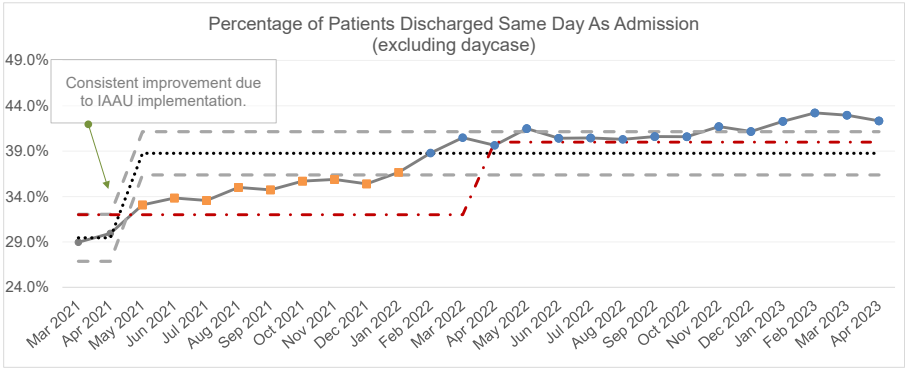
- Challenge to achieve ambulance Handover Times due to lack of space within the department caused by lack of flow out of ED
- Lack of rooms to be able to see new patients that arrive within the department
- Staff burnout and maintaining morale through ongoing pressures - impacting retention and recruitment
- Number of red flag (higher risk) patients in the Waiting Room
- Failure to meet triage targets

Actions:

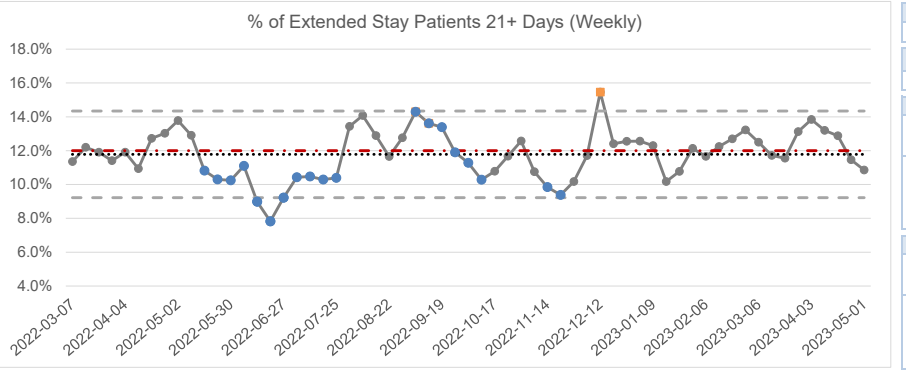
- QI project initiated to improve the flow within the department (October 2023)
- Work has commenced on improving ambulance handover mean times (Jun 2023)

Mitigations:

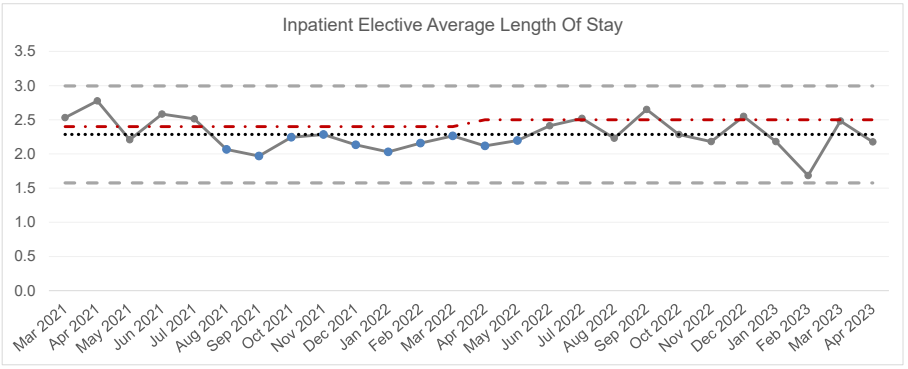
- Care standards are in place to ensure that the patients are reviewed regularly
- Two hourly Board Rounds in place and patients are reviewed where necessary
- Critical Medication Sheets are in place where required to ensure patients are receiving the medication they require whilst waiting for admission
- Position statements given at all Operational Meetings in relation to flow and bed status in ED
- In reach from relevant services is taking place daily
- Live monitoring of patients to ensure that there are no delays when there are available beds on the wards is in place
- Virtual ward, OPAT and Home First service now implemented
- Continued review of the patient numbers considering alternative pathways to ensure patients are seen and treated by the appropriate service
- Criteria to admit followed in ED to review appropriateness of admission and consideration of all alternative pathways



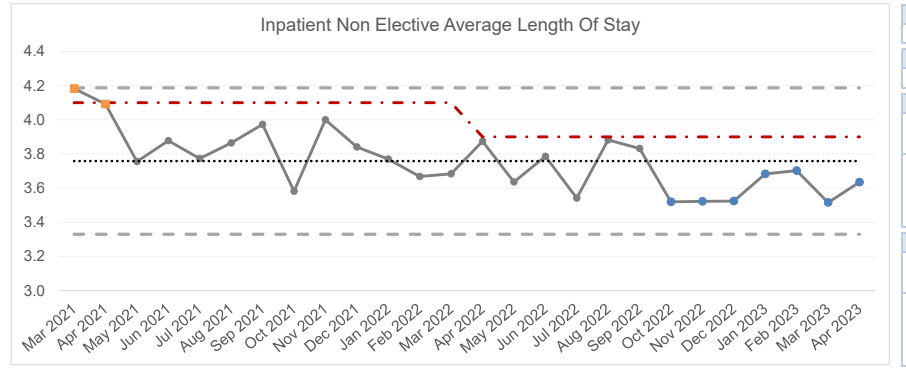
Apr 2023	Target	Variance	Assurance
42.3%	40.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
10.85%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
2.2	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
3.6	3.9	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target

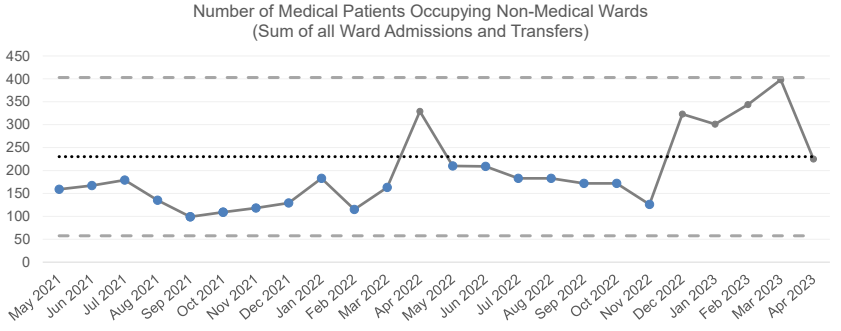
Data Analysis:
Discharged same day as admission: Note: Local target increased from 32% to 40% from April 22. Performance shows sustained improvement with recent data points showing the highest performance since 2020. The target can be expected to achieve and fail at random.
% Extended stay 21+ days: 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 fall within the expected range. The target can be expected to achieve and fail at random.
Non elective length of stay: Note: The target has been decreased from 4.1 to 3.9 from April 22. This indicator has shown an improvement coinciding with an increase in patients discharged on the same day as admission. The indicator can be expected to achieve and fail the target at random.

Challenges:
- Consultant vacancies impact on service delivery
- Increased medical staff sickness
- Covid and infection prevention constraints remain
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself to the creation of escalation beds
- Earlier more timely discharge is delayed as the discharge lounge at DPOW is also utilised as an inpatient area

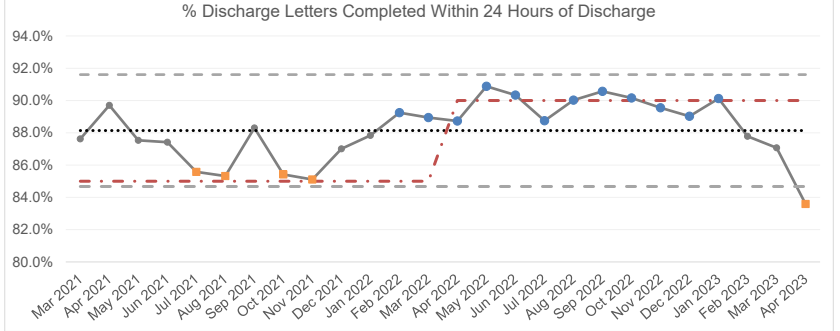
Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- High acuity levels and patients means more patients require further support on discharge

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

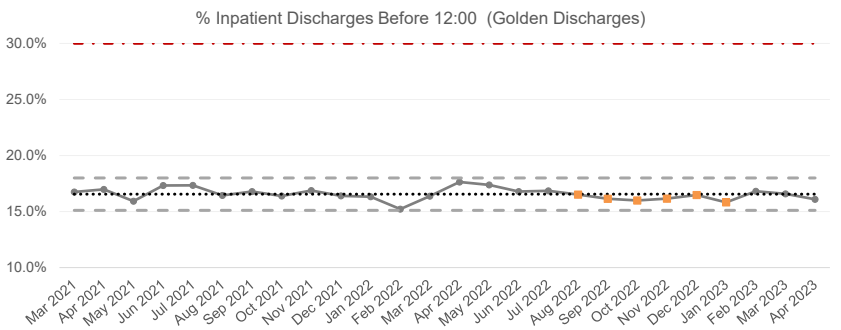
Mitigations:
- Virtual ward, OPAT and Home First now implemented
- Single Point of Access available with 2-hour community response in place
- Acute and Community joint working group established between Medicine and Community & Therapies
- Community Response Team GP supporting Category 3 & 5 calls
- Daily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



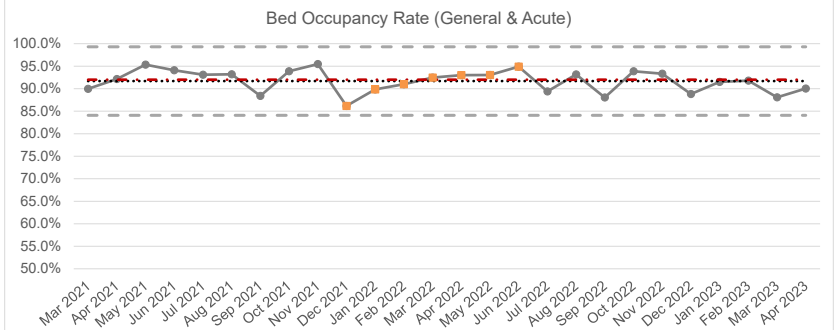
Apr 2023	225
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Apr 2023	83.6%
Target	90.0%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Inconsistently hitting passing and falling short of the target



Apr 2023	16.1%
Target	30.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Apr 2023	90.0%
Target	92.0%
Variance	Common cause - no significant change
Assurance	Inconsistently hitting passing and falling short of the target

Data Analysis:
Medical Outliers: Note: The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed usage of wards out of usual scope. Following a period of improvement, the last 5 months have recorded values between the mean and the upper process limit.
Inpatient discharge letters: Note: the local target of 85% has been increased to 90% in April 22. Following a period of improvement, data has fallen below the lower process limit in April 23, triggering special cause concern. The indicator can be expected to achieve and fail the target at random.
Inpatient discharges before 12:00: Performance is currently stable following a 6-month period of special cause concern. Current data indicates that the target will not be met without action, planned actions outlined below.
G&A Bed Occupancy: Performance remains stable within the expected range for the data. The target can be expected to achieve and fail at random.

Challenges:
- Consultant vacancies impact on service delivery
- Increased medical staff sickness
- Covid and infection prevention constraints remain
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself to the creation of escalation beds
- Earlier more timely discharge is delayed as the discharge lounge at DPOW is also utilised as an inpatient area

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

Actions:
- Expansion of virtual wards planned (May 2023)
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- Virtual ward, OPAT and Home First now implemented
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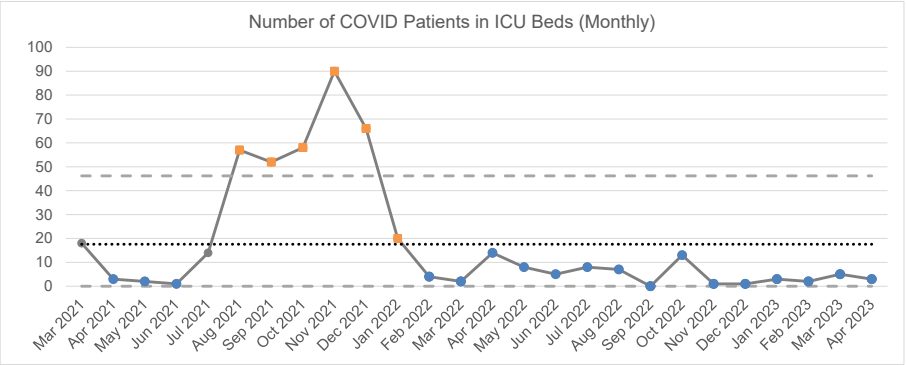
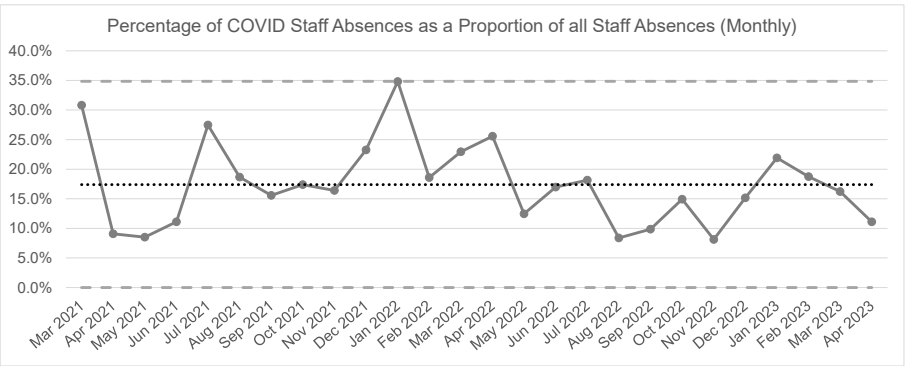
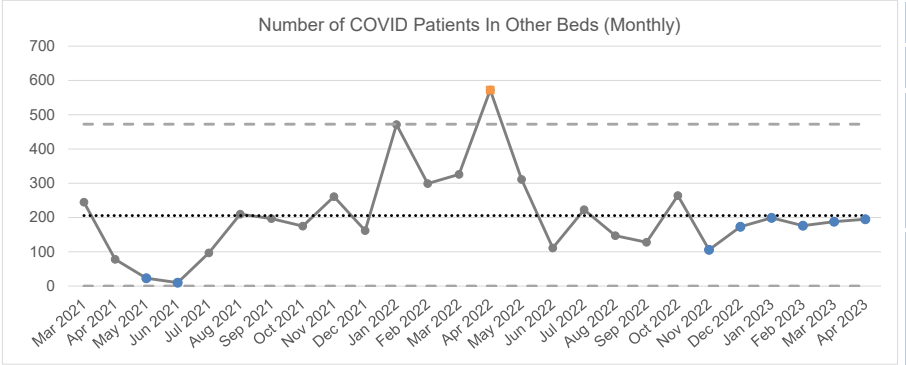


Apr 2023	3
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



Apr 2023	11.1%
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Apr 2023	195
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant

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Data Analysis:

COVID Patients In ICU beds: Note: calculations changed to Monthly as of Feb 23. The number of COVID patients in ICU beds has consistently recorded lower than 5 since Feb 22 and remains predominantly at the lower bounds of the process limits for this indicator.

COVID Patients In Other Beds: Note: calculations changed to Monthly as of Feb 23. The number of COVID patients in other beds remains low compared with spring 22 and is not recording a cause for concern.

COVID Staff Absences: Note: calculations changed to Monthly as of Jan 23. The rate has been volatile since 2021 with repeated changes between concerning and improving performance.

Challenges:

- Minimal side rooms available within Critical Care
- Delivering elective services within an unpredictable environment, due to covid
- Increase in incidence of Flu case

Key Risks:

- Inability to manage high levels of activity within Critical Care
- Increase in numbers of Covid and Respiratory Illness impacts on staff sickness and bed availability

Actions:

Mitigations:

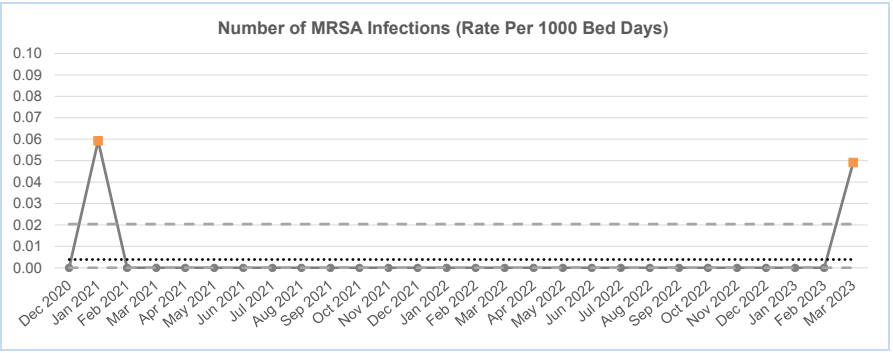
- Critical Surge plan in place for activation as required

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)*	Mar 2023	0.05	see analysis	**Alert**	H	n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Mar 2023	0.25	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Mar 2023	0.15	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Mar 2023	0.10	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Mar 2023	0.34	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	Nov 2022	101.4	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Mar 2023	100%	100%	**Highlight**	H	n/a
	Number of Serious Incidents raised in month	Mar 2023	17	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Mar 2023	0	0		n/a	n/a
	Duty of Candour Rate	Mar 2023	87%	100%	**Alert**	L	?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Mar 2023	4.5	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Mar 2023	3.8	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Apr 2023	95.7%	95.0%		H	?
	Care Hours Per Patient Day (CHPPD)	Mar 2023	8.3	No target			n/a
	Mixed Sex Accommodation Breaches	Mar 2023	3	0			?
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Apr 2023	4.8	No target			n/a
	Complaints Responded to on time	Apr 2023	82.0%	85.0%			?
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Mar 2023	590 out of 646	No target		n/a	n/a
	Number of Positive A&E Scores	Mar 2023	178 out of 287	No target		n/a	n/a
	Number of Positive Community Scores	Mar 2023	88 out of 90	No target		n/a	n/a
	Number of Positive Outpatient Scores	Mar 2023	183 out of 197	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Mar 2023	29 out of 32	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Mar 2023	40 out of 47	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Mar 2023	4 out of 4	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Mar 2023	40 out of 50	No target		n/a	n/a



Mar 2023
0.05

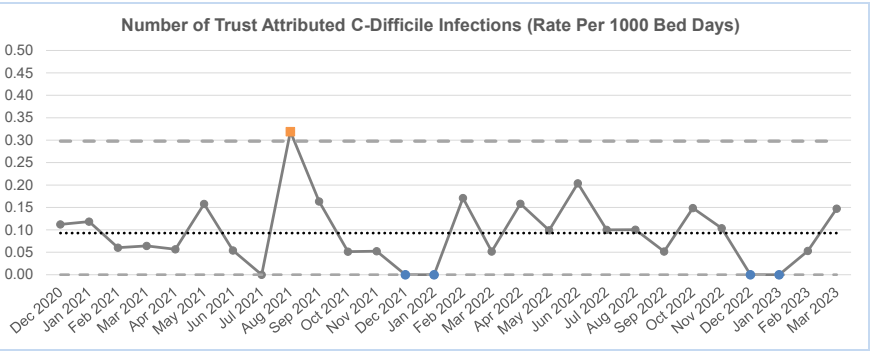
*Target
see analysis below

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Mar 2023
0.15

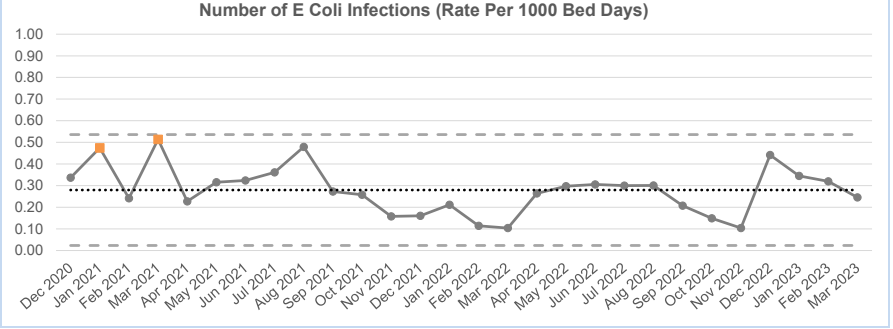
*Target
see analysis below

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Mar 2023
0.25

*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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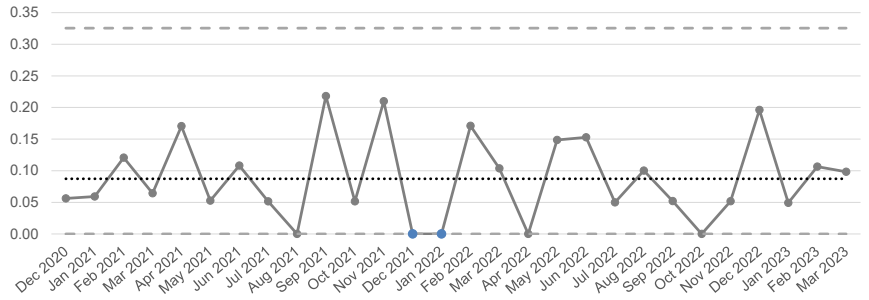
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 1 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 23 against an annual target of 21.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 65 against an annual target of 65.

Commentary:
The year end is as above. C.Diff performance was 2 over the annual target. However we remain the best performing Trust regionally with this.

Number of MSSA Infections (Rate Per 1000 Bed Days)



Mar 2023
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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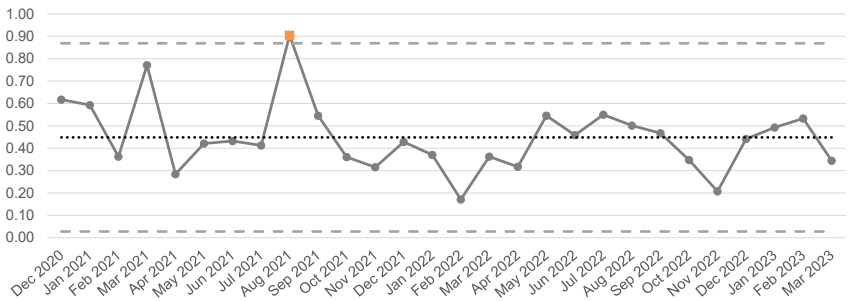
Number of Gram Negative Infections (Rate Per 1000 Bed Days)



Mar 2023
0.34
Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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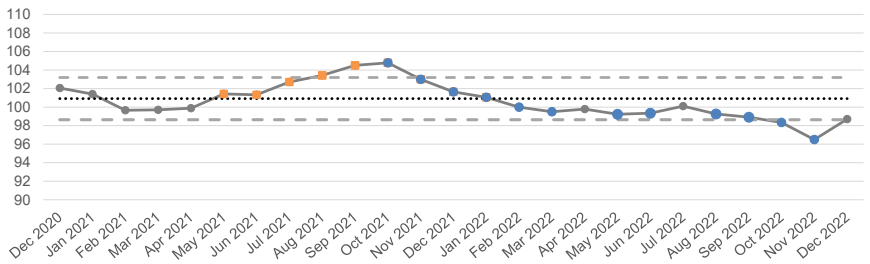
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 20, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 103 against an annual target of 97.

Commentary:
As above. IPC will be doing focused work in relation to gram negative infections which will be detailed in the Strategy plan for 2023/2025

Hospital Standardised Mortality Ratio (HSMR)
Rolling 12 month position



Dec 2022
98.7
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'as expected' range

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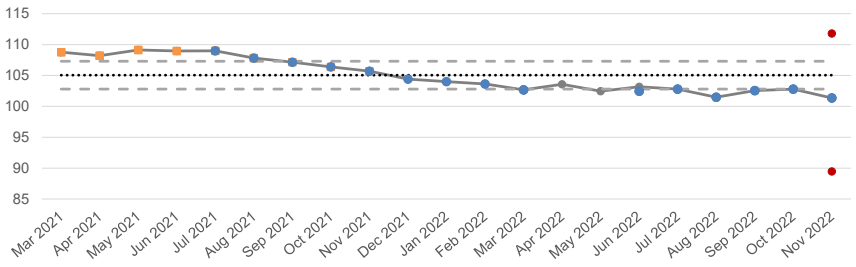
Summary Hospital level Mortality Indicator (SHMI)
Rolling 12 month position
Note: The red dots indicate the expected range



Nov 2022
101.4
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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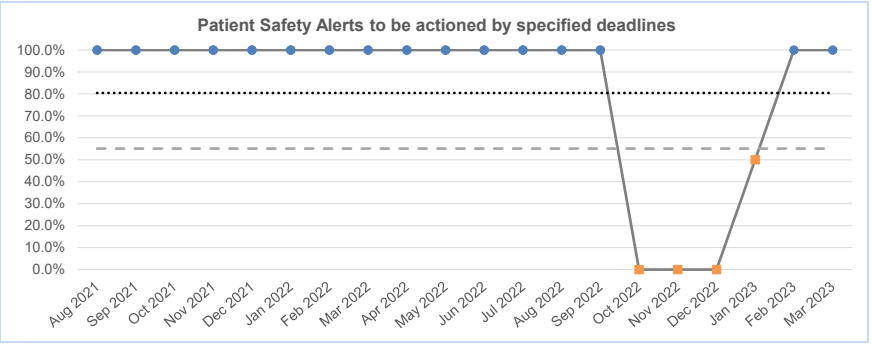
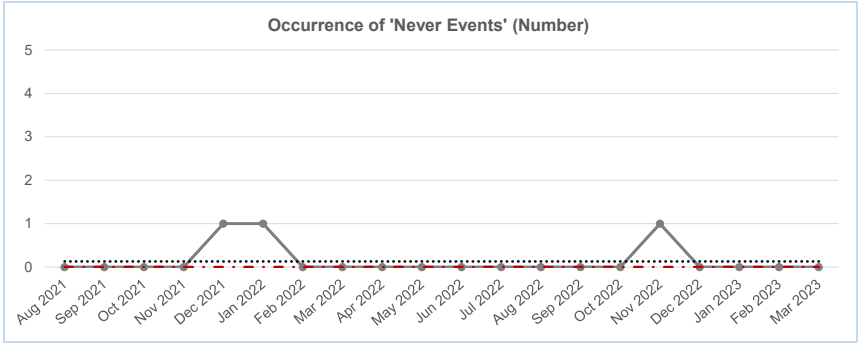
Data Analysis:
HSMR: We are not able to update this data until a new contract is in place.
SHMI: The data continues to perform well compared with expected performance. The data represents a rolling 12 month position.

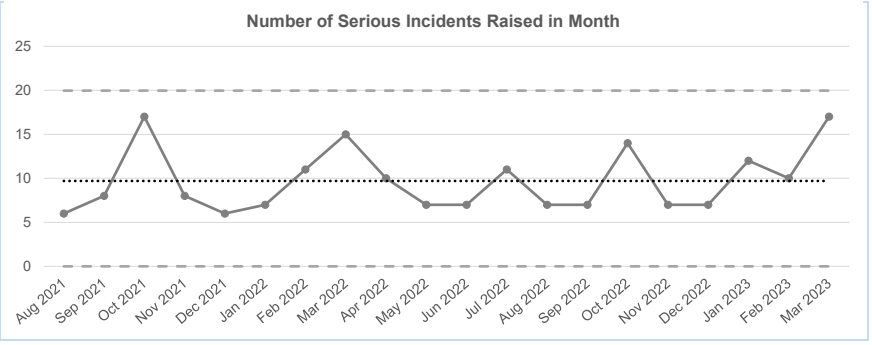
Commentary:
The Trust has a SHMI of 102.79 for the latest period January 2022 – December 2022, which is in the 'as expected' banding.
As part of the 2023/24 End of Life quality priority and QI project, an End of Life staff survey has been launched to help understand the challenges and areas of focus to allow future targeted support to wards.



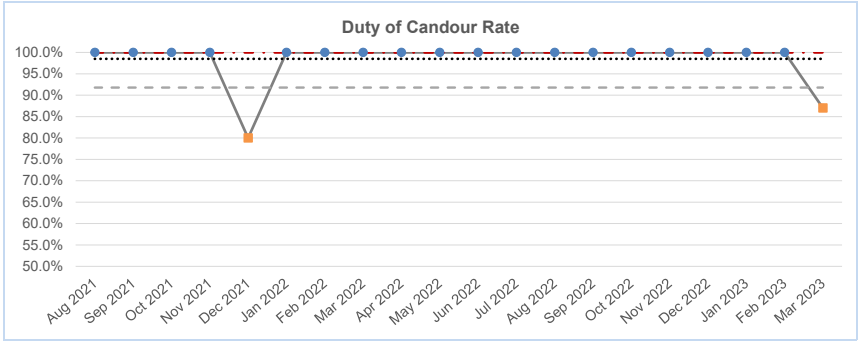
Mar 2023
100.0%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant



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



Mar 2023
17
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Mar 2023
87.0%
Target
100.0%
Variance
Special cause of concerning nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

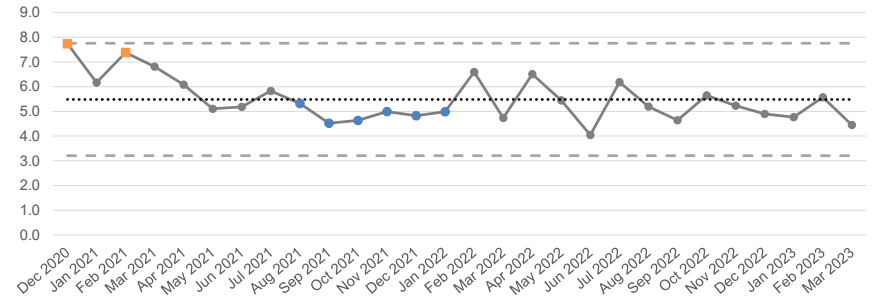
Data Analysis:

Patient Safety Alerts: After four months of concerning performance this indicator has recorded 100% for the past two months. However, the numbers involved are low.
Never Events: Due to the infrequency of never events an SPC is not appropriate. Never events data are a subset of the serious incidents data.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents. The data is within the expected range of variation.
Duty of Candour: The indicator has recorded concerning performance during March. One month's data is insufficient for determining whether this will continue.

Commentary:

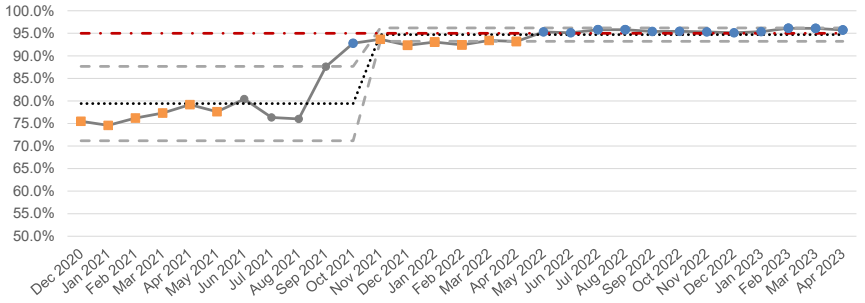
Two Duty of Candour breaches occurred relating to Pressure Ulcer Serious Incidents. Duty of Candour was undertaken but occurred just outside the 10 working day requirement. The Chief Nurse Directorate have recently commenced a new process for Pressure Ulcer incident review that should also enable more timely completion of the Duty of Candour letters by divisions.

Falls on Inpatient Wards (Rate Per 1000 Bed Days)



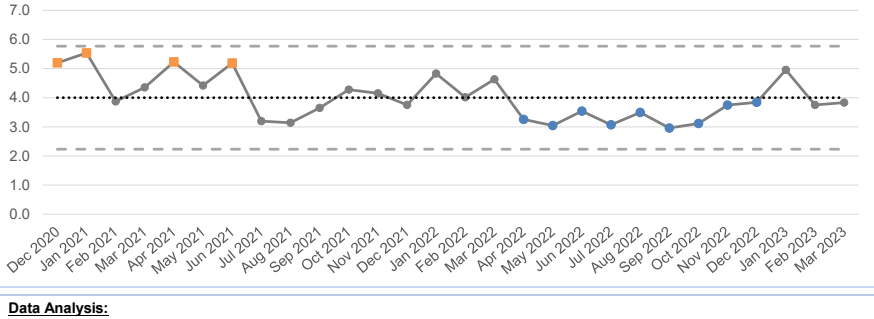
Mar 2023
4.5
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

Venous Thromboembolism (VTE) Risk Assessment Rate



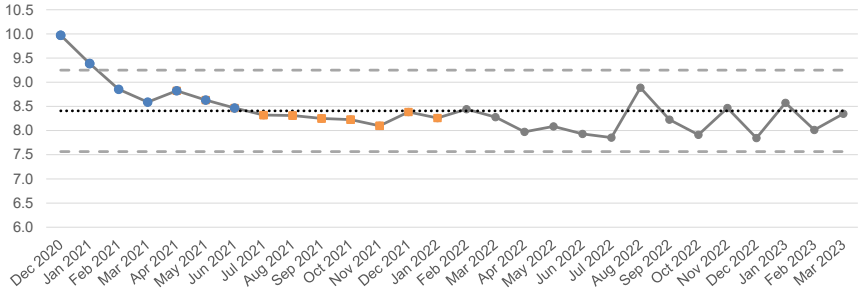
Apr 2023
95.7%
Target
95.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

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



Mar 2023
3.8
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

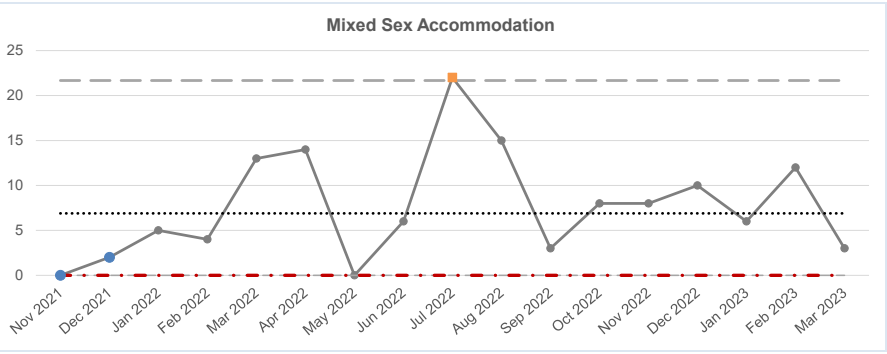
Care Hours Per Patient Day (CHPPD)



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

Data Analysis:
Falls on Inpatient Wards: Performance is stable and as expected.
VTE Risk Assessment: Performance has shown a significant improvement for the past 18 months and the target has been met for almost a year. However, more data is needed to provide assurance that the target will consistently be met.
Hospital Acquired Pressure Ulcers: Performance is consistently within the expected range for the data.
Care Hours Per Patient Day: Performance continues within the expected range for the data.

Commentary: Falls - the number of reported falls remains within the as expected range
Pressure Ulcers - Following an increase in January, the number of reported pressure ulcers has reduced and remains within the as expected range



Mar 2023
3

Target
0

Variance

Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target

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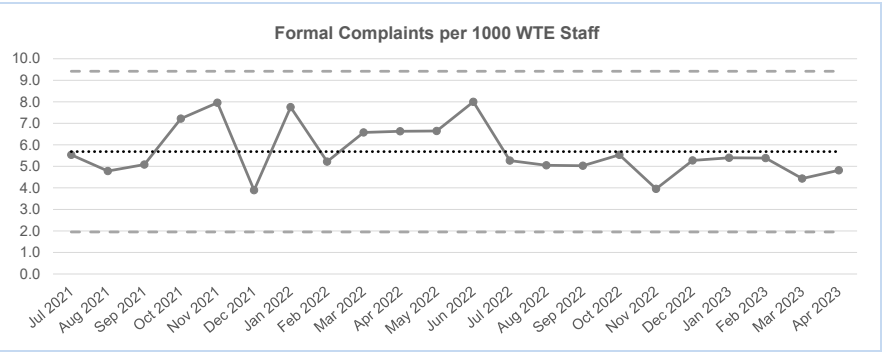
Data Analysis:

Mixed sex accommodation: With the exception of July 2022 performance is within the expected range of the data. Current data indicates that the target will not be met without action, planned actions outlined below.

Commentary:



Apr 2023
4.8

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore assurance is not relevant

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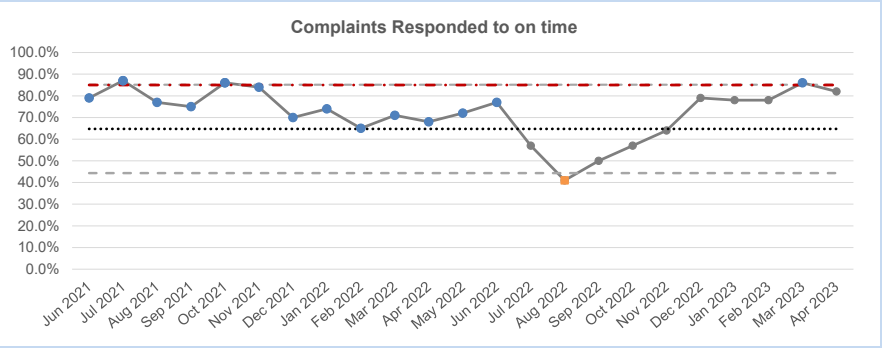

Apr 2023
82.0%

Target
85.0%

Variance

Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target

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Data Analysis:

Formal Complaints: The data continues within the expected range.

Complaints Responded to on time: The general direction of performance is upwards but not consistently enough to register improvement. The target was met in March 2023 for the first time since autumn 2021. More data is needed to provide assurance that the target will consistently be met.

Commentary:

Progress

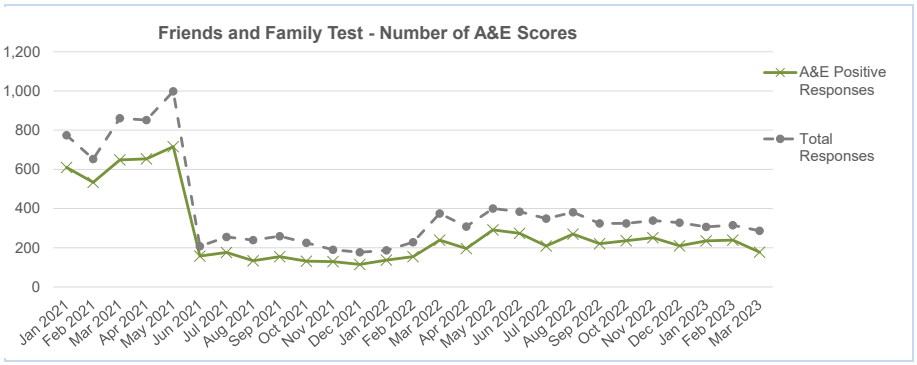
> Timescale for responding continues to achieve above 80%
> Caseload monitoring of team in place to ensure support when required
> Temp PALS Manager post now finished and Temp Patient Experience Manager now overseeing PALS
> Ullysses team requested to complete required changes as a priority to progress learning module and reporting tool
> Survey of Lead Investigators completed and training programme to be designed around feedback
> Updated survey link added to complaint responses for furtehr quality improvement opportunities

Risks

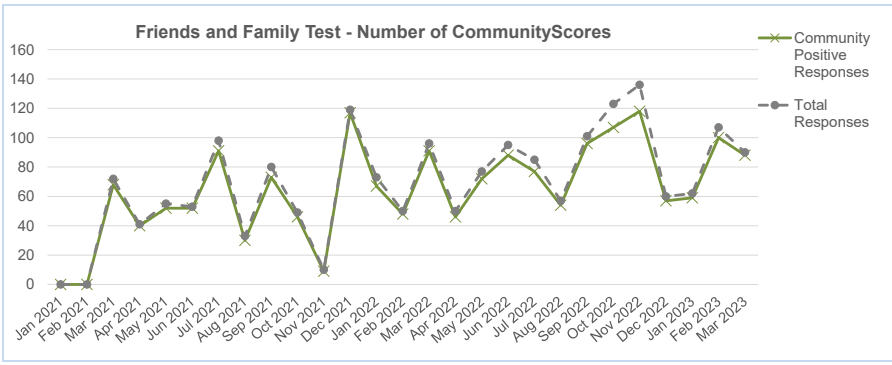
> Increased time required by clinical staff to manage complex complaint investigations remains an ongoing concern
> PALS management going back to Complaint Manager due to complexity of formal complaints and required oversight
> Sustanined compliance against KPI of 85% closed complaints managed in timescale , ongoing risk
> Reputational risk to Trust , ongoing risk

Mitigation

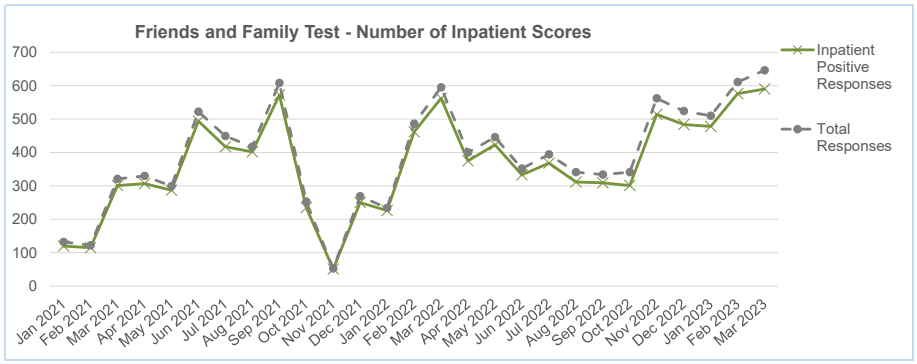
> Weekly Central Team Support and Challenge Meetings
> Chief Nurse Reporting
> PRIMS
> Monthly and weekly complaint report and feedback
> Escalation processes
> Divisional meetings with PALs and Complaint Manager
> Business case for permanent Patient Experience Manager



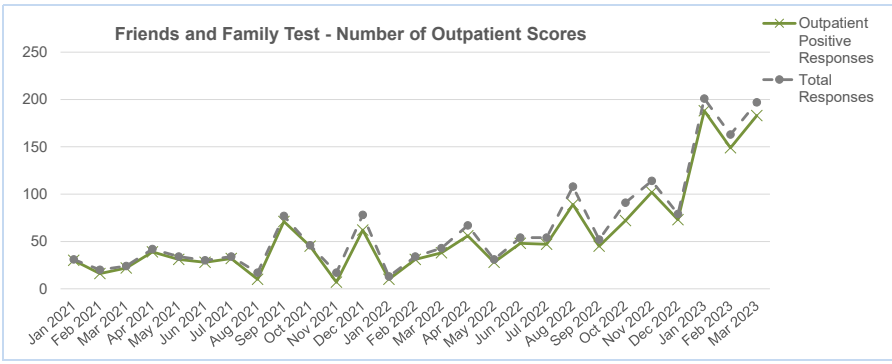
Mar 2023
178 out of 287
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2023
88 out of 90
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2023
590 out of 646
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



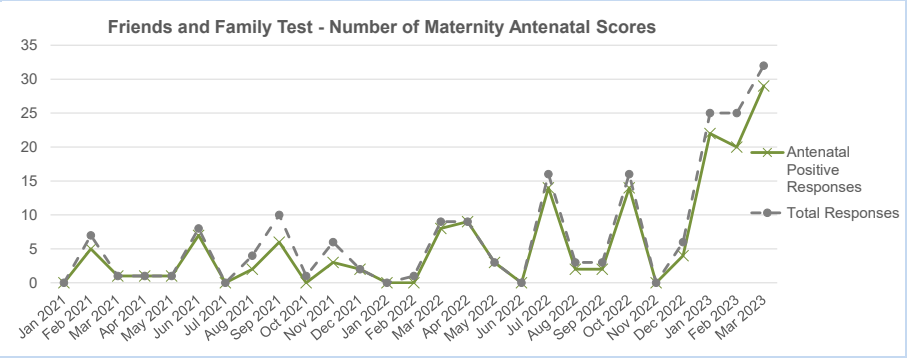
Mar 2023
183 out of 197
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

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.

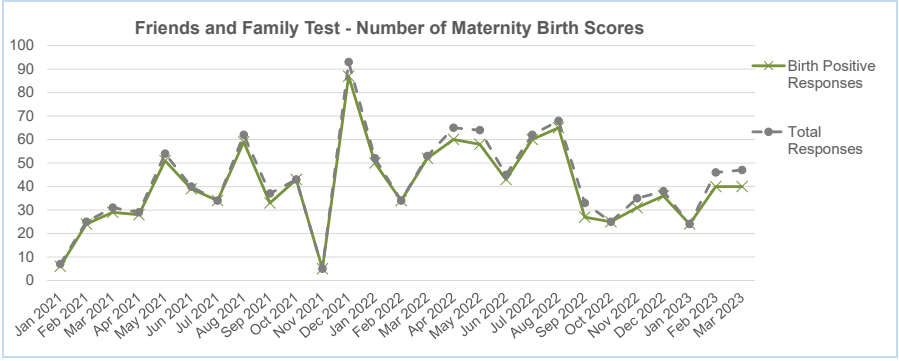
Commentary:
Progress
> Overall response rates increased across inpatient areas and some imprpovement in outpatient numbers
> ED response rates remain static and further changes to questionnaire implemented
> Community responses fluctating and further engagement planned
> Patient Experience Manager engagement continues
> FFT report now in circulation for increased divisional oversight
> Temp Patient Experience Manager post extended until 30th June pending business case outcome
> Procurement excerise for provider commenced

Risks
> Temporary Patient Experience Manager - loss of role
> 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

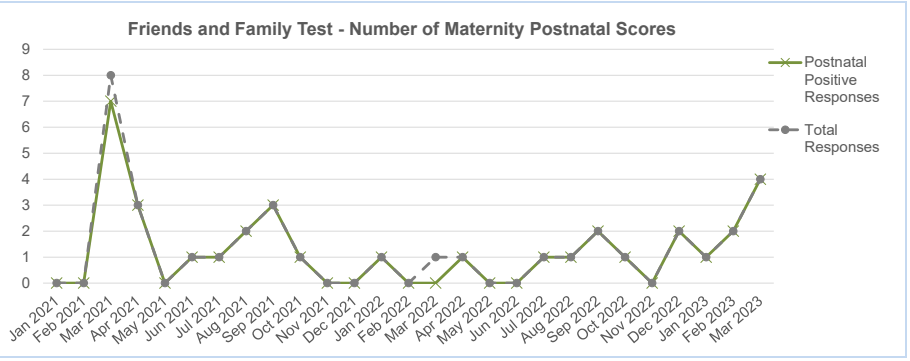
Mitigation
> Temporary Patient Experience Manager has priorities
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics
> Wisespread access across all areas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



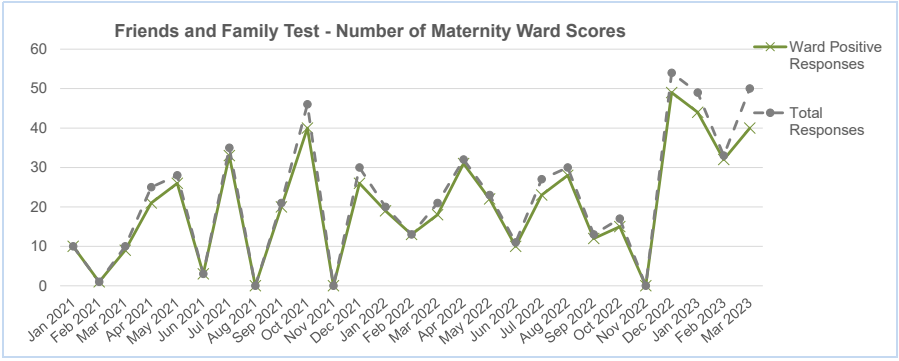
Mar 2023
29 out of 32
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2023
40 out of 47
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2023
4 out of 4
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2023
40 out of 50
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
Maternity Antenatal FFT: The majority of respondents continue to provide positive feedback.
Maternity Birth FFT: The majority of respondents continue to provide positive feedback.
Maternity Postnatal FFT: All respondents for the past 11 months have recorded positive feedback. However, survey uptake is low.
Maternity Ward FFT: The majority of respondents continue to provide positive feedback.

Commentary:
Progress
> Overall response rates increased across maternity
> Patient Experience Manager engagement continues
> FFT report now in circulation for increased divisional oversight
> Temp Patient Experience Manager post extended until 30th June pending business case outcome
> Procurement excerise for provider commenced

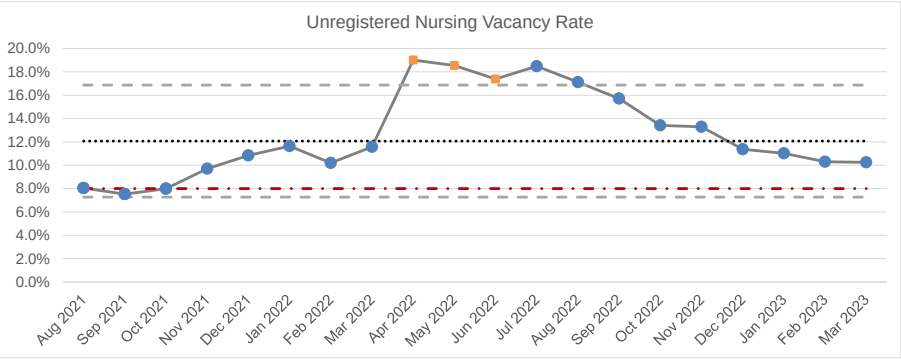
Risks
> Temporary Patient Experience Manager - loss of role
> Lack of representative feedback responses meaning reduced oversight of patient insights
> Staff engagement levels mean that response collection is impacted in many areas
> Methodologies are limited in some areas meaning accessibility is reduced

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

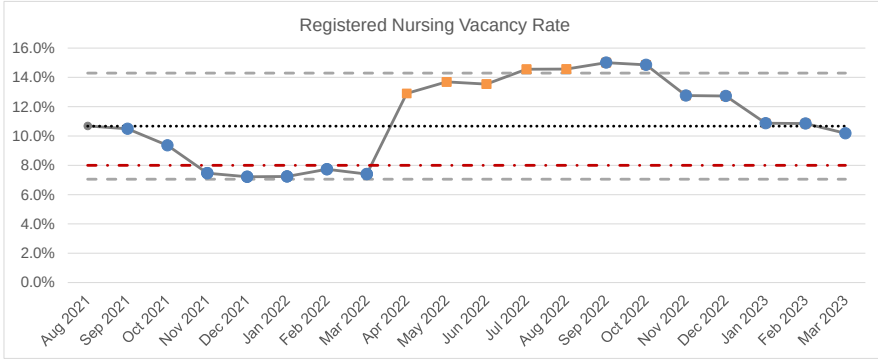
Scorecard - Workforce

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.

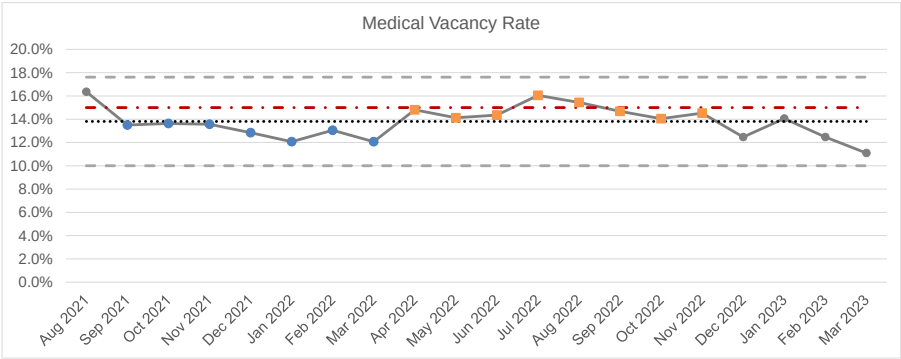
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Mar 2023	10.3%	8.0%	Alert		
	Registered Nurse Vacancy Rate	Mar 2023	10.2%	8.0%			
	Medical Vacancy Rate	Mar 2023	11.1%	15.0%			
	Trustwide Vacancy Rate	Mar 2023	9.7%	8.0%	Alert		
Staffing Levels	Turnover Rate	Apr 2023	11.0%	10.0%	Alert		
	Sickness Rate	Mar 2023	5.0%	4.1%			
Staff Development	PADR Rate	Apr 2023	83.0%	85.0%	Alert		
	Medical Staff PADR Rate	Apr 2023	96.0%	85.0%	Highlight		
	Combined AfC and Medical Staff PADR Rate	Apr 2023	81.9%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Apr 2023	89.3%	85.0%	Alert		
	Role Specific Mandatory Training Compliance Rate	Apr 2023	77.8%	85.0%	Alert		



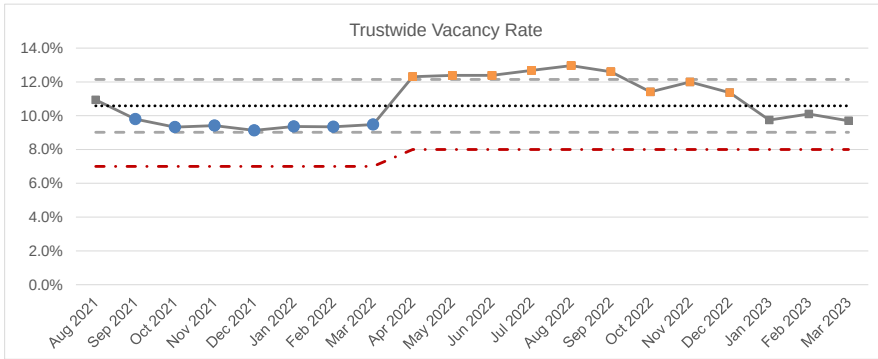
Mar 2023
10.3%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target



Mar 2023
10.2%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target



Mar 2023
11.1%
Target
15.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Mar 2023
9.7%
Target
8.0%
Variance
Common cause - no significant change
Assurance
Consistently 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 short period of deterioration, the vacancy rate has gradually reduced and has currently fallen within the expected range.
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: After a period of deterioration, the vacancy rate has gradually reduced and has currently fallen within the expected range.

Commentary:
Unregistered Nursing

A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. Successful mass recruitment events implemented with a pool process in place. Mass recruitment of HCAs implemented as BAU, with events planned for each quarter, with the next recruitment events taking place in June. Previous appointments undergoing checks and starting in role. The approach taken by NLAG for HCA recruitment regarding sourcing and new to care has been recognised by NHSi/e as good practice.

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

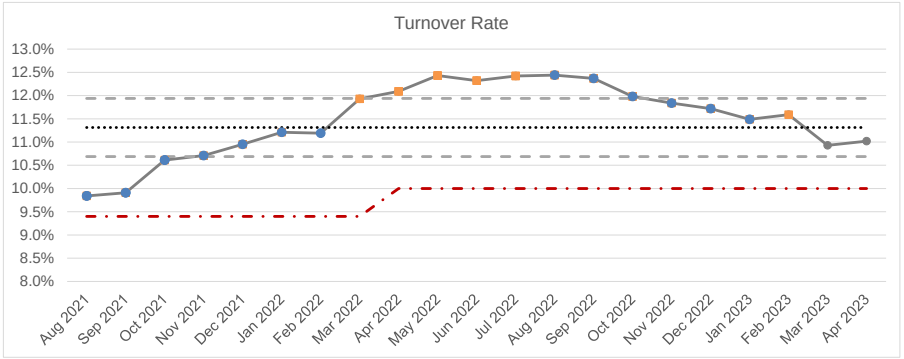
Registered Nursing
Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices. Implementation of a nursing workforce plan as part of the Nursing Strategy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

A project group led by the Chief Nurses office to oversee all activities. International recruitment ongoing with plans to appoint and start 119 international nurses in the financial year, next cohorts booked for May and July. Recruitment to circa 100 international nurses underway as part of Kerala recruitment project commencing May 23. Diversification of pipeline of international nurses to reduce risk. Nursing career frameworks and introduction of nursing apprenticeships currently being recruited to will see reliance on international nurse sourcing reduce longer term.

Commentary Vacancies Cont/d:
Medical Recruitment

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

Recruitment team continuing to engage with candidates.. A pipeline of 44 medical staff has been established awaiting start. A network of private landlords has been established to support accommodation needs where the Trust is unable to accommodate locally. Recruitment team are meeting the accommodation team weekly to review priorities and identify accommodation needs. The Trust are currently in talks with local authorities with a view to accessing social housing stock, which will increase available accommodation if successful. Medics recruitment for SAS grades in Anaesthetics and Medicine are under way as part of Kerala recruitment project from May 23, and application for the Trust to become a GMC sponsor to support this is in progress. Longer term sourcing of medics by TA team to be implemented. A Business Case has been successful to increase sourcing capability for Medical Staff, recruitment to this post is currently underway.



Apr 2023
11.0%

Target
10.0%

Variance

Common cause - no significant change

Assurance

F

Consistently failing the target

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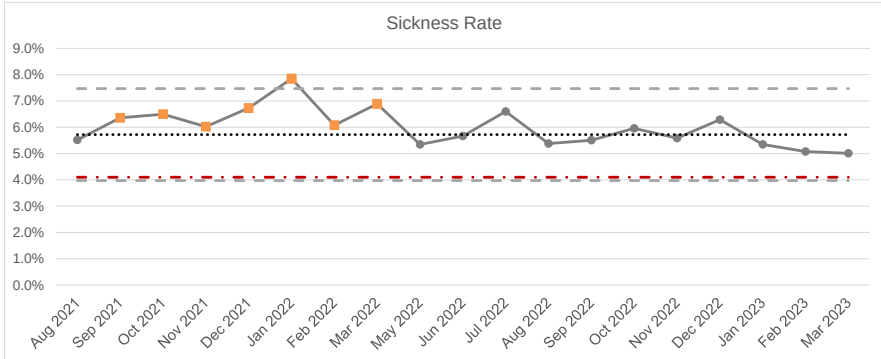

Mar 2023
5.0%

Target
4.1%

Variance

Common cause - no significant change

Assurance

?

Inconsistently hitting passing and failing the target

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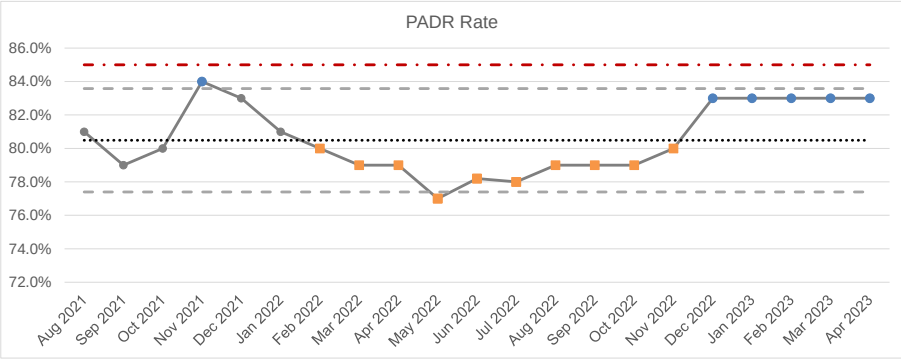
Data Analysis:
Turnover Rate: After a short period of deterioration in summer 2022, the turnover rate has gradually reduced and has currently fallen within the expected range.
Sickness Rate: Following a period of concern, the past few months of Sickness rate has been stable and is within the expected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

Commentary:

Turnover position has seen significant improvement over the last 6 months of 1.5% and is now closer to our 10% target at now 11%. A reduced turnover position will not be reflective of any one specific event but rather a combination of circumstances that have led to individuals maintaining their employment. New resignation guidance has been created to support managers to ensure all appropriate considerations are made when an employee advises their intention to leave their Job. The main aim of this guidance is to enable managers to have supportive retention conversations with staff to enable them to stay. Where this is not possible highlight the importance of understanding why an individual wishes to leave, learning from their expertise, retaining valuable skills wherever possible and ensuring employee are appropriately supported. The three top reasons for leaving through April are Retirement 16.90% Voluntary Resignation- Relocation 7.04% and Voluntary Resignation Other/Not Known 18.3%. Guidance has been created for Managers to avoid using where possible Other/Not known category for leave reason. The workforce intelligence team with collate exit information with a view to create a thematic response to reduce the rate of leavers.

We have seen an increase in cases being managed through to a case review hearing, this is enabling staff to return to work, be redeployed and in some cases the end result has been termination due to health. A process has been developed to further support the management of medical staff sickness, this is in the final stages of agreement ready to roll out to the divisions. The reviewed documentation within the toolkit is being used by the line managers and they are providing positive feedback, this work will continue based on their feedback to improve the process with the ultimate aim of improving the management of sickness absence which will result in lower sickness rates.



Apr 2023
83.0%

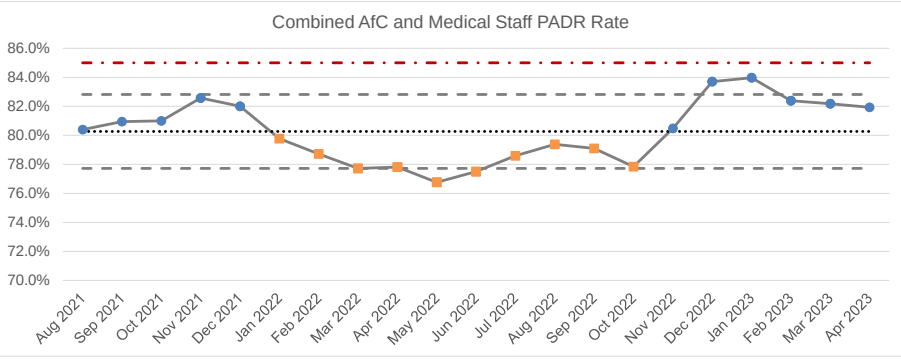
Target
85.0%

Variance

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

Assurance
SPCFailing

Consistently failing the target



Apr 2023
81.9%

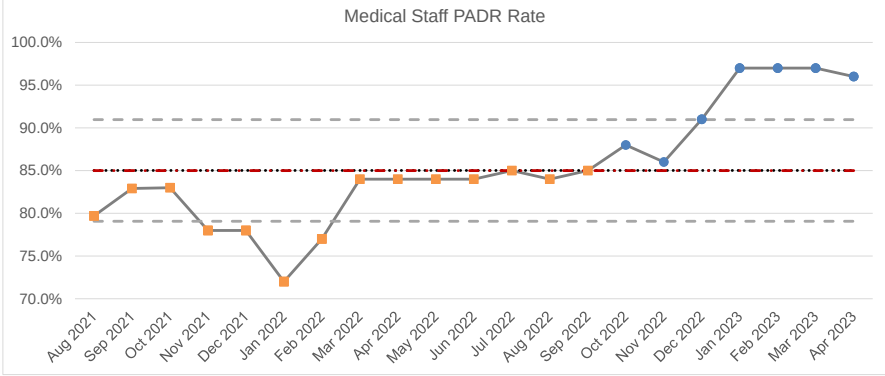
Target
85.0%

Variance

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

Assurance

Consistently failing the target



Apr 2023
96.0%

Target
85.0%

Variance

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

Assurance
SPCVariation

Inconsistently hitting passing and failing the target

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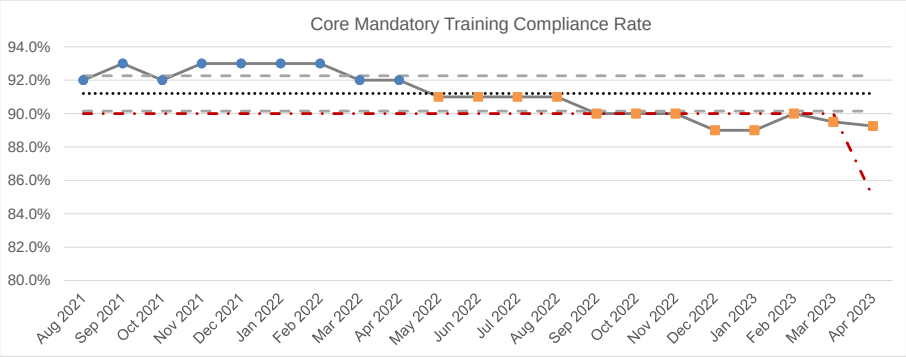
Data Analysis:
PADR Rate: After a period of deterioration, significant improvement has been seen in the last five months. Current data indicates that the target will not be met without action. Planned actions outlined below.
Medical Staff PADR Rate: There has been significant improvement over the last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

Commentary:
The PADR compliance rate has remained steady for the past 5 months following a period of improvement, though it still remains 2% below target. The Training and Development (T&D) administration team have continued with targeted communication to managers for out of compliance PADRs, and have supported with uploading completed documents to ESR. From 1.5.23, this support and monitoring will be moved to the ESR team who will also be providing targeted support to fully utilise manager self-serve for recording of PADRs. New guidance and bespoke Hub page has been designed to support Managers with the PADR process which will be lunched in the Manager newsletter this month

Commentary:
The PADR compliance has remained at a steady rate for medical staff and above the target of 85% and this is in despite of 7% increase of doctors that require an appraisal with NLaG (there are currentl 477 doctors connected to NLaG for appraisal). To maintain this rate of compliance, there is dedicated resources to ensuring doctors are supported with completion of appraisal. This includes a full establishment of appraisers (55), dedicated coordinator who provides 1:1 support and advice to all doctors that require it, timely reminders of appraisal and gathering of supporting information (such as incidents) which is done by the coordinator, a clinical lead for appraisal, and a document management system which doctors have dedicated accounts and is managed and overseen by the coorindator. The RO office also utilises external stakeholders to sustain the engagement which include the GMC and working the GMC to host events and workshops relating to revalidation, Good Medical Practice guidance and Fitness to Practice.



Apr 2023
89.3%

Target
85.0%

Variance

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

Assurance

Consistently passing the target

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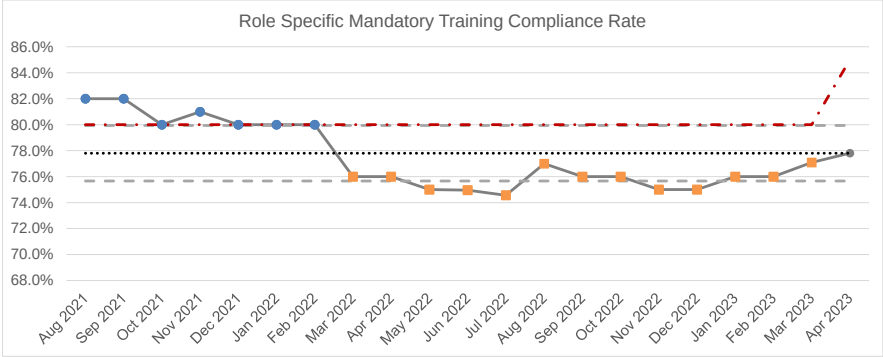

Apr 2023
77.8%

Target
85.0%

Variance

Common cause - no significant change

Assurance

Consistently failing the target

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Data Analysis:
Core Mandatory Training: The last eleven months has recorded a concern, and the latest month has fallen outside the expected range. Note the target has been decreased to 85% from April 23
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past year. Note the target has been increased to 85% from April 23.

Commentary:
Only two core mandatory training programmes remain significantly below the target of 85%; Fire Safety at 75.13% and Advanced Prevent Awareness at 46.72%. Fire Safety has seen a significant improvement since the last report through targeted communication to individuals out of compliance. The withdrawal/DNA rate also continues to improve month on month, now at 36% (3% improvement since last report), again through targeted communication to individuals. The decline in compliance for Advanced Prevent Awareness has resulted from changes in requirements for specific staff groups. The T&D administration team are communicating directly with staff that are now required to complete this competency and will continue to monitor compliance closely. As highlighted in the previous report, this temporary decline was expected and plans are in place to minimise the length of time that compliance will be impacted.

Role specific mandatory training has seen a steady improvement for the past 4 months, now at the highest percentage compliance for over a year. The T&D team continue to focus on reducing the high volumes of staff out of compliance for Level 2 Adult Basic Life Support. The number out of compliance is now below 900, with a further targeted fortnight planned for June 2023 providing an additional 480 places for this resus programme. There have been on-going staffing issues with the Moving and Handling training team due to sickness and changes in job role. This has resulted in a temporary decline in overall Moving and Handling compliance. The Head of Training and Development has worked with the Safety Lead to review and make relevant changes to training required for specific staff groups and modules. These changes have resulted in more fit for purpose training and will ensure more efficient use of resorces moving forward. The lowest Moving and Handling compliance rate is for Module 11 so an additional 100 places are being offered in June 2023, with targeted communication to all those out of compliance. In order to work towards achieving the higher compliance target for role specific mandatory training, the team have set obectives to develop and monitor the annual training delivery plans throughout the year, ensuring the required training places are made available, DNA rates are minimised and all resources are fully utilised.

IPR Appendix - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

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

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisation)s. If NLAG's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than NLAG. The colour shading is intended to be a visual representation of the ranking of NLAG (red indicates most organisations are performing better than NLAG, green indicates NLAG is performing better than many organisations. Amber shows NLAG is in the mid range).

Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 18/05/2023

* 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 methodology 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	Apr 23	63.5%	92.0%	64	63 / 171	Mar 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Apr 23	657	0	59	70 / 170	Mar 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Apr 23	38.6%	1.0%	21	124 / 157	Mar 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Apr 23	51.1%	85.0%	7	126 / 135	Mar 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Apr 23	61.4%	95.0%	10	118 / 131	Apr 23
	Urgent Care	Number Of Emergency Department Attendances	Apr 23	13,133	No target	44	81 / 145	Apr 23
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Apr 23	454	0	14	132 / 154	Apr 23
	Flow	Bed Occupancy Rate (General & Acute)	Apr 23	90.0%	92.0%	43	90 / 157	Q3 22/23
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Apr 23	6.3%	5.0%	69	51 / 162	Mar 23
	COVID	Number of COVID patients in ICU beds (Weekly)	Apr 23	3	No target	24	154 / 203	Apr 23
	COVID	Number of COVID patients in other beds (Weekly)	Apr 23	195	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	Mar 23	0.05	No target	100	1 / 137	Feb 23
	Infection Control	Number of E Coli Infections	Mar 23	0.25	No target	75	35 / 137	Feb 23
	Infection Control	Number of Trust Attributed C-Difficile Infections	Mar 23	0.15	No target	95	8 / 137	Feb 23
	Infection Control	Number of MSSA Infections	Mar 23	0.10	No target	67	46 / 137	Feb 23
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Nov 22	101.4	As expected	42	70 / 120	Dec 22
	Safe Care	Number of Serious Incidents Raised in Month	Mar 23	17	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Mar 23	8.3	No target	29	135 / 191	Feb 23
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Apr 23	95.7%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Apr 23	4.8	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Apr 23	82.0%	1	33	89 / 132	Feb 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Mar 23	5.0%	4.1%	59	89 / 214	Dec 22

Scorecard - Access and Flow (F&P Committee)

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Apr 2023	63.5%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Apr 2023	657	0	Alert			Board
	Total Inpatient Waiting List Size	Apr 2023	11,753	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Apr 2023	38.6%	1.0%	Alert			Board
	Number of Incomplete RTT Pathways*	Apr 2023	38,159	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Apr 2023	16,768	No Target			n/a	FPC
	% of Inpatient Live Waiting List Risk Stratified	Apr 2023	100.0%	99.0%				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Apr 2023	48.1%	37%	Alert			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Apr 2023	32,450	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Apr 2023	6.3%	5.00%	Alert			Board
	% Outpatient Non Face To Face Attendances	Apr 2023	24.0%	25.00%	Alert			Board
	% Outpatient summary letters with GPs within 7 days	Apr 2023	51.6%	50.0%				FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Apr 2023	84.3%	99.0%	Alert			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Apr 2023	27.7%	23.0%			n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Apr 2023	51.1%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Apr 2023	28	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Apr 2023	25.0%	75.0%	Alert			Board
	Cancer Request To Test In 7 Days*	Apr 2023	54.9%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Apr 2023	89.6%	93.0%	Alert			FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Apr 2023	68.0%	93.0%	Alert			FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Apr 2023	68.6%	75.0%				FPC
	Cancer Request To Test In 14 Days*	Apr 2023	82.2%	100.0%	Alert			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Apr 2023	92.5%	96.0%				FPC
	Cancer Waiting Times - 31 Day Surgery*	Apr 2023	100.0%	94.0%				FPC
	Cancer Waiting Times - 31 Day Drugs*	Apr 2023	85.4%	98.0%	Alert			FPC
	Cancer Waiting Times - 62 day Screening*	Apr 2023	66.7%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Apr 2023	61.4%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Apr 2023	13,133	No Target			n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Apr 2023	237	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Apr 2023	454	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Apr 2023	340	0	Alert			Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Apr 2023	42.3%	40.0%				Board
	% of Extended Stay Patients 21+ days	Apr 2023	10.9%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Apr 2023	2.2	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Apr 2023	3.6	3.9				Board
	Number of Medical Patients Occupying Non-Medical Wards	Apr 2023	225	No Target			n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Apr 2023	83.6%	90.0%	Alert			Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Apr 2023	16.1%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Apr 2023	90.0%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Apr 2023	9.2%	No Target	Alert		n/a	FPC
	% of Extended Stay Patients 7+ days	Apr 2023	41.6%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Apr 2023	22.4%	No Target			n/a	FPC
COVID	Number of COVID patients in ICU beds (Monthly)	Apr 2023	3	No Target			n/a	Board
	Number of COVID patients in other beds (Monthly)	Apr 2023	195	No Target			n/a	Board
	% COVID staff absences (Monthly)	Apr 2023	11.1%	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)*	Mar 2023	0.05	see analysis	**Alert**	H	n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Mar 2023	0.25	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Mar 2023	0.15	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Mar 2023	0.10	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Mar 2023	0.34	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Nov 2022	101.4	As expected		L	As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Apr 2023	15	Reducing			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Apr 2023	186	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Aug 2022	140.1	110.0	**Alert**	H	F	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Mar 2023	100.0%	No target	**Highlight**	H	n/a	Board
	Number of Serious Incidents raised in month	Mar 2023	17	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Mar 2023	0	0		n/a	n/a	Board
	Duty of Candour Rate	Mar 2023	87.0%	100.0%	**Alert**	L	?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Mar 2023	4.5	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Mar 2023	3.8	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Apr 2023	95.7%	95.0%		H	?	Board
	Care Hours Per Patient Day (CHPPD)	Mar 2023	8.3	No target			n/a	Board
	Mixed Sex Accommodation Breaches	Mar 2023	3.0	0			?	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Apr 2023	4.8	No target			n/a	Board
	Complaints Responded to on time	Apr 2023	82.0%	85.0%			?	Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Mar 2023	590 out of 646	No target		n/a	n/a	Board
	Number of Positive A&E Scores	Mar 2023	178 out of 287	No target		n/a	n/a	Board
	Number of Positive Community Scores	Mar 2023	88 out of 90	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	Mar 2023	183 out of 197	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Mar 2023	29 out of 32	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Mar 2023	40 out of 47	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Mar 2023	4 out of 4	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Mar 2023	40 out of 50	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Apr 2023	91.0%	90.0%			?	Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Mar 2023	75.0%	90.0%			?	Q&S
	Escalation of NEWS in line with Policy	Feb 2023	3.3%	No target		n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	Mar 2023	47.4%	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)*	Feb 2023	57.9%	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)*	Feb 2023	0.0%	90.0%		n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool	Mar 2023	40.0%	90.0%		n/a	n/a	Q&S
	Rate of Children who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Children	Mar 2023	42.1%	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)*	Mar 2023	70.0%	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)*	Mar 2023	56.0%	No target		H	n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	Mar 2023	62.0%	No target			n/a	Q&S
	Patients prescribed an antibiotic	Feb 2023	65.6%	50.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Mar 2023	1.4%	No target		L	n/a	Q&S
	Perentage of Antibiotic prescriptions with evidence of a review within 72 hours	Feb 2023	48.7%	70.0%		n/a	n/a	Q&S

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	Audience
Vacancies	Unregistered Nurse Vacancy Rate	Mar 2023	10.3%	8.0%	Alert			Board
	Registered Nurse Vacancy Rate	Mar 2023	10.2%	8.0%				Board
	Medical Vacancy Rate	Mar 2023	11.1%	15.0%				Board
	Trustwide Vacancy Rate	Mar 2023	9.7%	8.0%	Alert			Board
Staffing Levels	Turnover Rate	Apr 2023	11.0%	10.0%	Alert			Board
	Sickness Rate	Mar 2023	5.0%	4.1%				Board
Staff Development	PADR Rate	Apr 2023	83.0%	85.0%	Alert			Board
	Medical Staff PADR Rate	Apr 2023	96.0%	85.0%	Highlight			Board
	Combined AfC and Medical Staff PADR Rate	Apr 2023	81.9%	85.0%	Alert			Board
	Core Mandatory Training Compliance Rate	Apr 2023	89.3%	85.0%	Alert			Board
	Role Specific Mandatory Training Compliance Rate	Apr 2023	77.8%	85.0%	Alert			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Apr 2023	7	No Target	Alert		n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Apr 2023	13	12	Highlight			WFC
	Number of Suspensions Live in Month	Apr 2023	4	No Target	Alert		n/a	WFC
	Average Length of Suspension (Weeks)	Apr 2023	23	No Target	Alert		n/a	WFC

Appendix C - Glossary

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

NLG(23)095

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6 June 2023
Director Lead	Ellie Monkhouse, Chief Nurse/Executive Maternity & Neonatal Safety Champion
Contact Officer/Author	Nicola Foster, Associate Chief Nurse - Midwifery, Gynaecology & Breast Services
Title of the Report	**Maternity & Neonatal Oversight Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this new highlight report is to provide the Board with an oversight of the Trust's maternity and Neonatal services. A full report is provided to the Quality and Safety Committee, with key highlights provided for Board Assurance and oversight in line with best practice and information/papers provided to other trust boards following a review by the Chief Nurse. Highlights of key areas are summarised for assurance and information. The Board is asked to note this report and its contents. • Midwifery vacancy rate demonstrates a slightly improving picture in April, although remains challenging. Positively the first cohort of four international midwives have commenced in post in March. • The Trust have reported compliance, with confirmation of all 10 safety actions within the Maternity Incentive Scheme for the second successive year and await publication of Year 5. • Current ongoing Quality Improvement (QI) projects within maternity services include Induction of Labour, Maternity Triage and Neonatal Thermoregulation. Our next QI project will be to review the provision of Antenatal Clinic and Day Units cross site (to include capacity, demand, criteria and staffing) • The Trust is on the Maternity Safety Support Programme hosted by NHS England (NHSE) via the national maternity team, led by the Chief Midwifery Officer for England. We are now entering the exit phase of the programme. A review of the original diagnostics which took place in July 2021 have taken place. This shows that all of the original diagnostics are almost complete. The next stage of the process is to share our Sustainability Plan with the board to enable us to move to the next stage of the process. Our plan is attached in Appendix II. The board will continue to be updated on this as we progress through the exit process. • We continue to work on our plan against the NHSE Maternity Self-assessment tool. Opportunities for improvement have been identified and translated into an action plan which will be progressed by the Family Services division. • The Maternity Single Oversight Plan was published in March 2023. • A Midwifery Strategy is currently in draft following a consultation period

	• The planned National Maternity Team assurance visit will be replaced by an assurance visit from the LMNS (Autumn 2023).	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Maternity and Neonatal Oversight Board Report
May 2023

1. Introduction

This is the Board Maternity and Neonatal Services Oversight Report. This report provides information to the Board around the workforce, quality and safety of our maternity and neonatal services. An extensive review of maternity services board papers took place as part of the development of this new report and format.

In line with the requirements of Clinical Negligence Scheme for Trusts (CNST), Ockenden reports and now the newly published Single Oversight Plan published in March 2023 there is an expectation around what insight and oversight the Board has around Maternity Services.

The Trust currently remains on the Maternity Support Programme, however, we are starting our journey to exit this programme. A sustainability plan is required as part of this process that needs to be shared with the Trust Board, this can be seen in Appendix II.

2. Workforce/Staffing

There has been a reduction in vacancies in March:-

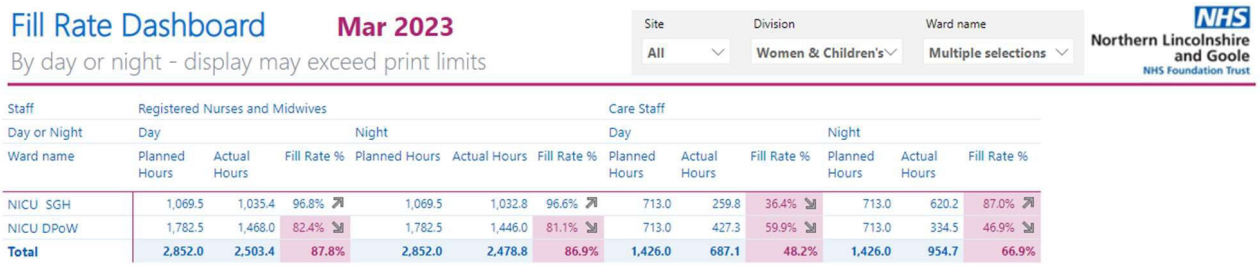
DPoW
Registered reduced from 18.0 to 16.5
Unregistered reduced from 3.3 to 2.8

SGH
Registered reduced from 20.0 to 15.0
Unregistered remained static at 1.1

Maternity Wards Fill Rates and CHPPD Mar 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**93.4%**	**▼ -0.1%**	**86.1%**	**▲ 7.2%**	**14.0**	**▲ 1.55**
Registered Nurses and Midwives	89.7%	▼ -2.1%	82.5%	▲ 4.1%	8.6	▲ 0.77
Care Staff	99.9%	▲ 3.5%	92.5%	▲ 12.6%	5.4	▲ 0.77
Central Delivery Suite	**86.9%**	**▼ -8.3%**	**57.1%**	**▼ -5.7%**	**37.2**	**▲ 9.25**
Registered Nurses and Midwives	85.8%	▼ -11.0%	53.2%	▼ -6.4%	30.8	▲ 7.89
Care Staff	92.3%	▲ 3.8%	77.4%	▲ 1.1%	6.5	▲ 1.36
Jasmine & Honeysuckle	**91.0%**	**▲ 1.7%**	**78.1%**	**▲ 6.2%**	**10.5**	**▼ -2.06**
Registered Nurses and Midwives	87.0%	▲ 1.6%	72.1%	▲ 4.5%	6.8	▼ -1.33
Care Staff	99.1%	▲ 2.0%	90.6%	▲ 9.6%	3.7	▼ -0.73
Ward 26 SGH	**86.6%**	**▲ 2.4%**	**62.9%**	**▼ -0.4%**	**7.4**	**▲ 0.59**
Registered Nurses and Midwives	84.1%	▲ 0.6%	65.6%	▼ -0.8%	5.3	▲ 0.31
Care Staff	93.5%	▲ 7.3%	55.4%	▲ 0.6%	2.2	▲ 0.27
Total	**89.7%**	**▼ -1.0%**	**71.7%**	**▲ 1.7%**	**12.6**	**▲ 0.56**

The Trust wide maternity dashboard is shown in **Appendix I**.



Fill Rate Dashboard Mar 2023

By day or night - display may exceed print limits

Site: All | Division: Women & Children's | Ward name: Multiple selections

Northern Lincolnshire and Goole NHS Foundation Trust

Staff	Registered Nurses and Midwives						Care Staff					
Day or Night	Day			Night			Day			Night		
Ward name	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %
NICU SGH	1,069.5	1,035.4	96.8%	1,069.5	1,032.8	96.6%	713.0	259.8	36.4%	713.0	620.2	87.0%
NICU DPoW	1,782.5	1,468.0	82.4%	1,782.5	1,446.0	81.1%	713.0	427.3	59.9%	713.0	334.5	46.9%
Total	**2,852.0**	**2,503.4**	**87.8%**	**2,852.0**	**2,478.8**	**86.9%**	**1,426.0**	**687.1**	**48.2%**	**1,426.0**	**954.7**	**66.9%**

The fill rate for Registered Nurse (RN) at Scunthorpe General Hospital (SGH) Neonatal Intensive Care Unit (NICU) is above the target of 95% for both days and nights. At Diana Princess of Wales Hospital (DPoW), Grimsby, the fill rate is less due to an increase in the establishment which is being recruited to. Bed occupancy is reviewed daily and shifts are only covered when necessary if there is full cot occupancy. The fill rate for health care assistants is low at both sites, this is due to the daily review and movement of staff between Children and NICU to keep areas safe and some vacancy and Long-Term Sickness (LTS) gaps which are being managed appropriately.

3. Patient Experience/Service User Feedback

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

Formal Complaints and PALS Data

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

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

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

New of new PALS	Mar-23	Apr-23
Gynaecology	10	5
Obsterics	3	1
Paediatrics (including neonates)	9	4
Breast	1	1

The paediatric service, which includes the neonatal services, received the highest number of formal complaints during the reporting period, with the highest occurring theme being of clinical treatment. Gynaecology services received the highest number of PALS concerns with themes of delays, this predominantly featured clinic pathways, and communication, including attitude and behaviours of staff.

Overall divisional themes arising from closed cases, where the issues have been fully investigated, are delays, which included delay in diagnostic information impacting on clinical pathway, this learning has been shared divisionally. Communication was also a key theme, including accessibility, as a result of this Family Services have been provided with dedicated interpreter on wheels devices, including a key community clinic, and a training update on the use of these. There has been an increase in time to respond to PALS and this has been highlighted through divisional reporting, there is an established process in place and at times these increases are due to complexity of concerns.

Service User Feedback
Whilst the appointment of a Maternity Voices Partnership (MVP) chair is arranged, we continue to utilise opportunities to gain feedback including Friends and Family, national Maternity Survey and social media and the patient element of '15 steps'. There is a Local Maternity Neonatal Service (LMNS) 'Ask A Midwife' service which is popular amongst women and their families to access and is also a means of imparting up to date information, public health messages – Safe Sleeping, Thermoregulation etc and also events such as Antenatal Education.

There were no PALS or formal complaints received for either Neonatal Unit in March 2023.

4. Assurance

Two 15 Steps Challenge visits took place within Maternity Services during March 2023 and April 2023, these were to the Antenatal Outpatient Clinic at Goole District Hospital and to the Pink Rose Outpatient Clinic at DPoW Hospital. Both clinic areas achieved outstanding ratings, Antenatal Clinic improving their rating from Good in 2022 and Pink Rose Clinic maintaining their outstanding rating. Themes reported are minimal due to both areas achieving and / or exceeding expected standards of professional practice.

Acute 15 Steps Challenge Visits			
Date of visit	Ward/ Department	Rating 2023	Previous Rating
29/03/2023	Antenatal Clinic GDH	29/03/2023	25/01/2022
26/04/2023	Pink Rose Suite DPOW	26/04/2023	24/02/2022
29/03/23	Midwifery GDH	OUTSTANDING	GOOD

[R1][R2]

Standards	Areas for consideration
Standard 1: Observation	• **Information:** Antenatal Clinic could benefit from creative displays and education boards. Staffing information re: who staff are in the clinic. Information regarding the birthing pool facility – as staff were very proud of this service
Standard 2: Documentation	**Not completed in outpatient areas**
Standard 3: Patient Feedback	**No themes for consideration – Note positive patient feedback**
Standard 4: Staff Feedback	**No themes for consideration – Note positive staff feedback**

5. Feedback

Maternity & Neonatal Safety Champions
The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMNS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes. There are embedded monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the venue each time. It provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication.

The walkaround on 30 March consisted of meeting staff on Ward 18 (Antenatal and Postnatal Ward) and Pregnancy Assessment Centre including midwives, health care assistants and

medical staff. The walk round was extremely positive and staff were keen to share with us the positives about their areas including improvements made within Pregnancy Assessment Centre following their 15 Steps and the ward move to Ward 18 whilst the flooring and décor was being improved on Ward 26.

Escalated Issues

- Discussion with the safety champions included hydration for staff and patients within the Pregnancy Assessment Centre. The Deputy Manager was asked to look at possible hydration stations and to escalate if there were any blocks on ordering this piece of equipment.

- Consultant Ward Rounds are not always being completed each day on the Antenatal/Postnatal Ward. **Action:- Clinical Divisional Director to discuss with Clinical Lead and identify the issues.**

6. Quality Improvement

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

This Quality Improvement Project aim was to intentionally Implement a fully operational maternity Triage Service across the whole of the Maternity Service in Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), that utilises a Nationally recognised Triage Model by March 2023 in order to enhance the patient experience and care. Project currently paused and awaiting Human Resources (HR) recommendation.

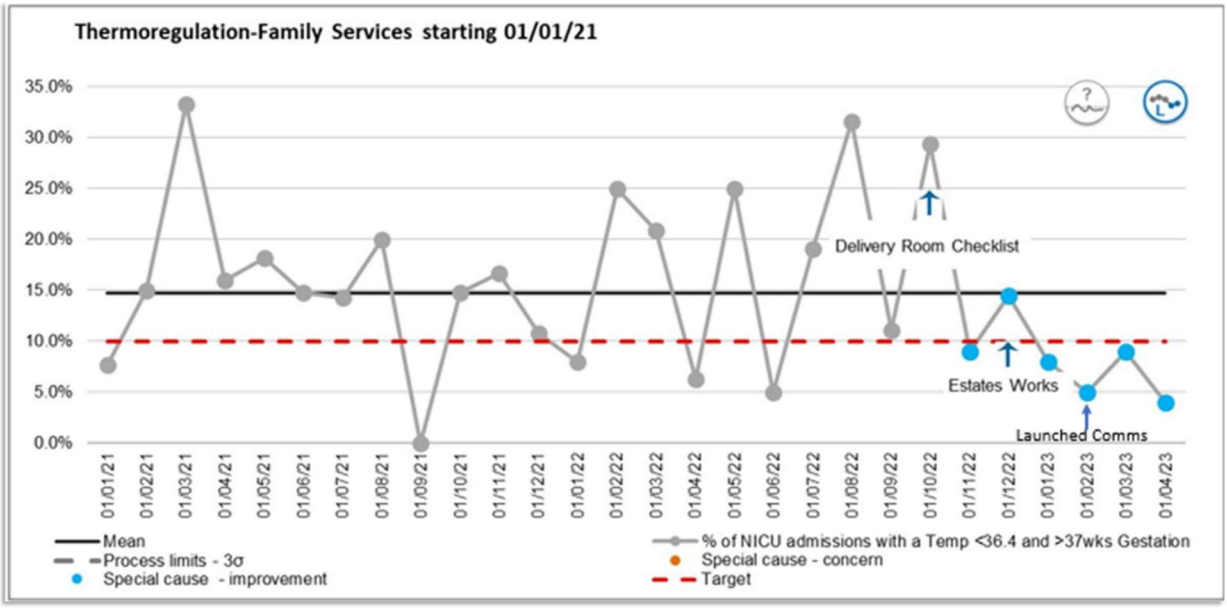
To date Phase 1 and 2 have been completed which focused on the implementation of a telephone triage single point of access which follows the BSOTS model. This went live in October 2022 and have answered 5190 calls to date using the BSOTS model for triage thereby centralising and standardising the advice given to patients. Having consolidated various phone lines into one single points of access this has also benefitted our wards, Antenatal Day Units (ADU) and community teams in reduced phone calls by 20hrs per week on average releasing time to care back to frontline teams. The service has also been able to utilise experienced midwives who were unable to carry out patient facing roles in a new way bringing to bear their years of experience to benefit patients making these staff members feel valued. 92% of patients using this new services have rated it either “excellent” or “very good”.

Focus has now moved to Phase 3 for full implementation of the BSOTS model which following the above telephone triage of a patient, if it is deemed they need to be assessed face to face. This extensive service redesign will change our physical footprint of our wards and areas, although fundamentally the service will be doing the same amount of work but in a different way.

The project is currently working with HR and Estates colleagues to assess requirements and agree timescales to progress Phase 3. Whilst discussions are continuing the BSOTS paperwork has been implemented Trust wide.

Reducing Thermoregulation

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



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

7. Serious Incident Reporting

Open Maternity Serious Incident Investigations as at 10.05.23
There are currently 5 Maternity Serious Incidents open in the Trust. For 2, the investigation is being undertaken by Healthcare Serious Investigation Branch (HSIB).

STEIS Ref	Site	Description	Stage	Immediate actions and learning points	Deadline date
2022 20796	DPOW	Unexpected baby death	Investigation	The neonatal resus pro forma is being reviewed as it is not user-friendly for an emergency situation.	HSIB investigation
2022 26951	SGH	IUD Delayed Induction	Report Writing	Familiarisation of Fetal Growth policy re timing of inductions. Doctors reminded of availability of the Consultant on Call if there is Consultant present in the clinic.	06.06.2023
2023 398	DPOW	HSIB - IUD	Draft Report	Call screening to be completed by a registered midwife on WebV. Laminated cards for CTG interpretation placed on the CTG monitors Review of appropriate escalation completed by Senior Midwifery Team (outcome reported to SI Panel that escalation was compliant with policy requirements).	HSIB investigation
2022 18557	DPOW	Birth injury – fractured skull	Draft Report	To add to safety huddle re: use of fetal pillow for full dilatation LSCS and not to manually disimpact fetal head.	22.05.2023
2023 8658	DPOW	Maternal Cardiac Arrest	Investigation	Reviewing the issues relating to referral and acceptance for Interventional Radiology (HUTH) Investigating the decision making and potential disagreements between staff during the cardiac arrest.	20.07.2023

Maternity Serious Incident Completed Reports (May 2023)

STEIS Ref	Site	Description	Stage	Learning points
2022 2522	DPoW	Maternal Cardiac Arrest	Action Plan Ongoing	• Administer antihypertensive medication in severe hypertension, in a timely manner. • Avoid administration of Syntometrine and Ergometrine to patients with hypertension. • Full drug names, not abbreviations, to be written on handover boards. • All clinical rooms must be able to accommodate resuscitation equipment and trollies, including bereavement rooms if these are used as clinical rooms.
2022 7551	DPoW	Neonatal Death	Action Plan Ongoing	• When there is a lack of agreement between staff regarding the interpretation of a CTG, escalate to a Senior Clinician. • A new antenatal CTG interpretation sticker to be created and used, that incorporates an action plan to aid better focus on the whole clinical picture. • All CTG reviews should be performed using either antenatal cardiotocograph (CTG) classification sticker or intrapartum cardiotocograph (CTG)

STEIS Ref	Site	Description	Stage	Learning points
				classification as appropriate, and not to be written in freehand. • Emphasis on defining types of fetal decelerations to be shared at both sites. • There should be shared communication between the anaesthetic team and the obstetric team of the fetal heart rate and maternal pulse on commencing CTG in theatre and regular communication thereafter.
2022 10750	DPoW	Fractured skull following instrumental delivery	Action Plan Ongoing	• Written consent to be taken for all instrumental births (undertaken in both the operating theatre and the birth room). • Staff to be aware of the rare complication of subgaleal haematoma and neonatal clinical presentation.
2022 6473	DPOW	HSIB - HIE	Closed	• All women / birthing people should be risk assessed on admission to ensure mothers / birthing people are assigned the correct care pathway with the appropriate fetal monitoring. • When carbon dioxide levels are unresponsive, further measures to be used to reduce the Baby's respiratory efforts to help achieve normal levels promptly and maintain them.
2022 17384	SGH	Pre-term birth neonatal death	Closed	• Maternity notes must be available to all midwives for booking appointments. • All women who meet the criteria must be referred to the Pre-Term Birth Prevention Clinic (PTBPC) using the referral form within the guidance. All women following their first scan (dating scan) must be seen by a registered health professional (Midwife/ Doctor), to ensure relevant advice, guidance, information and referral for further diagnostic testing or medication is provided. • The VBAC Checklist to be completed fully and referrals made

STEIS Ref	Site	Description	Stage	Learning points
				to Pre-Term Birth Clinic as required.

Risks, learning points & themes
In addition to the learning points identified in the completed investigations above, there are other risks identified as below:-

- The Maternity Voice Partnership Lead is vacant which will mean the Trust may not achieve CNST next year.
  The risk of this is financial and reputational.
- Implementation of the second phase of the maternity triage QI project may have a potential delay due to potential staff consultations
- Obstetricians may potentially not have access to electronic scan reports when the new maternity services EPR (Badgernet) is implemented, as a result of the systems incompatibility with the current Viewpoint package. Work is being undertaken to ensure that the interfaces are being built.

8. Sustainability Plan

The Trust is moving towards an exit from the MSSP Programme. As part of this process a review of the initial diagnostic done in 2021 has been reviewed. The first sustainability plan is included in **Appendix II**. The plan needs to be supported by the Trust Board in order to progress to the exit plan external process. As identified in the diagnostic review, the Trust has achieved, with evidence, the majority of the initial actions identified. Our Maternity Improvement Advisors and our regional maternity team, including the regional and Deputy Chief Midwife are supporting us with this process. There is an expectation as part of our exit plan that the Board are kept up to date on the progress on delivery of the plan, the board maybe asked to contribute to any external exit process.

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

The national plan was published in March 2023. The delivery plan is directed at frontline staff and leadership and describes the building blocks that need to be in place to ensure the needs of women, babies and families are at the heart of services. It summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards and Systems including Local Maternity and Neonatal Systems and Operational Delivery Networks, and NHS England. The areas of focus are:-

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

10. Maternity Self-Assessment Tool

The maternity self-assessment tool, along with the maternity services sustainability plan, forms the basis for the organisation exiting from the Maternity Safety Support Programme hosted by NHSE and was initially presented to the Trust Management Board on 6 March 2023. The self-assessment outcomes provide assurance of good self-assessed compliance with the majority of descriptors used to benchmark organisations in the core principles of good safety standards and offers assurance that the Trust's maternity operational service delivery meets national standards, guidance and regulatory requirements. Opportunities for improvement have been identified and translated into an action plan (see below) which are being progressed by the Family Services Division with Trust wide/corporate support.

These actions are monitored through divisional governance with board assurance provided via the Division's regular report to the Quality and Safety Committee, through to Trust Board. The self-assessment tool will be monitored through the Maternity Improvement and Transformation Board.

Of the 17 improvement opportunities identified within the action plan, five have been completed and evidenced. The remaining twelve actions are on track for completion with all due completion by July 2023.

11. CNST Evidence

Maternity Incentive Scheme (CNST) - year four
Following a robust confirm and challenge process both internally and with the ICB/LMNS, full compliance has been reported to NHS Resolution prior to the 2 February 2023 submission date.

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

Maternity Incentive Scheme, year five, is awaited.

12. Conclusion

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

Complaints and PALS remain in low figures, and these are investigated and resolved within the expected time limits. The Friends and Family show excellent feedback with an average score of 4.92 (increased from 4.78) and a 93.9% (increased from 88.3%) positive experience.

There were two 15 Steps Challenge Visit during March 2023. The Antenatal Clinic and Midwifery Teams both were rated as outstanding.

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

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

Serious incidents (SI) and HSIB cases remain low with one newly reported SI in May 2023. As with complaints and PALS, due to the limited number there are no themes however all learning is widely shared across all areas and reported into the regional meeting.
The maternity self-assessment tool forms a basis for the organisation to exit from the Maternity Safety Support Programme and the action plan within the report shows the outstanding issues which are being worked through.

Appendix I – Maternity Dashboard

Trustwide Maternity Dashboard

Indicator	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Midwife to Birth Ratio	24.9	25.1	25.0	26.2	26.2	25.8	24.8	22.9	24.2	23.7	23.4	22.2
Red Flags	30.0	24.0	18.0	34.0	16.0	9.0	17.0	9.0	19.0	3.0	1.0	3.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	2.0	1.0	1.0	5.0	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	2.0	3.0	2.0	2.0	1.0	1.0	0.0	3.0	1.0	0.0	2.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	2.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	2.0	2.0	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	1.0	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	11.0	6.0	13.0	5.0	4.0	5.0	3.0	9.0	1.0	1.0	1.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	24.0	10.0	8.0	10.0	6.0	3.0	11.0	3.0	5.0	1.0	0.0	0.0
Continuity of Carer %	19.0	20.0	18.0	12.0	12.0	12.0	14.0					
In Receipt of %	11.0	8.0	11.0	9.0	8.0	9.0	8.0					
CoC In Receipt of %	69.0	68.0	58.0	70.0	72.0	68.0	66.0					
Continuity Team Caseload	524.0	488.0	488.0	305.0	305.0	295.0	311.0					
Divert / Unit Closures	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	88.1	88.0	88.1	84.1	84.1	85.5	89.0	96.2	91.0	93.1	92.3	97.2
Labour Co-ordinator Supernumerary Status %	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	99.5	100.0
Vacancies	46.6	47.3	43.5	44.5	45.2	51.7	41.6	41.1	40.4	42.2	41.7	34.4
Vacancies - Registered	38.1	40.3	38.8	39.8	40.6	42.2	39.8	34.4	34.4	36.0	37.3	30.5
Vacancies - Unregistered	8.5	7.0	4.7	4.7	4.6	9.6	1.8	6.7	6.0	6.1	4.4	3.9
Serious Incidents	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0
Complaints	2.0	1.0	3.0	2.0	3.0	1.0	3.0	2.0	0.0	1.0	2.0	1.0
PALS	5.0	6.0	5.0	1.0	6.0	5.0	6.0	4.0	3.0	3.0	3.0	3.0
Sickness Absence (Division) %	8.8	5.9	5.8	6.8	6.4	6.0						

Appendix II – Sustainability Plan

Action ID	Sustainability Action Plan	Specific actions to be implemented to ensure ongoing sustainability	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date/ Timeline	Evidence
SAP1	Developed maternity risk management strategy	Periodic review as per document control policy	17/5/23 - Strategy in development	Strategy ratified at Obstetric Governance Meeting and available on the Trust intranet		Chief Nurse	Head of Midwifery	Jun-23	
SAP2	Benchmarked against maternity self-assessment tool with a QI plan to be reviewed quarterly at the maternity transformation board chaired by Chief Nurse attended by the NED and MVP lead to be reviewed quarterly	Self-assessment tool action plan - monitored at QI and Monitoring Group, Maternity Transformation Board and presented at Trust Board.	9/5/23 Ongoing	Minutes of QI and Monitoring Group, Maternity Transformation Board and Trust Board. Completion of action plan.		Chief Nurse	Associate COO	Jul-23	
SAP3	To develop and refine the SMART approach to QI plans in response to learning from incidents and complaints	Incident review meeting - action log, Action plan re Complaints (monitored at QI and Monitoring Group Meeting) Embed process for triangulation of themes and trends for incidents, complaints and claims.	9/5/23 Action log commenced for Incident Review Meeting and Complaints Action plan monitored at the QI and Monitoring Group. Work in progress to embed triangulation of themes.	Incident Review Action log and Minutes from the QI and Monitoring Group.		Chief Nurse	Associate Chief Nurse	Jul-23	
SAP4	Develop a PMA QI plan around A-Equip model	Service reconfiguration re: team model. Consider benchmarking against Birmingham A Equip model	9/5/23 Meeting planned with Lead PMA. Pastoral support , recruitment and retention midwife in post	Model implemented		Chief Nurse	Associate Chief Nurse	Jul-23	
SAP5	Develop the Matrons and their role as visible leaders supporting the senior team to implement the quality improvements	QI course completed by Maternity Matron (DPOW) Further Matron post - Gynaecology and Breast to support maternity services.	9/5/23 Matron post - Gynaecology and Breast is currently advertised (planned date for interview 13/6/23) Plans for Matrons and managers within the Division to attend Trust 'Leading with Kindness, Courage and Respect Programme'	Matron for Gynaecology and Breast in post and Matrons booked onto the course.		Chief Nurse	Associate Chief Nurse	Jul-23	
SAP6	Support plans to increase establishments of the governance team and reduce portfolios of the senior clinical teams so the maternity services have capacity to have senior oversight and messages to the executive team are not diluted under the umbrella of family services	Work on-going. Review completed - March 2023	9/5/23 Recruitment agreed for Maternity audit and compliance manager and Governance Deputy posts.	Maternity audit and compliance manager and Governance Deputy in posts.		Chief Nurse	Associate COO	Jul-23	
MSAT1	Leadership development opportunities	Leadership and development programme for potential future talent (talent pipeline programme)	Evidence required. Leadership Development Strategy				Tori Hordon, Organisational Development Business Partner	May-23	
MSAT2	Maternity strategy, vision and values	Maternity strategy in place for minimum 3-5 years	14/4/23 Draft document, awaiting illustration to be added prior to wider circulation for comments.				Division Tri	Jun-23	
MSAT3	Maternity strategy, vision and values	Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	14/4/23 as above				Division Tri	Jun-23	
MSAT4	Maternity strategy, vision and values	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	14/4/23 as above				Division Tri	Jun-23	
MSAT5	Maternity strategy, vision and values	Maternity strategy aligned with trust board LMNS and MVP's strategies	14/4/23 as above				Division Tri	Jun-23	
MSAT6	Non-executive maternity safety champion	NED appointed as one of the board level maternity safety champions and working to national role descriptor	14/4/23 NED in post, working to national role descriptor. Core member of Safety Champion monthly walk-rounds				Chief Nurse	Apr-23	In h/family services/divisional managers/maternity/self assessment tool
MSAT7	Multi-professional engagement workshops	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans	Evidence required				Division Tri	Jun-23	
MSAT8	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	Evidence required				Dave Sprawka	Feb-23	Evidence\VBR
MSAT9	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Evidence required				Richard Dickinson, Associate Director of Quality Governance	Jul-23	
MSAT10	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	Evidence required. Divisional framework in development.				HRBP	Jul-23	
MSAT11	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	Evidence required. In progress at divisional level.				HRBP	Jul-23	
MSAT12	Maternity governance structure	Maternity governance and leadership team roles review	Review underway supported by MIA. Recruitment in progress for additional leadership roles				Division Tri	May-23	
MSAT13	Proactive shared learning	Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	Evidence required				Richard Dickinson, Associate Director of Quality Governance	Jun-23	
MSAT14	Safety huddles	Audit of compliance against safety huddle guideline/SOP	Evidence required				Division Tri	Jun-23	
MSAT15	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz
MSAT16	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz
MSAT17	Trust wide Swartz rounds	Broad range of specialties leading sessions	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz

Red	Overdue
Amber	On track
Green	Completed

NLG(23)096

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	6 June 2023
Director Lead	Dr Kate Wood, Chief Medical Officer
Contact Officer/Author	Richard Dickinson, Associate Director of Quality Governance Fiona Moore, Head of Quality Assurance
Title of the Report	**Annual Quality Account 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	Each year the Trust is required to publish an annual Quality Account by the national deadline of 30th June 2023. The attached paper is the draft Quality Account which provides an overview of the Trust's performance, particularly the progress made against the Quality Priorities for 2022/23 and sets out future priorities going into 2023/24. The Trust is required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. However, due to the impact of COVID-19 some national data collection was paused leading to delays in publication. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update. As per national guidance no external audit is required for this year's publication. However, the Trust commissioned Audit Yorkshire to undertake an internal audit to gain assurance that the Trust has appropriate and effective controls in place to ensure it produces a robust Quality Account in line with national guidance. The review found that adequate arrangements have been put in place to ensure timely completion of the Quality Account, and that data reported within the Quality Account is accurate, up to date and from a reliable source. No formal recommendations were made. Due to national data validation deadlines out with the control of the Trust the Commissioning for Quality and Innovation (CQUIN) Quarter 4 data presented in the table on pages 34/35 will require updating post 16th June prior to publication. Approval is requested from the Trust Board of Directors for the Quality Account to be released for publication. Signature by the responsible person (most senior employee) and Chair of the Board is required on p75 ahead of publication.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.

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

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

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

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2022/2023

Kindness · Courage · Respect

CONTENTS

PART 1: Statement on quality from the Chief Executive of the Northern Lincolnshire and Goole NHS Foundation Trust

After two years dominated by responding to the COVID-19 pandemic directly the 2022/23 financial year was a year of coping with the indirect consequences of it. The most obvious impact of the pandemic has been the increase in the number of patients waiting for operations and procedures across the country. At our Trust we saw an increase although it was proportionately lower than many other areas as we did everything we could during the pandemic to keep our operating theatres running. Given this we were asked to provide support to other local hospitals – in particular Hull and, to a lesser extent, York – and take some patients from their waiting lists. This work amounted to several hundred patients.

Another consequence of the pandemic has been the impact it has taken on our staff. After two of the toughest years the NHS has ever faced our staff started the 2022/23 year tired, stressed and facing a difficult year in terms of both their work and the economic climate they were facing. I must report, as I have in my statements in previous Quality Accounts, our staff responded superbly to all the challenges put in front of them throughout the year. Throughout our hospital, community services, pathology services and support functions our teams went above and beyond, again and again, to do everything they could to care for patients and provide services. As in previous years we continued to experience growing demands – for example from patients attending our Emergency Departments (EDs) and in responding to changing guidance and to discharging patients from our wards. And all this in some working environments which are not always the best to work in and in some services where we are carrying more staff vacancies than we would want. Our staff coped incredibly with all this, and more – I want to thank them publicly through this statement for everything they have done in the past year.

Despite the pressures our staff faced and their own levels of tiredness they still managed to achieve some fantastic results. I should start by noting the Trust's continued and sustained performance in its Summary Hospital-level Mortality Indicator (SHMI). The SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology and is one of the best overall indicators for the delivery of safe services in hospitals. It is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. At the time of writing (April 2023) the Trust had a SHMI of 101.35 for the period December 2021 to November 2022. This was in the 'as expected' banding, was a lower score than the previous month (102.79 - 'as expected', November 2021 to October 2022) and the lowest ever SHMI score for the Trust since the figure was first introduced. It is also above the median for all trusts in England, a dramatic improvement on just a few years ago, when the Trust was consistently among the very worst performers in the country. This really is an excellent performance in a key indicator.

Another key indicator of the quality and safety of the services provided by hospitals is the results of a Trust's Care Quality Commission (CQC) inspection. I'm pleased to report the Trust achieved what is necessary to leave the Quality Special Measures it

has been in since 2017 after a CQC inspection in June and July 2022 recognised many improvements in the Trust's hospitals. Published in December 2022, the CQC's report recognises efforts to improve leadership, culture, safety, complaints and to tackle our waiting lists. Inspectors said they saw many good examples of patients receiving compassionate care, with staff ensuring patients' privacy and dignity were maintained and it was evident that staff worked hard to achieve the best possible outcomes for people throughout the services they inspected. The Trust is no longer rated 'Inadequate' for safety in any of its services and has maintained its 'Requires Improvement' rating. Scunthorpe General Hospital and the Diana Princess of Wales Hospital in Grimsby are both rated 'Requires improvement' and Goole and District Hospital is rated 'Good' overall. The Trust's community services were not inspected on this occasion. The CQC grade our services across our three hospitals in 112 'service domains'; we saw improvements across 35 of these 'service domains' and saw a reduced grading in only two. The CQC inspection covers five areas; Safe, Effective, Caring, Responsive and Well Led. At a Trust level Caring is 'Good' across the board and Safe, Effective, Responsive and Well Led are rated 'Requires Improvement'.

The CQC also releases the results of several patient surveys it undertakes throughout the year and we have seen improvement in those scores too. There was improvement in the feedback regarding our maternity services and I was particularly pleased to see the positive changes in our national inpatient results (which surveys patients who have stayed in hospital for one night or more) after the Trust was showing as an outlier in 2019. We have also seen some huge improvements in where we see and treat patients. We invested more than £35 million in the construction of new Emergency Departments in both Grimsby and Scunthorpe. Not only are these units twice the size of those they replace, helping us to meet the growing demand for our care, but our clinical teams have been involved in the design and build from the very beginning. In doing so, they have ensured that everything from the layout of the building to the location of equipment has been designed around what is best for our patients. Work is now underway on the refurbishment of our former Emergency Departments to convert them into Acute Assessment Units and Same Day Emergency Care provision, with both expected to open later in 2023. We also completed a series of smaller schemes, which are providing significant benefits to our patients. These included at Grimsby: a fully upgraded oxygen supply system, replacing the aging structure we previously had in place with a modern system that allows us to provide a consistent strong level of flow across the site; installing state-of-the-art digital X-ray equipment; creating a new lung function testing area; installing a second CT in our new Emergency Department; the demolition and removal of the temporary building which once housed our Critical Care Unit; and improving the safety of all patients, staff, and visitors to the site by installing a new fire alarm system. At Scunthorpe we have undertaken a full refurbishment of Ward 25, which has been transformed into a light and airy space, purpose built to limit the spread of infection; fully refurbished our fluoroscopy facilities and installed new equipment; installed new Maxillio Facial facilities to boost these services; and replicated the mortuary improvement works being done at Grimsby.

So, an incredible year of change and progress at the Trust. Of course, not everything has gone as we would have wanted. Because of our hospitals being so often full, too often patients waited a long time to be seen and treated in our EDs or to be transferred to a ward, and this meant that, with our EDs full, we didn't always have the space in our

EDs to take patients out of ambulances as quickly as we wanted to help the ambulance crews attend other calls. And, despite some great work which you can read about later in the document, we still have much work to do to improve the experience of patients who are reaching the end of their life. An area where we still, sadly, see ratings of 'Inadequate' from the CQC. Improving our end-of-life provision remains a key priority for the Trust in the coming year, as it has been in previous years.

As it has been in previous years our challenge for 2023/24 remains the same: to make sure our staff are able to offer the best possible patient care, by looking after them (our staff) and supporting them as they recover from such an intense few year, whilst at the same time doing everything we can to maintain our waiting lists and managing the increased demand we are experiencing for urgent care. If anyone can manage to do this, our staff can; they are superb and deserve huge credit. Once again, very many thanks to them all.

I can confirm that the Board of Directors has reviewed the 2022/23 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 14 April 2023

About Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'the Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire and therapy services at all our sites. The Trust provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire and has approximately 750 beds across three hospitals. The site locations are:

- Diana, Princess of Wales Hospital in Grimsby (also referred to as DPoW),
- Scunthorpe General Hospital located in Scunthorpe (also referred to as SGH),
- Goole & District Hospital (also referred to as GDH), and
- Community nursing services in North Lincolnshire.

The Trust was originally established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to reflect that the Trust did not just operate hospitals in the region. The Trust is now known as **Northern Lincolnshire and Goole NHS Foundation Trust.**

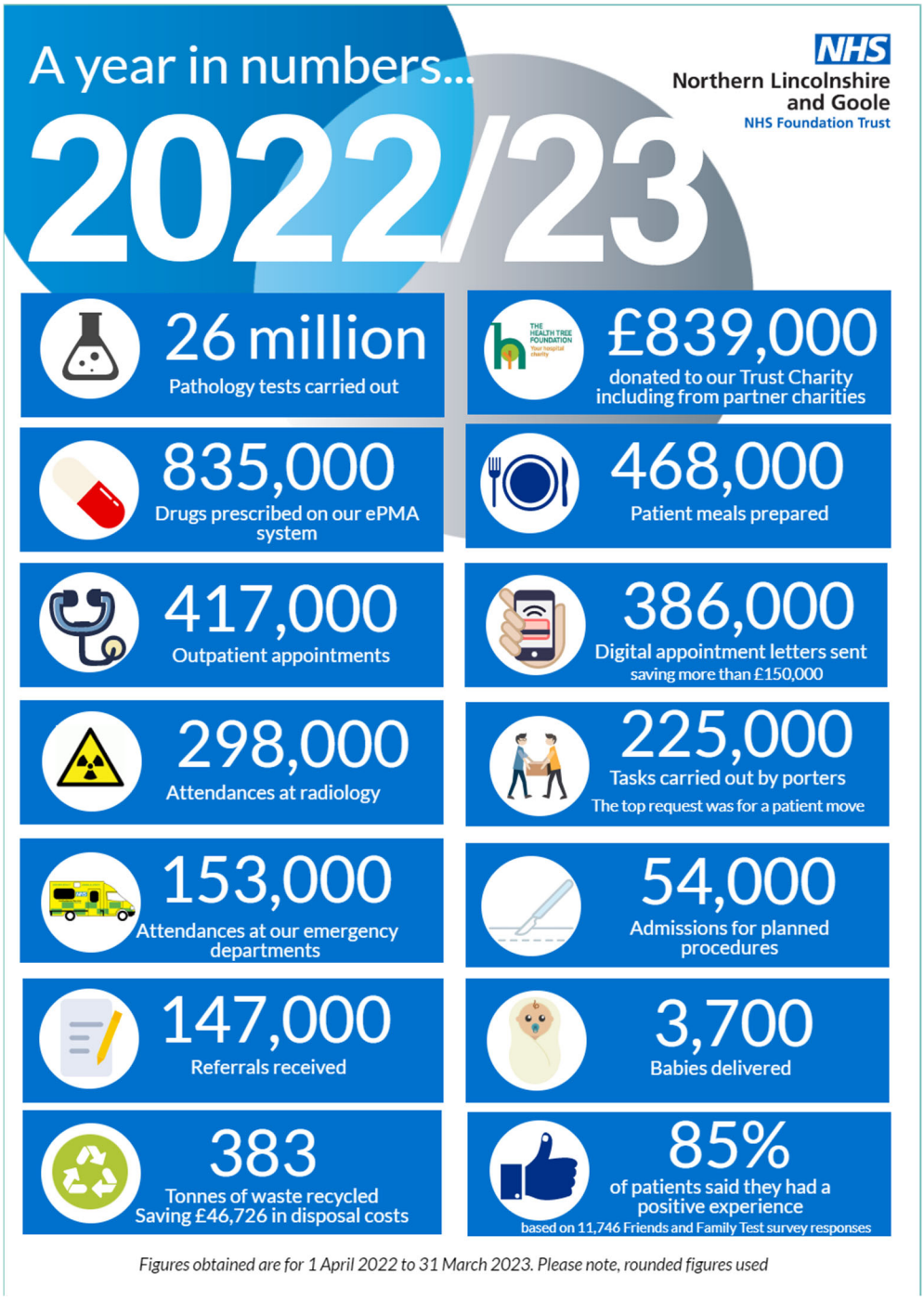


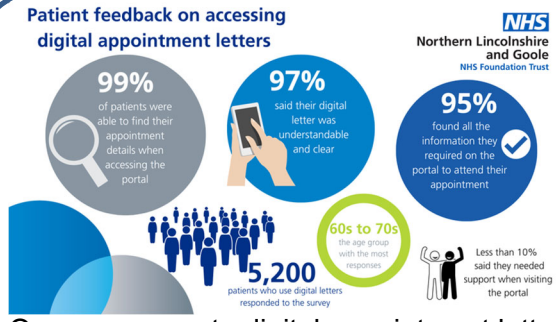
Figure 1: 2022/23 - A year in numbers

Proud Moments of 2022/23

The Trust was proud to be shortlisted as finalists in two categories at the 2022 Health Service Journal (HSJ) Partnership Awards which recognise outstanding contribution to healthcare. Staff have been working hard to get patients who are fit to leave hospital home as soon as possible. The Discharge Improvement Project, which has been a whole system effort across Northern Lincolnshire, has been recognised in the Integrated Care Partnership of the Year category. As a result of our efforts over the last two years the Trust is well under the national average for 'long length of stay' figures which reflect the length of time patients stay in hospital and is one of the best performing trusts in the North. The success of North Lincolnshire's vaccination programme was also recognised in the Covid Vaccination Programme category.

The Trust's latest CQC report showed an improving picture with the Trust no longer rated 'Inadequate' for safety in any of its services and has maintained its 'Requires Improvement' rating. Goole & District Hospital was rated as **Good** overall and the Diagnostic Imaging Core Service was highlighted for 'Outstanding practice'.

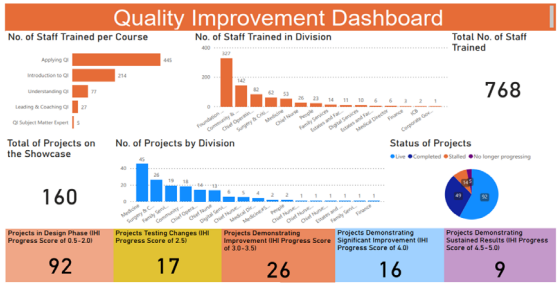
The Trust's infection control rates are among the lowest in England.



Our move over to digital appointment letters in Outpatients has been featured in a national digital playbook. The article covers the scope of the project, the functionality and the benefits to patients and staff. It highlights how the Trust have saved £152,000 in the first year, after switching over to digital letters.

The Quality Improvement Showcase launched in Nov 2022 to capture, showcase and celebrate QI initiatives from across the trust. It has over 160 QI projects documented with over 40% showing a measurable improvement with the remainder at various stages of testing and measuring data.

The Showcase allows staff to share their QI journey with others enabling cross divisional learning whilst inspiring and empowering colleagues to undertake their own QI projects.



Proud Moments of 2022/23

April Schwartz Round

Introduction of Schwartz Rounds offering a safe, reflective space for staff to share stories with colleagues about their work and its impact on them. The Rounds increase feelings of compassion towards patients, improve communication, and create more openness to receiving support.

First internationally educated midwives joined the Trust from their home country of Ghana. They will be supported through the Trust's preceptorship programme.

Development of two new EDs and AAUs. This has been supported by a significant national capital investment of £25m.

A range of improvements to clinical and education environments, mammography room at Grimsby and a maxillofacial room, a HYMS room and a fluoroscopy room at Scunthorpe, supported through charitable funding.

Introduction of Maternity triage telephone service. The service, which is for anyone who has medical concerns in pregnancy from 16 weeks onwards, has taken 3,500 calls since it launched on 31 October 2022. It is receiving great feedback and providing an invaluable service. Phase 3, which will see dedicated triage areas for people to attend at Scunthorpe and Grimsby, is coming soon.

We continue to see areas achieve good and outstanding in the 15 steps Programme. This is a continuous audit cycle that allows us to observe the environments from which we deliver care, review our documentation and through patient and staff feedback, highlight good practice and areas for improvement.

Proud Moments of 2022/23

The End of Life team were shortlisted in the Nursing Times Awards for team of the year.

The team, who work across hospitals in Scunthorpe, Grimsby, and Goole, as well as in the North Lincolnshire community, have been recognised for their commitment to improve End of Life care to our patients.

When a patient is near the end of their life, we support them and their loved ones to make it as comfortable as possible in line with their wishes for how they would like to be cared for.

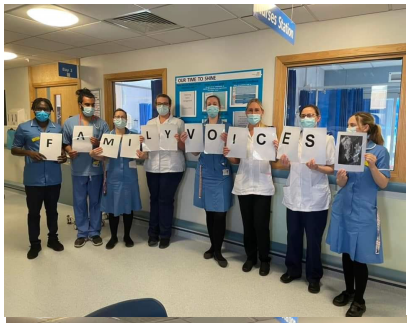
The Bluebell Principles, rolled out across the Trust, focus on better communication with the patients and family, recognising the signs of someone dying and developing individual care plans for each patient to ensure the care we provide is patient-centred, holistic, and consistent.

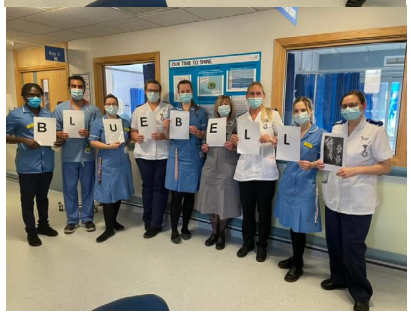
Sixty-eight End of Life Champions have also been trained to lead on the Bluebell Principles and support colleagues in their areas.

The Bluebell logo has been introduced and will be used in several ways when patients are at the end of their life. A simple Bluebell displayed on the room door of patients who are near the end of their life tells any staff entering the room the person is at the end of their journey with us. Bluebells symbolise humility and kindness, two important qualities to show our patients.

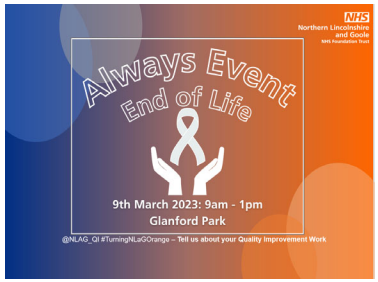
During the pandemic, many of our staff were faced with caring for patients at the end of their lives. Our hope is the Bluebell Principles will support any member of staff privileged enough to care for someone at such an important time of their lives and lead to even better patient care.

The Trust recognises that early recognition of patients at End of Life and support for patients and families goes beyond the End-of-Life team and is everyone's responsibility.





The Trust held an End-of-Life Quality Improvement 'Always' Event in March 2023 which focussed on understanding how we can support recognition and appropriate care planning for people who are approaching End of Life on our wards. Emerging themes and what good looks like will be the focus of our End of Life Quality Priority, Quality Improvement work in 2023/24.



Gareth's Story

Patient stories are recognised as providing valuable awareness and can help inform the Trust about current and ongoing patient experience or patient safety issues, which can generate debate, learning and actions.

Patient stories tend to be both objective and subjective, highlighting what happened and how that made someone feel. Getting the experience of care right is of the upmost importance to the Trust and we want everyone to receive the care and treatment they require, and this means that sometimes we may have to do things a bit differently, to get that same safe care and treatment outcome.

Gareth and his mum wanted to share their positive experience with us, following working with our Learning Disability Nurse Specialist, Emma Watts. Ensuring Gareth received the treatment he needed meant Emma and our staff worked with him, and his mum, over several weeks before his treatment date to ensure his visit went both smoothly and safely.

Gareth sums up his own experience below and details the collaborative approach used in delivering safe, person centred care.

My name is Gareth, I am 28 years old with a learning disability, autism and cerebral palsy. My mum is writing this for me as I don't read or write but can understand what I want and in my own way let her know what I like and what I don't like.

As I have grown older I don't like hospitals, I won't go to appointments or have someone come to my house. But things have changed a little this year and as I had a 'bad toe' that needed surgery, I needed to have it done. With the help and support of Marie my learning disability support worker and Emma the Learning Disability Nurse from hospital as well as the theatre staff and nurses on ward 28 and of course the surgeon the surgery has been completed and all is well.

Marie and Emma worked together with my mum to put together a plan to visit the hospital as a fun trip, have a drink of Dr Pepper and sit in the hospital car park. I did that a few times and I enjoyed the trips out. My mum was included in an MDT on teams with the surgeon and other professionals as my LPA /mum to discuss what was the best plan for me. On the day of the operation I went for my usual trip out to the hospital but this time I had an important job to deliver a letter to Emma inside the hospital, I like helping.

I took the letter with Marie, we all went to sit in the garden where I met some nice nurses who asked me what I liked to eat. "Ham sandwiches and strawberry ice cream" I said. I drank my Dr Pepper but this time it helped me be relaxed and not anxious as I usually was in different places. After a while I went for a ride in a wheelchair to theatre and two nice men helped me on a trolley. I wasn't anxious Marie was there.

I didn't know but my mum was in the car park waiting for me to go to sleep. When I woke up I was on a ward still on the trolley, not a hospital bed as I don't like them. Marie and my mum were there to give me a hug for being so brave. My toe was better. The nurses I had seen in the garden brought ham sandwiches and strawberry ice cream for me. I am so pleased I had my toe made better. Since then I have also been to Grimsby Hospital for an EEG twice.

I can't promise to always go to hospital but they have a plan that's just for me for when I need help to go. My mum isn't as worried now she has support to help me if I am not well. I have even agreed to help Emma with the

garden for learning disabilities and sent ideas for lights and animals to make it nice to visit. I am waiting for Emma to let us know when there is some money to buy the things for the garden.

Thank you for taking the pain away from my bad toe and helping me and my mum to get the help I needed without any extra anxiety and stress.

PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Quality priority planning for 2023/24

Quality priorities for 2023/24 were developed and set in accordance with the Trust's quality strategy and drawing on triangulated information from a wide range of quantitative and qualitative data sources including complaints, incidents, inquests, litigations, Structured Judgment Reviews (SJRs), clinical audit, risk registers, staff, and patient surveys. A long list of potential quality priority topics was developed and formed the basis of a survey monkey that was shared with all staff, the Trust Governors, stakeholders including Healthwatch, the Integrated Care Board (ICB) and local residents and service users through the Trust's communications and social media channels.

Analysis of the survey feedback was then used for wider consultation within the Trust which resulted in a short-list of quality topics. Building on the momentum and success of the Trust's Quality Improvement team the Trust took the opportunity to implement a new bottom up, Multi-Disciplinary Team (MDT) approach to setting the quality priorities and associated Key Performance Indicators (KPIs) by hosting a one day Quality Improvement quality priorities workshop to ensure engagement with the correct people drawing on feedback from all disciplines to identify what the problem is, what the root cause and drivers are, what needs to change, how the Trust will change it and how the Trust will measure success. This approach will improve Trust wide ownership and engagement and will facilitate coproduction to ensure that the quality priorities and KPIs that are set are Specific Measurable Achievable Relevant Timely (SMART) as well as triangulation with the CQC actions. The workshop took place on the 26 January 2023 and was a positive engaging session with 52% of participants rating the session as excellent and 48% rated it as good. Each topic table produced fishbone diagrams, driver diagrams, measurement plans and project charter documents to help develop the quality priorities. These were refined further by the Trust's Quality & Safety Committee and Trust Board.

5 quality priorities for 2023/24, covering the 3 domains of quality – patient safety, clinical effectiveness, and patient experience were selected:

(1) End of Life: To improve personalised palliative and end of life care to ensure patients are supported to have a good death. *(Clinical effectiveness and patient experience).*

(2) Deteriorating Patient: Improved recognition and responding to the deteriorating patient in patients age 16+. *(Clinical effectiveness and patient safety*).

(3) Sepsis: Improved recognition and responding to sepsis in patients. *(Clinical effectiveness and patient safety).*

(4) Medication safety: To improve the safety of prescribing weight dependent medication to adults. *(Clinical effectiveness and patient safety).*

(5) Mental capacity: Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording. *(Clinical effectiveness and patient experience).*

Recognising that communication is a key element linked to our workstreams, it will be included within the quality priorities as an associated qualitative KPI where appropriate. Communication is known to be a broadly applicable element of many aspects of how care is provided, so focusing on patient communication for critical phases of care, such as End of Life and managing patients' mental capacity to make decisions are areas where undertaking patient and their carers views through surveys to gain insight into their experiences brings value. We also see that elements of communication between staff can contribute to safe and effective care, so the Trust will explore this through the Deteriorating patient workstream as well.

Progress against the 2023/24 quality priorities will be monitored monthly through a defined approach of data analysis and review in the Quality and Safety section of the Integrated Performance Report (IPR), with overall outcome measures included in the Trust Board IPR. Success will be measured through tracking progress and trends against baseline and targets for each of the quality priorities associated KPIs.

Assurance and performance against the Quality Priorities will also be monitored via the Trust Management Board, Quality & Safety Committee, Quality Governance Group and Divisions monthly performance meetings.

2.2 Looking back on our priorities for improvement in 2022/23

As part of the Trust's annual setting of priorities in 2022/23, the Trust had set 6 quality priorities:

(1) **Mortality improvement:** Focusing on care at the end of life, we will reduce the number who die within 24 hours of admission and reduce emergency admissions for those in the last 3 months of life.

(2) **Deteriorating Patient:** In line with the CQUIN to improve safety, we will ensure we observe NEWS2, escalate when it is high, and respond with treatment.

(3) **Sepsis:** Focus on improving sepsis six screening and the response within 1 hour.

(4) **Increasing Medication safety:** Improve the recording of patient weights, reduce medication omissions, and improve appropriate antibiotic prescribing.

(5) **Friends & family Test and PALS:** These are key to patient experience so we will aim to respond to 70% of PALS in 5 days by the end of the year and improve response rates in the Friends and Family test so we better understand what our patients want.

(6) **Safety of Discharge:** Focusing on seamless safety across organisation boundaries, by improving the timeliness of discharge letters and helping ensure hospital beds are for those who need them by improving the speed of discharge once a patient is well.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained improvements. The tables and narrative below show a summary of achievement against the key measures of success for each of the quality priorities.

Key	
	Target achieved
	Improvement but below target
	No statistically significant change
	Decline, target not achieved

Mortality Improvement - Summary of milestones achieved, challenges and next steps

Mortality Improvement	Target	Outcome
Reduction in the number of patients dying within 24 hours of admission to hospital	Reducing	Target achieved. The number of patients dying within 24 hours of admission to hospital has decreased year on year from 249 in 2020/21, to 201 in 2021/22 and 193 in 2022/23.
Reduction in the number of emergency admissions for people in the last 3 months of life	Reducing	No statistically significant change. Common cause variation with 181 emergency admissions for people in the last 3 months of life in March 2023 compared to 208 in March 2022 and 202 in March 2021.
Reduction in the out of hospital SHMI to 110	Reducing	No statistically significant change. The out of hospital SHMI rolling 12 month position remains high at 140.1 in August 2022 compared to 138 in April 2022, 125 in April 2021 and 143 in April 2020.

The Trust expanded the Medical Examiner Service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths providing oversight and scrutiny of the quality of care for patients who die during admission. Case studies have been presented at the Trust's Mortality Improvement Group to share learning and improve quality of care.
The Trust was a pilot site, providing feedback to NHS England, for the new national mortality reporting system SJR plus and was one of the first Trust's in England to successfully transition to the new system in December 2022. This has provided the Trust with improved oversight of high-level mortality information and learning from structured judgement reviews to identify themes and improve quality of care.

The system wide roll out of Electronic Palliative Care Coordination system EPaCCs as the single shared record for preferred place of care and advanced decisions on escalation has progressed during 2022/23 although there were delays experienced in community nursing. Full access to the shared document will see the joint working of all agencies come together to maintain patients care at home where possible. The Trust has been working to promote access to EPaCCs through communication channels on social media and on the Trust's intranet. Respiratory, frailty and paediatric virtual wards were introduced which enhance community services visibility and accessibility at the front door of both hospitals where patients who present as End of Life can be supported to be cared for in their preferred place.

Case reviews of patients who die within 24 hours of admission or who are admitted to hospital in the last 3 months of life have been undertaken alongside community and primary care partners to discuss the quality of care provided, identify gaps in provision of services or pathways that could have enabled patients to die in their preferred place.
The Trust's percentage of deaths reported in the SHMI with palliative care coding continues to be low in comparison to peers and national average. This is linked to gaps in access to a

Palliative care consultant at Grimsby. Appointment of Palliative Care Nurse to focus on advanced care planning in the community was successful but a gap in consultant recruitment remains. Future rounds of Palliative care consultant recruitment are planned.

Care home staff were provided with equipment to undertake basic observations to better inform GPs of the patient's condition to reduce hospital admission. A pilot project was introduced to implement a NEWS2 type system in care homes to help with monitoring of the deteriorating patient. Early identification of palliative care, frailty index and standard palliative resources were rolled out across North East Lincolnshire care homes, with training to upskill staff on palliative management. A community dashboard is in development by NHSE to understand admission reason by care home to allow comparison with Primary Care Network/GP frailty and End of Life rates. This work will be taken forward in 2023/24.

The Divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life and a bespoke training package was developed for ED staff. ReSPECT awareness compliance has also improved however authorship training remains low and will be an area for further improvement work in 2023/24.

A Trustwide Quality Improvement 'Always' Event was held in March 2023 which engaged frontline clinicians in articulating change ideas focussed around:

- The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care.
- Appropriate use of the Last Days of life pathway which underpins evidence-based care.
- Timely recognition of EOL.

The themes and learning identified from this work will be carried forward and developed further in 2023/24 as part of the Trust's End of Life Quality Priority and on-gong quality improvement projects.

Deteriorating Patient - Summary of milestones achieved, challenges and next steps

Deteriorating Patient	Target	Outcome
Percentage of patient observations recorded on time (Adults)	90%	Target achieved for adult observations recorded on time with mean 90.55% and median 90.69%.
Percentage of patient observations recorded on time (Paediatrics)	90%	No statistically significant change for Paediatric observations recorded on time. The target was met or exceeded for 6 out of 12 months and achieved 100% in August 2022. However, overall, no statistically significant difference as remained below target with 75% recorded in March 2023 and April 2022. The mean value was 84.37% and the median was 86.62% over the 12 month period.
Escalation of NEWS in line with policy	No target	No statistically significant change with 3% in February 2023 compared to 0% in April 2022.
Clinical assessment undertaken within 15 minutes of arrival in ED	90%	Whilst the target was not met there was no statistically significant change with 47.4% recorded in March 2023 compared to 44% recorded in April 2022.

The Trust achieved the financially incentivised CQUIN CCG3 recording, escalation and response to NEWS2 for unplanned critical care admissions achieving over 80% in each quarter against a target range of 20 to 60%. The Trust's Critical Care Outreach team keep a record of all patients they review (times of referral, times of review, any areas of good practice). This data is supporting the Quality Improvement team to identify areas for improvements if patients have had delayed escalation.

Wards identified not achieving current target have been supported with focused support from the Deteriorating Educational lead. A standard of the month was introduced and the Paediatric and Neonatal Patient Safety Lead Nurse provides teaching to students about Paediatric Early Warning Score (PEWS) requirements and reinforcement as part of safety huddles. Stop and Check safety huddles were introduced on wards which highlights any patient at risk of deterioration.

Quality improvement work continues and will be carried forward as part of the Deteriorating Patient Quality Priority in 2023/24.

Sepsis - Summary of milestones achieved, challenges and next steps

Sepsis	Target	Outcome
Rate of patients screened for Sepsis	90%	Whilst the target was not met there was improvement from 40% of adults screened in April 2022 to 57.89% screened in February 2023. Similarly, an improvement in paediatric screening from 25.92% in April 2022 to 40% in March 2023.
Rate of patients who had the Sepsis six completed within 1 hour for patients who have a red flag	90%	0% of adults had documented evidence of the Sepsis six being completed within 1 hour. Paediatric patients improved from 21.42% in April 2022 to 42.1% in March 2023.

The Critical Care Outreach Team monitor all escalations into the team and share any good practice and opportunities for learning. Ward spot checks are carried out on all wards by the Educator and Deteriorating Patient/Sepsis nurse. Follow up discussions with staff to check staffs understanding of sepsis has demonstrated improvements. Stop and Check safety huddles continue to highlight any patients requiring a sepsis screening.

Sepsis tool completion is included on Doctors induction and Clinical Leads are supporting conversations with medical staff to promote completion of the Sepsis tools and dispel 'paper exercise' opinion. A booklet for agency/bank staff has been developed so that they are aware of the escalation process.

Escalation either from the healthcare support workers, who undertake patients' observations, to the registered nurses or onward to the Critical Care Outreach team is not electronically documented and so accountability is lacking resulting in missed opportunities for timely treatment. Sepsis screening is optional to complete on Web V rather than automatic or mandatory. Digital solutions have been explored and will be carried forward for discussions in 2023/24.

Adult and paediatric sepsis screening is not recorded electronically in ED. This has proved challenging as Trust wide data reported for sepsis screening via PowerBi does not include

primary sepsis screening in ED. In the interim until we can provide further assurance through robust reporting mechanisms, we are assured that patients are safe and cared for appropriately through triangulation of other robust data sources such as our incidents, claims, complaints, and mortality data. The Trust is not an outlier for Sepsis shock in the SHMI diagnosis group and identification of Sepsis is not a theme from the Medical Examiner case record reviews or Structured Judgement Reviews. Introducing electronic primary sepsis screening in ED will be the focus of work carried forward as part of the Sepsis 2023/24 Quality Priority.

Medication Safety - Summary of milestones achieved, challenges and next steps

Medication Safety	Target	Outcome
Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA of WebV	Increasing	No statistically significant change with common cause variations between 61.62% in April 2022 to 70% in March 2023 and peak of 78.57% in May 2022.
Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV	Increasing	Target achieved. Significant improvement from 13.13% in April 2022 to 56% in March 2023.
Reduction in medication omissions without a valid reason for ward areas using EPMA	Reduction	Target achieved. Sustained low percentage of omissions over the past 16 months and achieved reduction from 1.9% in April 2022 to 1.4% in March 2023 compared to 13% in August 2021.
Reduction in patients prescribed an antibiotic	Reduction	Increase from 40.7% in March 2022 to 65.6% in February 2023. Although this is comparable to 66.4% in June 2021.
Antibiotic prescriptions have evidence of a review within 72 hours	70%	Decline from 69.1% in March 2022 to 48.7% in February 2023. Although the target was exceeded in June 2022 with 72.5% reviewed within 72 hours.

The two new ED builds completed at DPoW and SGH have the facility to weigh patients in ambulance arrivals area to aid compliance with actual weight being documented. The Trust has taken several other steps to improve medication prescribing safety in relation to recording patient's weight including introducing Paracetamol templates on EPMA. The paracetamol templates in the EPMA system have all been restricted and modified to aid the prescriber. Templates were created with the dose and frequency locked down so that the prescriber could not deviate from the BNF dosing for Paracetamol. Multi-route templates with weight-based calculations for the IV doses were then implemented, resulting in the prescriber having to input the patients' weight before the prescription can be added to the drug chart.

Unfortunately, the weight field in the EPMA system cannot be made mandatory, however the way that the multi-route templates have been set up means that it is easier to input the patient's weight (for the dose to be calculated) than it is to override the warnings. Warning notifications have also been added to the templates.

Role specific help buttons have been added to user logins. These include links to guides on the inputting of weights and numerous other guides, help topics and top tips for using the system.

Changes to the EPMA system were made such that the weight now expires in the system after 30 days. If a prescriber tries to use an expired weight, they are informed to update the weight to a current one, this also happens at each subsequent administration. They can override this and continue to use the old weight however the overriding is recorded in the system. A 30-day expiry ensures that weights from previous episodes/visits are expired and prompts staff to update.

Improved communication of system changes via emails, WhatsApp groups and top tip announcements are included on the Trust's intranet site, the HUB. A Medication Safety Newsletter is produced and distributed monthly highlighting the importance of documenting actual patient weight for prescribing.

A new 'weight' button has been added to EPMA to enable easier access to the weight recording page within the system, with the intention of making weight recording easier by all healthcare staff involved in patient care.

A key challenge is that the Trust's electronic patient record system Web V is not linked to the Trust's electronic prescribing system EPMA which prevents sharing of weight data between the two systems. Reporting functionality in EPMA relating to the weight field has also been limited. The next steps are to improve reporting from the EPMA system to improve oversight to enable improvement support to be targeted. The Trust is exploring the possibility of a BOT to overcome cross system data transfer and will be carried forward as part of the 2023/24 Medication Safety Quality Priority.

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary and is reviewing the indications on EPMA to ensure they are fit for purpose. The Trust facilitates education and training both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses. The aim is to reduce unnecessary or inappropriate antimicrobial prescribing through an effective stewardship programme and annual strategy plan. Results of audits are shared with relevant governance committees and clinicians to highlight issues around stewardship and prescribing.

The Pharmacy Technician workforce is currently fully established across both main hospital sites. There is work ongoing to upskill the technician workforce to further support the pharmacist teams at both sites. However, Pharmacist staffing levels continue to be challenging with gaps at the SGH site. The Trust has been exploring all options to improve capacity including a recruitment drive, use of locum agencies, relocations packages offered, Star Chamber and shared working with Hull University Teaching Hospitals NHS Trust is being explored.

Friends and Family Test and PALS - Summary of milestones achieved, challenges and next steps

Friends & Family Test and PALS	Target	Outcome
PALS concerns are managed within timescale (5 working days)	70%	No statistically significant change. 62.85% of PALS concerns trust wide were closed within timescale in March 2023 compared to 62.5% in April 2022.
To improve the Friends and Family response rates	Inpatient 40%, ECC 20%, OPD 4%, Community 5%, Day case 25%	Although the FFT response rates for the 5 areas has not increased in line with the ambitious target percentages identified, overall, the Trust FFT response rate has increased by 45.17% with 932 FFT reviews in April 2022 and 1352 FFT reviews in March 2023. The response rate increased by 51% between September 2022 and February 2023 with the introduction of the PALS manager.

The Trust set a target of 60% of PALS concerns managed within timescale (5 working days) for Quarter 1/2, aiming for a stretch target of 70% by Quarter 4. The PALS team have taken a proactive approach to managing PALS concerns which has maintained performance over the past year. Steps taken include:

- Weekly reports sent to Divisional Senior Management Team of current PALS position.
- PALS Team proactive in sending out reminders to Divisions on the date the PALS concern is due.
- Improvement in PALS Team engaging with and offering support to Divisional Teams.
- Improved communication between Wards, Matrons & PALS Team when concerns raised regarding an inpatient for earlier resolution.
- Early escalation to senior leaders/managers if concerns are not being addressed in a timely manner.
- PALS Teams more proactive in supporting Divisions in resolving concerns prior to them being sent to Division.
- Dedicated oversight for a six month period, resulting in interventions in long standing concerns and resolution.
- Monthly updates of Divisional changes distributed within the PALS Team.
- Triangulation of data from FFT/PALS/Insights is captured at Round Table and Nursing Metric Meetings.

The 5 working days target is challenging for complex PALS concerns that have multi team involvement, but do not warrant formal complaint investigation. Increased clinic activity and priorities also impacts the timescales of those concerns that involve clinical and nursing teams. Change of handlers or concerns being sent to incorrect handlers can cause unnecessary delays.

The Trust has taken the following steps to improve Friends and Family Test (FFT) response rates:

- Engagement between the Patient Experience Manager & Department/Ward/Area Managers with individual meetings.
- Development of monthly FFT report for Senior Management Teams.

- Development of monthly feedback reports to each Department/Ward/Area Manager.
- Attendance at Governance and Departmental Meetings.
- Review and amendments to A&E survey.
- Weekly meetings with external provider.

Increased clinic activity and staffing levels means FFT collections and discussions have been challenging. There are limited methodologies for data collection in some areas which will be explored in future. Mandatory verification email address requested on external providers collection site has caused a barrier to patient's/families leaving anonymous feedback. This will be resolved in 2023/24. The Trust will continue to review and explore different collection methodologies and engage with staff and external providers in the future.

Safety of Discharge - Summary of milestones achieved, challenges and next steps

Friends & Family Test and PALS	Target	Outcome
Discharge letter completed within 24 hours of discharge.	85%	Target achieved with an annual mean of 89.42%.
Outpatient Clinic Summary to be sent to the patient's General Practitioner within 7 days of the appointment	50%	Target achieved in most recent months with 70% in March 2023 compared to 30.26% in April 2022.
Improve the proportion of patients discharged before 12 noon	30%	No statistically significant change with 16.56% in March 2023 compared to 18.01% in April 2022 and 16.56% in April 2021.
Improving trend showing a reduction in length of hospital stay 21 days	12%	Fluctuating performance but overall below the national average and the Trust is one of the best performing trusts in the region. Lowest value 7.83% achieved in week commencing 20 June 2022.

The trust set a target of 85% of discharge letters to be completed within 24 hours of discharge. Mid-year a stretch target of 90% was set to drive further improvement. The Trust's performance for the percentage of extended stay patients beyond 21 days is under the national average and one of the best performing Trusts in the region. The Trust has introduced consultant ward rounds on weekends, an electronic handover system and created a 7-day escalation process to address any blockages relating to discharge. Work has been undertaken to ensure patients who require support on discharge are supported by the most relevant team in a timely manner, ensuring they have prompt access to the services they require to enable them to leave a hospital bed. The use of voluntary sector organisations has also been increased to support timely discharge.

Other steps taken to improve performance include:

- 7-day Same Day Emergency Care (SDEC) ward set up.
- Virtual wards for respiratory, frailty and paediatrics established.
- Acute Frailty Assessment service and two integrated hospital discharge Hubs have been established for North Lincolnshire and North East Lincolnshire.
- Outpatient Parenteral Antibiotic Therapy (OPAT) and Home first now implemented.

- Work taking place within care homes to support falls, therapy and training provided within Northern Lincolnshire, SAFE service now operating direct referrals from Urgent Care Service (UCS) and Single Point of Access (SPA) to enable anticipatory/proactive management of frailty.
- Acute and Community joint work group established between Medicine and Community & Therapies.
- Community Response Team GP supporting Category 3 & 5 calls.
- 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.
- Multiagency discharge events have been held.
- Early identification of complex discharges prior to having no criteria to reside.
- Pilot for complex discharges and multiple admissions discharge expert panel.

The discharge lounge at SGH is no longer able to facilitate patients with stretchers which has caused flow delays due to a move to allow Ward 18 to be used. The DPoW discharge lounge is being used ad-hoc for inpatient beds which has impacted on discharge times. The Trust is exploring upgrading the discharge lounge capacity and opening hours

2.3 Statements of assurance from the Board

2.3a Information on the review of services

During 2022/23 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services. The 7 services are taken from the Trust's standard contract with the ICB as the "categories of service which the Provider is commissioned to provide under this contract". These are:

- A&E Services
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services
- Urgent Treatment Centre Services

The Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health and care services for 2022/23.

2.3b Information on participation in clinical audits and national confidential enquires

During 2022/23, 53 national clinical audits and 10 National Confidential Enquiries into Patient Outcomes and Deaths (NCEPODs) were listed in the Quality Accounts for completion. During 2022/23, 51 national clinical audits and 7 NCEPODs covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 50 (98%) of the national clinical audits and 7 (100%) of the NCEPODs. Whilst 2 projects were listed for completion at the beginning of the year, these were delayed by the national audit supplier and will commence in 2023/24. Both audits have been excluded from the Trust's overall participation rate.

Participation did not occur for 1 (2%) national clinical audit; the National Ophthalmology Database Audit as the audit data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

The tables below list all National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advise Trusts to Participate in. It also provides a breakdown of those applicable to the Trust and participation details during 2022/23.

Table 1: National Clinical Audits

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
1.	Breast and Cosmetic Implant Registry	✓	✓	20	100%	Report writing/Action planning
2.	Case Mix Programme	✓	✓	1,353	100%	Project still underway
3.	Child Health Clinical Outcome Review Programme	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
4.	Cleft Registry and Audit Network Database	X	X	N/A	N/A	N/A
5.	Elective Surgery: National PROMs Programme	✓	✓	625	90.1%	Awaiting publication of results
6.	**Emergency Medicine QIPs:**					
	a. Pain in children	✓	✓	166	100%	Action Planning
	b. Assessing for cognitive impairment in older people	✓	N/A	N/A	Commences April 2023	Planning underway
	c. Mental health self-harm	✓	✓	40	On-going	Project still underway
7.	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	✓	✓	169	100%	Awaiting Publication of Results
8.	**Falls and Fragility Fracture Audit Programme:**					

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	a. Fracture Liaison Service Database	✓	✓	669	On-going	Project still underway
	b. National Audit of Inpatient Falls	✓	✓	6	On-going	Project still underway
	c. National Hip Fracture Database	✓	✓	483	100%	Report writing/Action planning
9.	**Gastro-intestinal Cancer Audit Programme:**					
	a. National Bowel Cancer Audit	✓	✓	273	100%	Awaiting Publication of Results
	b. National Oesophago-gastric Cancer	✓	✓	104	100%	Awaiting Publication of Results
10.	Inflammatory Bowel Disease Audit	✓	✓	522	100%	Action Planning
11.	LeDeR - learning from lives and deaths of people with a learning disability and autistic people	✓	✓	22	100%	Action Planning
12.	**Maternal and Newborn Infant Clinical Outcome Review Programme:**					
	MBRRACE - UK; Saving Lives, Improving Mother care - Maternal mortality surveillance and confidential enquiries	✓	✓	0	100%	Report writing/Action planning
	MBRRACE - UK Perinatal Mortality Surveillance and Confidential Enquiries	✓	✓	8	100%	Report writing/Action planning
13.	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
14.	Mental Health Clinical Outcome Review Programme	X	X	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
15.	Muscle Invasive Bladder Cancer Audit	✓	✓	14	100%	Report writing/Action planning
16.	**National Adult Diabetes Audit:**					
	a. National Diabetes Core Audit	✓	✓	1220	100%	Action Planning
	b. National Diabetes Foot Care Audit	✓	✓	157	On-going	Project still underway
	c. National Diabetes Inpatient Safety Audit	✓	✓	9	On-going	Project still underway
	d. National Pregnancy in Diabetes Audit	✓	✓	36	100%	Awaiting Publication of Results
17.	**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:**					

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	a. Adult Asthma Secondary Care	✓	✓	180	On-going	Project still underway
	b. Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	652	On-going	Project still underway
	c. Paediatric Asthma Secondary Care	✓	✓	31	On-going	Project still underway
	d. Pulmonary Rehabilitation Audit (Primary Care)	X	X	N/A	N/A	N/A
18.	**National Audit of Breast Cancer in Older Patients**	✓	✓	239	100%	Awaiting Publication of Results
19.	**National Audit of Cardiac Rehabilitation**	✓	✓	1074	100%	Report writing/Action planning
20.	**National Audit of Cardiovascular Disease Prevention (Primary Care)**	X	X	N/A	N/A	N/A
21.	**National Audit of Care at the End of Life**	✓	✓	89	100%	Awaiting Publication of Results
22.	**National Audit of Dementia**	✓	✓	80	On-going	Report writing/Action planning
23.	**National Audit of Pulmonary Hypertension**	X	X	N/A	N/A	N/A
24.	**National Bariatric Surgery Registry**	X	X	N/A	N/A	N/A
25.	**National Cardiac Arrest Audit**	✓	✓	73	On-going	Project still underway
26.	**National Cardiac Audit Programme:**					
	a. National Congenital Heart Disease Audit	X	X	N/A	N/A	N/A
	b. Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	267	On-going	Project still underway
	c. National Adult Cardiac Surgery Audit	X	X	N/A	N/A	N/A
	d. National Audit of Cardiac Rhythm Management	✓	✓	273	On-going	Project still underway
	e. National Audit of Percutaneous Coronary Interventions	✓	✓	411	On-going	Project still underway
	f. National Heart Failure Audit	✓	✓	287	On-going	Project still underway
27.	National Child Mortality Database	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
28.	National Clinical Audit of Psychosis	X	X	N/A	N/A	N/A
29.	National Early Inflammatory Arthritis Audit	✓	✓	28	On-going	Project still underway
30.	National Emergency Laparotomy Audit	✓	✓	200	On-going	Project still underway
31.	National Joint Registry	✓	✓	740	96%	Report writing/Action planning
32.	National Lung Cancer Audit	✓	✓	346	100%	Action Planning
33.	National Maternity and Perinatal Audit	✓	✓	3445	100%	Report writing/Action planning
34.	National Neonatal Audit Programme	✓	✓	657	100%	Awaiting Publication of Results
35.	National Obesity Audit	X	X	N/A	N/A	N/A
36.	National Ophthalmology Database Audit	✓	X*	N/A	N/A	N/A
37.	National Paediatric Diabetes Audit	✓	✓	284	On-going	Project still underway
38.	National Perinatal Mortality Review Tool	✓	✓	8	100%	Action Planning
39.	National Prostate Cancer Audit	✓	✓	294	100%	Awaiting Publication of Results
40.	National Vascular Registry	X	X	N/A	N/A	N/A
41.	Neurosurgical National Audit Programme	X	X	N/A	N/A	N/A
42.	Out-of-Hospital Cardiac Arrest Outcomes	X	X	N/A	N/A	N/A
43.	Paediatric Intensive Care Audit	X	X	N/A	N/A	N/A
44.	Perioperative Quality Improvement Programme	✓	✓	11	55%	Project still underway
45.	**Prescribing Observatory for Mental Health:**					
	a. Improving the quality of valproate prescribing in mental health services	X	X	N/A	N/A	N/A
	b. The use of melatonin	X	X	N/A	N/A	N/A
46.	**Renal Audits:**					
	a. National Acute Kidney Injury Audit	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	b. UK Renal Registry Chronic Kidney Disease Audit	X	X	N/A	N/A	N/A
47.	**Respiratory Audits:**					
	a. Adult Respiratory Support Audit	✓	✓	N/A	Commenced March 2023	Project still underway
	b. Smoking Cessation Audit- Maternity and Mental Health Services	✓	N/A	Commences April 2023	Planning underway	N/A
48.	Sentinel Stroke National Audit Programme	✓	✓	242	100%	Report writing/Action planning
49.	Serious Hazards of Transfusion UK National Haemovigilance Scheme	✓	✓	17	100%	Awaiting Publication of Results
50.	Society for Acute Medicine Benchmarking Audit	✓	✓	107	100%	Action Planning
51.	Trauma Audit and Research Network	✓	✓	494	Ongoing	Project still underway
52.	UK Cystic Fibrosis Registry	X	X	N/A	N/A	N/A
53.	UK Parkinson's Audit	✓	✓	60	100%	Awaiting Publication of Results

**Note: The Trust did not participate in the National Ophthalmology Database Audit as this is not a mandated audit and data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.*

Table 2: National Confidential Enquires

Count	Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
3.	**Testicular torsion**	✓	✓	7	100%	Awaiting National Report
	Transition from child to adult health services	✓	✓	3	75%	Awaiting National Report
	Juvenile Idiopathic Arthritis	✓	✓	Ongoing		
13.	**Community Acquired Pneumonia**	✓	✓	4	57%	Project still underway
	Chron's Disease	✓	✓	6	75%	Project still underway

Count	Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
	End of Life Care	✓	N/A	Commences Spring/Summer 2023	N/A	N/A
	Endometriosis	✓	✓	Ongoing		
	Epilepsy: Hospital Attendance	✓	✓	7	100%	Ongoing
	Physical Health in Mental Health Hospitals	X	X	N/A	N/A	N/A
14.	**Real-time surveillance of patient suicide**	X	X	N/A	N/A	N/A
	Suicide (and homicide) by people under mental health care	X	X	N/A	N/A	N/A

The reports of 30 National clinical audits were reviewed by the provider in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Programme	Summary of some actions taken
National Neonatal Audit Programme (NNAP)	- Doctors to visit the mother on Maternity Wards where appropriate and within 24 hours of admission to the neonatal unit. - Where parents are unable to be present at ward rounds, ensure contact is made alternatively to provide an update. - Posters to be displayed on nursery doors to ensure parents are aware that they are to be involved and updated in the care of their baby. - PeriPrem passports implemented to ensure standards are being met. - Ensure staff are aware of the importance to utilise the Jitsi Meet App and alternative communication methods to involve parents and update them on their baby within 24 hours of admission. - Safety Huddles (where medical staff are present) to include standards summary of NNAP standards for awareness purposes. - BadgerNet is to be included within the doctor induction training day to raise awareness of the NNAP measures. - The Quarterly dashboards (published by NNAP) are to be presented at the Trust wide Children's service clinical audit meeting to ensure staff are aware of the NNAP standards and any shortfalls in compliance are identified.
National Pregnancy in Diabetes Audit	- Young patients are made aware of the importance of the issues relating to unplanned pregnancy during their appointment in the young adult diabetes clinic. - Patients are offered DESMOND structured education in relation to weight management and diabetes prevention. - Reinforce the benefits of pregnancy preparation by way of a diabetes interface forum with primary care.

National Audit Programme	Summary of some actions taken
	- Local practice nurses to be made aware of the preconception clinic.
Sentinel Stroke National Audit programme (SSNAP)	- Stroke awareness marketing campaign launched to raise awareness of stroke signs and symptoms to aid early recognition/intervention. - Liaise with relevant teams to ensure patient goals are clear.
IBD Registry	- Updated consent process implemented so patients now get up to date information from the registry regarding latest developments in treatment/management of IBD.
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry – Saving Lives Improving Mothers Care.	- Diagnosis and Treatment of Cancer whilst Pregnant Guidance to be reviewed. A new guideline is being written to ensure women are aware of risks and choices available to them.
National Oesophageal Cancer Audit (NOGCA 2020)	- Contact to be made with Primary Care to raise the consistently above average rate of patients diagnosed with OG Cancer following emergency admission.
National Emergency Laparotomy Audit (NELA) 2021	- Audit Department to pass a list to the Surgery Business Manager of any cases that are in the NELA sample but show as incomplete on NELA webtool. This is to then be raised with the surgeons at the weekly Quality Meeting.
COPD Audit	- Review of COPD cases undertaken identifying an issue with an algorithm which will boost case ascertainment for future publications.
NACAP Children's & Young People Asthma audit	- Discharge Bundle to be raised with all nursing staff and encouraged to compete on WebV. - - Clinical Nurse Specialists are included within the Junior Doctors Induction, to highlight the KPIs. - Review the prescribing of steroids with the Paediatric Emergency Nursing Team to ascertain if this can be included within their roles.
Fracture Liaison Service Database	- Annual review through radiology reports to boost identification of Vertebral Fractures to ensure submission rates are in line with best practice
Elective Surgery: National PROMS Programme	- Deep dive of data carried out to establish if there are any issues that have contributed to the deterioration of patient reported outcomes.
Early Inflammatory Arthritis	- Specific Early Inflammatory Arthritis Clinics to be introduced to provide more clinic time to assess progress and outcomes with regards to Disease Modifying Drugs
Royal College of Emergency Medicine: Pain in Children	- Introduction of mandated field for Pain Scoring on arrival into the ED/ECC electronic systems.
National Audit of Dementia	- Pilot document introduced to aid the completion of Delirium Screening in patients over 65.
National Audit of Breast Cancer in Older People	- To introduce the Fitness assessment form for older patients and ensure this is uploaded to the Somerset system.

The reports of 31 local clinical audits were reviewed by the provider in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit Topic	Summary of some actions taken
Audit of GI Beed	- Implementation of Glasgow/Blatchford score as a mandated electronic field into ED/ECC Symphony System.
Emergency Department Documentation	- Adoption of stamps by ED/ECC Nursing Staff to improve documentation.
Audit of Weighing Prescribing	- Introduction of Weight Bridges in the ED/ECC to improve the weighing of patients and ensure accuracy of weight dependent drug doses
Cirrhosis Fibrosis CQUIN Audits	- Introduction of new Alcohol Care Team as well as Web V screening and referral tools to ensure best practice pathways are met for this subset of patients to assess kidney health early in the pathway
Local Version of National Ophthalmology Database Audit (NOD)	- Medical Secretaries to highlight any patient who has gone more than 6 months from their pre-operative assessment when they attend for their cataract operation that they need the Visual Acuity check performing prior to the operation.
Paediatric SEPSIS Audit	- The Monthly Dashboard is used to monitor the use of the SEPSIS pathway in children who are admitted, and the results are presented at the Clinical Audit Meeting to raise the importance of adhering to policy.
Paediatric Early Warning Scoring	- The Monthly Dashboard is used to monitor the use of the PEWS Tool and presented at the Clinical Audit Meeting. - Areas of low compliance are displayed as standard of the month in the wards.
Facing the Future Audits	- Paediatric collaborative document (electronic and paper version) to be reviewed to ascertain if additional fields for capturing information can be added.
Audit of Paediatric Documentation Audit:	- The monthly rapid cycle documentation audit is discussed at the Clinical Audit meeting to highlight the standards which consistently have low compliance and to raise the importance of documenting patient height, weight, head circumference and centiles.
Pain Assessment Audit	- Processes surrounding pain scoring within the Trust are to be reviewed as part of a Quality Improvement Project.
Audit of Electronic Discharge Summaries (Surgery)	- Surgery Doctors Induction to include a summary of the standards required when completing Discharge Summary Letters to ensure staff are aware. - Electronic Prescribing system (EPMA) to be linked to Web-V system to pre-populate medication information on the discharge summaries.
ReSPECT Audit	- Development of a continuing 'Lead Educator' post to raise awareness and deliver education regarding the importance of ReSPECT. - Education plan produced and shared at the End-of-Life Operational Group.
Gynaecology Electronic Discharge Summary Audit	- Presenting complaint, to be added as a compulsory field relating to surgical cases. - Consultant job plans to be reviewed to ensure patients have a clinical assessment within 14 hours of admission.
Paediatric Documentation	- Implementation of electronic documentation at DPOW, awaiting role out at SGH.

Local Audit Topic	Summary of some actions taken
Hernia Day Case Rate Audit:	- The General Surgery Business Support Manager has discussed with the relevant administration Teams the importance of categorising Hernia procedures correctly on the booking system, reinforcing that unless stated otherwise by the surgeon or pre-assessment staff then hernia procedures should be day cases. - The General Surgery Management Team to provide data to the clinicians about any Day Case hernia procedure that results in an admission so this can be reviewed for learning points. - Urology clinicians to provide guidance on how best to send patients home with a catheter and place this information in posters on relevant wards. - An audit of the completion of booking forms inputted on to the booking system will be undertaken, to assess whether Day Case/Inpatient bookings matched the resultant procedure.

The Trust takes part in the annual benchmarking audit that measures performance against the learning disability improvement standards. The improvement standards were launched in 2018 by NHS Improvement to ensure the provision of high quality, personalised and safe care from the NHS for adults and children with learning disabilities and/or autism across England. The NHS Long Term Plan (2019) further pledged that over the next five years, the improvement standards would be implemented by all services funded by the NHS. The improvement standards against which trust performance is measured are respecting and protecting rights, inclusion and engagement, workforce and specialist learning disability services, the first three are universal standards that apply to all NHS trusts, and the fourth is a specialist standard that applies specifically to trusts that provide services commissioned exclusively for people with a learning disability or autism In addition to the data collection by the Vulnerabilities team, 50 staff and 100 patient surveys were sent out that were directly returned to NHSBN. Compliance with these standards demonstrates that a trust has the right pathways and resources in place to deliver high quality patient outcomes that people with a learning disability or autism, their families and carers deserve and expect. The results of the survey were published in November 2022 and the Trust compares favourably to other trusts that took part, for those areas where there is an identified gap the Trust is developing an improvement plan to address these issues.

2.3c Information on participation in clinical research

Clinical research is an essential part of maintaining a culture of continuous improvement. In 2022/2023 there was a reduced focus on COVID-19 public health trials and the Research Team were able to re-commence studies that had been put on hold during the pandemic. The team also commenced a broad range of new clinical research studies, for example, studies relating to, cardiology, urology, dermatology amongst other specialities. The Trust has received several congratulations of achievement from studies relating to how the Trust has conducted the research and the recruitment it has achieved. Whilst undertaking these studies the team are due to, or will achieve close to, the recruitment figure set by the Clinical Research Network.

The number of patients receiving NHS services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2022/23 that were recruited during that period (01 April 2022 to 31 March 2023) to participate in research approved by a research ethics committee or Health Research Authority was 1100.

The Trust has 23 studies recruited. 2023/24 will see the team continuing their reduced focus on providing research post COVID public health trials and continue to increase recruitment via a mixture of non COVID commercial/portfolio studies. The recruitment will include focussing on collaborative working with other organisations, to take research out to previously underserved communities in line with the Trust's high level objectives agreed with the Clinical Research Network.

Clinical research has allowed the world's population to gain knowledge and develop treatments and the Trust continue to support this by providing clinical research for our local communities.

2.3d Information on the Trust's use of the CQUIN framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience, and improvements against outcomes.

Use of the CQUIN payment framework

A proportion of the Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2022/23 the requirement for national ICB CQUINs was to report on all applicable CQUINs but also choose 5 schemes, for each contract, that would have a financial value attached.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value. Funding was given to the Trust based on the assumption that the Provider would achieve full compliance with the applicable CQUIN Indicators and would therefore earn the full 1.25% value. Due to the contractual arrangements in 2022/23 there was no financial risk to the Trust for non-achievement of the CQUIN.

National CQUIN schemes 2022/23 for ICBs include:

- Staff Flu Vaccinations (Non-financial)
- Appropriate antibiotic prescribing for UTI in adults aged 16+ (Non-financial)
- Recording of NEWS2 score, escalation time and response time for unplanned critical care services (Financial)
- Compliance with timed diagnostic pathways for cancer services (Non-financial)
- Anaemia screening and treatment of all patients undergoing major elective surgery (Financial)
- Timely communications of changed to medicines to community pharmacists via the Discharge Medicines Service (Financial)
- Supporting patients to drink, eat and mobilise after surgery (Financial)

- Cirrhosis and Fibrosis test for alcohol dependent patients (Financial)
- Treatment of community acquired pneumonia in line with BTS care bundle (Non-financial)
- Assessment, diagnosis, and treatment of lower leg wounds (Non-financial)

NHS England Specialised Services (NHSE):
The Trust receives a CQUIN value of 1.25%. The CQUIN payment was based on the block contract value: however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Payment System and all other expenditure contracted on "pass through" basis.

The NHSE specialised schemes of 2022/23 include:

- Shared Decision Making (SDM) conversations (Financial)

NHSE took a light touch approach to the reporting of CQUINs and agreed that where a provider has engaged and fully participated with the CQUIN schemes but has failed to achieve the requirements fully, due to issues outside of their control (including any future Covid surges) the commissioner would reinvest the CQUIN scheme monies it has recovered with the provider but may identify areas of quality and innovation for the provider to focus the investment on.

The Trust has achieved the highest performance to date with achievement against all the financial incentivised CQUIN, exceeding the maximum targets. For the non-financial CQUIN, the Trust achieved the target for 1 and showed improvement over each quarter for a further 2 CQUINs. The most improvement was seen in the financial incentivised CQUIN **CCG9** Cirrhosis and fibrosis tests for alcohol dependent patients where the Trust achieved 67% in Quarter 3 compared to 11.4% in Quarter 1.

Key	
	Target achieved or exceeded
	Target not achieved but Improvement over full year
	Target not achieved

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CCG1 Flu vaccinations for frontline healthcare workers	Non-financial	**70%**	**90%**	**N/A**	**N/A**	**31%**	**31%**	
CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+	Non-financial	**40%**	**60%**	**42%**	**43%**	**37%**	**42%**	
CCG3 Recording, escalation and response to NEWS2 for unplanned critical care admissions	Financial	**20%**	**60%**	**85%**	**84%**	**80%**	Available after 19 June 2023	

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CCG4 Compliance with timed diagnostic pathways for cancer services	Non-financial	**55%**	**65%**	**18.35 %**	**22.3%**	**18.1%**	Available after 19 June 2023	
CCG5 Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	Non-financial	**45%**	**70%**	**16%**	**17%**	**27%**	Available after 19 June 2023	
CCG6 Anaemia screening for those undergoing major elective surgery	Financial	**45%**	**60%**	**86%**	**85%**	**76%**	Available after 19 June 2023	
CCG7 Timely communication of medication changes via discharge medicines IT software	Financial	**0.5%**	**1.5%**	**N/A**	**N.A**	**1.53%**	Available after 19 June 2023 **Estimate 1.456%**	
CCG8 Supporting patients to eat drink and mobilise post-surgery	Financial	**60%**	**70%**	**72%**	**78%**	**77%**	Available after 19 June 2023	
CCG9 Cirrhosis and fibrosis tests for alcohol dependent patients	Financial	**20%**	**35%**	**11.4%**	**18.7%**	**67%**	Available after 19 June 2023	
CCG14 Assessment, diagnosis and treatment of lower leg wounds	Non-financial	**25%**	**50%**	**1.63%**	**0**	**10%**	Available after 19 June 2023	
PSS2 Achieving high quality shared decision-making conversations in specific specialised service (Cardiology)	Financial	**Min 65%**	**Max 75%**	**88%**	**92%**	**NA**	**89%**	

2.3e Information relating to the Trust's registration with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2022/23.

The Trust has not participated in special reviews or investigations by the Care Quality Commission during the reported period.

Care Quality Commission (CQC) ratings grid for the Trust:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

From their last inspection of the Trust in June and July 2022 (of which the report was published on the 2nd December 2022) the outcome was as follows:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diana Princess of Wales Hospital	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022
Goole & District Hospital	Good ↑↑ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good ↑↑ Nov 2022	Requires Improvement →← Nov 2022	Good ↑ Nov 2022
Scunthorpe General Hospital	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022
Overall trust	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

Several significant improvements were published in the report, including:

- The improvement of Goole District Hospital rating to ‘Good’ overall
- The Trust safety rating improved to ‘Requires improvement’ from ‘Inadequate’.
- Maternity and Surgery Core Surgery ratings increased to ‘Good’ for responsive
- Rating increase to ‘Good’ from ‘Inadequate’ for Outpatients Core Service
- The Diagnostic Imaging Core Service was highlighted for ‘outstanding practice’ and a ratings increase from ‘Inadequate’ to ‘Good’ overall for Goole District Hospital and Scunthorpe General Hospital

The Trust celebrated several positive findings within the report, including no significant concerns around fundamentals of care and no requirement notices were issued. Inspectors also said they saw good examples of patients receiving compassionate care, with staff ensuring patients privacy and dignity were maintained 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 along with a commitment to learning and quality improvement highlighted. The report identified improvements to data management as was strengthening of operational financial management and governance arrangements.

The 2022 report had 93 ‘Must do’ and 59 ‘should do’ actions across all three sites, these have been reviewed and incorporated into a robust action plan which the Trust has already made progress with. Initial actions and feedback to the CQC was completed in December 2022 following publication of the report.

During the last year and whilst waiting for the new report, the Trust progressed completion of several actions that were identified as part of the 2019 actions. At the time of publication of the 2022 report, 85% of 2019 actions were rated green or blue meaning they were on target or complete.

Following the latest report, the Trust amended the assurance ratings from blue/green/amber/red to language in line with Recovery Support Programme:

Full assurance	Evidence of embedded and sustained improvement
Significant assurance	Evidence of improvement and the improvements becoming embedded, but yet to be sustained
Moderate assurance	Some evidence of improvement but this has yet to be embedded and sustained
Limited assurance	Limited evidence of improvement and limited evidence of the improvements being embedded or sustained
No assurance	No evidence of improvement

A monthly report provides detail and assurance on progress and is presented at the Trust Management Board and various sub-committees. At the time of writing in March 2023, the Trust had 123 open CQC actions, of those, two were rated full assurance, 23 were rated significant assurance, 52 moderate assurance and 39 rated limited assurance. There are no actions with no assurance and seven to be rated. At the time of publication (June 2023), further progress has been made and the Trust currently has eight rated full assurance, 27 rated significant assurance, 48 rated moderate assurance and 42 rated limited assurance with no actions with no assurance and none awaiting a rating. The Trust continues to have regular engagement meetings with the CQC and provides them with regular updates on progress with the plan along with supporting evidence.

2.3f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data (as of April 2023):

- Which included the patient's valid NHS Number was:
  - 99.98 % for admitted patient care
  - 99.97 % for outpatient care
  - 99.57 % for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
  - 100 % for admitted patient care

- 100 % for outpatient care
- 100 % for accident and emergency care.

2.3g Information governance assessment report

The Information Governance Data Security and Protection Toolkit (DSPT) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health and Social Care policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage, and destruction of data both within the organisation and between external organisations. The submission deadline for the 2022/2023 DSPT Assessment is 30th June 2023.

The 2021/22 Version of the DSPT was released on the 20 July 2021, with an initial baseline assessment date of the 28 February 2022 followed by the final submission of the 30 June 2022. The current status for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust following submission of the 21/22 DSPT is Approaching Standards.

As of March 2023, there were two actions remaining on the improvement plan. Responses to these actions will be captured in the 23/24 return. The remaining actions are as follows:

20/21 DSP ref	2020/21 DSPT Evidence Item Text
3.2.1	Have at least 95% of all staff, completed their annual Data Security Awareness Training?
10.1.1	The organisation has a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration.

2.3h Information on payment by results clinical coding audit

Northern Lincolnshire & Goole NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission as these no longer take place.

To provide coding quality assurance Northern Lincolnshire & Goole NHS Foundation Trust completed a Trust-wide random sample audit of 200 Finished Consultant Episodes (FCEs - the time a patient spends under the continuous care of one care professional) for the period November 2021 – March 2022 and, in addition, re-commenced regular staff audits in April 2022. These audits were performed by NHS Digital approved auditors based at Hull University Teaching Hospitals as part of the Clinical Coding shared service.

The Trust-wide audit attained the level of standards met, and 77% of staff audits achieved either standards met or standards exceeded, using the Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust to determine the standard achieved (table below). Any below the target of standards met are given additional training and are re-audited within 3 months. The Trust will continue a rolling programme of yearly audits for all Clinical Coding staff throughout 23/24

	Level of Attainment	
	Standards Met	Standards Exceeded
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedures	>=90%	>=95%
Secondary Procedures	>=80%	>=90%

2.3i Learning from Deaths

During 2022/23, 1,648 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died in hospital as an inpatient. In addition to this, 243 deaths occurred in ED or were dead on arrival and there were 6 still births. The inpatient deaths comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 388 in the first quarter
- 341 in the second quarter
- 441 in the third quarter
- 478 in the fourth quarter

As at the 31st March 2023, 1546 have been reviewed by the Medical Examiners, 216 have had a Structured Judgement Review (SJR) and 1 has been subject to a serious incident investigation. In 1 case, a death was subjected to both a SJR and a serious incident investigation. The number of deaths in each quarter for which an SJR or a serious incident investigation was carried out (as of 29 May 2023) was:

- 87 in the first quarter
- 84 in the second quarter
- 44 in the third quarter
- 14 in the fourth quarter

(Note the number of cases in quarter three and four will be less at the time of publication due to a time lag incurred through coding validation and the SJR review process).

3 representing 0.18% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. [Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].

In relation to each quarter, this consisted of:

- 1 representing 0.06% for the first quarter
- 2 representing 0.18% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the SJR which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record.

Any SJR completed that identifies that further understanding is needed is subject to a second independent review. This process links into the Trust's Serious Incident process. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2022/23

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2022/23

And,

An assessment of the impact of the actions taken by the Trust during 2022/23:

Following on from the success of the introduction of the Medical Examiner Service at the Diana Princess of Wales Hospital site in April 2021 the Trust expanded the service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths. The service now has full establishment with 1.1 whole time equivalent Medical Examiners comprising of 9 Medical Examiners and 4 full time equivalent Medical Examiner Officers. This is an invaluable service that oversees and scrutinises the quality of care for patients who die during admission. The benefits of the service for the families or carers are likely to be the most impactful as the service provides clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences the families or carers may be experiencing. Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including identifying areas for improvement as well as highlighting good practice. The service ensures a correct and accurate cause of death is registered and appropriate deaths are referred to the coroner. Representatives from the Medical Examiners attend the Trust's Mortality Improvement Group and share a case review for learning bi-monthly. The Trust has invested in a bespoke module for SystmOne to allow primary care to refer deaths to the Medical Examiner Service for review. This will facilitate more robust scrutiny of community deaths.

In 2021/22 the Trust worked collaboratively with NHS England's Better Tomorrow: Learning from Deaths, Learning for Lives team to pilot the national Mortality Reporting Dashboard and transitioned from paper SJRs to NHS England's electronic SJR system, ORIS. This collaborative working has continued and strengthened in 2022/23 with the Trust invited, by NHS England, to deliver a presentation to Blackpool Teaching Hospitals NHS Foundation Trust as well as presenting at national webinars to share the Trust's experiences of transitioning to the new electronic system. The Trust was also a pilot site, providing feedback to NHS England, for the new national SJR plus system that was developed by NHS England to replace ORIS. The Trust was one of the first in England to successfully transition from ORIS to the new SJR Plus system in December 2022.

The Trust is committed to continuously learning from deaths to improve the quality of care provided to patients, their families, and carers. The following learning themes have been identified in 2022/23:

- Incomplete or poor quality documentation in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents.
- Missed opportunities to discuss DNACPR and ReSPECT documents.
- Missed opportunity for recognition of End of Life (EOL) pathway at earlier stage.
- Lack of anticipatory care planning.

- Mental capacity assessments not completed/poor documentation.

Actions implemented to address areas for improvement include:

- The Divisional Doctors Induction has been updated to include an early introduction to ReSPECT and EOL.
- ReSPECT forms require counter signature by a Consultant.
- A revised last days of Life Document has been produced and has been piloted, with plans to roll out to all wards. It is hoped that the revised version will promote better utilisation. The document review identified a gap in spiritual support to EOL patients and their loved ones. This has led to the development of a small working party and a draft leaflet regarding spirituality is currently in progress.
- Bespoke EOL training package developed for all ED staff.
- EOL Champions in place within ward areas.
- Medical Defence Union representatives have attended Quality and Safety/Audit Meetings to raise awareness of the risks of poor quality documentation.
- The Mental Capacity Act/Deprivation of Liberty Safeguards team have been providing additional training and support to staff to improve compliance and quality of mental capacity assessments and best interest forms. This work will be continued into 2023/24 as part of the Trust's Mental Capacity Quality Priority.
- A Trust wide quality improvement project is underway aiming to deliver a single pain assessment tool which will be used for all patients, including those who are at the end of their life. This is on track to deliver by the end of March 2023.

Building on the success of the Bluebell model introduced on several acute ward areas in 2021/22, the model has been rolled out to all ward areas in 2022/23. The model encourages the discussions and earlier identification of EOL and provides staff with the skills and confidence to identify and discuss patients EOL care needs. The positive impact of implementing this model is demonstrated in staff feedback as well as feedback from families using the Family Voices Diary. The Bluebell project has been instrumental in demonstrating good care as reported in the Trust's CQC report.

Compliance with syringe driver training has significantly improved due to targeted training via in reach onto ward areas where operational pressures inhibit staff from being released to attend classroom or virtual sessions. ReSPECT awareness compliance has also improved however authorship training remains low and will be an area for further improvement work in 2023/24.

A Trustwide Quality Improvement 'Always' Event was held in March 2023 which engaged frontline clinicians in articulating change ideas focussed around:

- The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care.
- Appropriate use of the Last Days of life pathway which underpins evidence-based care.
- Timely recognition of EOL.

This work will be developed further in 2023/24 as part of the Trust's EOL Quality Priority and on-gong quality improvement projects.

2.3j Details of ways in which staff can speak up

Annual Update on Speaking Up:

All NHS staff should be able to speak up regarding any concerns they may have in full confidence of not suffering any form of detriment as a result. The Trust is committed to ensuring that employees working for the Trust are not only encouraged to do this but are actively supported and guided as to how they can do this, should they feel the need to, whether they are concerned about quality of care, patient safety or bullying and harassment within their workplace.

The Trust has encouraged and supported staff to speak up by instituting several mechanisms for staff to raise concerns, these include:

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:
    - Through the Trust's nominated Freedom to Speak Up Guardian
    - Via the Human Resources Department, a part of the Trust's People Directorate
    - Using 'Shout Out Wednesday' in Family Services to raise any concerns.
    - Logging an incident on the Trust's incident reporting tool hosted on Ulysses
    - Contacting 'Ask Peter' which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian

The Trust's Freedom to Speak Up Guardian, their role, contact details and the principles of Freedom to Speak Up process is communicated to all new starters within the Trust as part of the corporate induction programme. The Trust's appointment of a substantive guardian in 2020 has led to a significant increase in the number of concerns raised and the role of the Guardian is widely publicised to all. Feedback shows staff would feel safe to speak up again.

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events (including a highly publicised campaign for the NGO Speak Up month in October), and additional magazine features. The Guardian is active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email

address and a dedicated mobile telephone number. Staff can also raise concerns using the Staff App, which gives another portal to access Guardian support.

In February 2023, the Trust formally adopted the Freedom to Speak Up Policy and Process for the NHS, which was developed by the NGO and NHSE with a recommendation that all Trusts adopt it. The Policy has been amended to include relevant Trust contacts. The Freedom to Speak Up Guardian responds to all concerns raised under this process and follows through each case according to the individual requirements providing regular communications and feedback until the case is concluded. Evaluation feedback from staff raising concerns has shown confidence in the Guardian and the overall process.

The Trust's Freedom to Speak Up Guardian meets monthly with the Chief Executive and the Director of People (who is the Executive Sponsor) and bi-monthly with the Trust Chair and Non-Executive Director with specific responsibility for Freedom to Speak Up who provides support to this function. The Freedom to Speak Up Guardian also meets monthly with the Trust Patient Safety Specialist to discuss any concerns raised in relation to Patient Safety. A quarterly Freedom to Speak Up Guardian report is reviewed by the Trust Management Board and the Workforce Sub-committee prior to being presented to the Trust Board by the Freedom to Speak Up Guardian. This ensures the Trust, and its board are kept up to date on concerns including sufficient details as per the National Guardian's recommendations. An overview of the report is shared with all staff by quarterly infographics. The Guardian is also sharing information to all Divisions about the number and nature of the concerns raised via the HR business partners. This information now forms part of the Divisions performance review meetings and information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2021/22 there was a significant increase in concerns raised with 157 cases brought to the Guardian, and in 2022/23, 220 concerns were brought to the Guardian. The latest staff survey indicates increased confidence in staff being able to raise concerns about anything and an increase that the organisation will address concerns, however there is a decline in staff feeling safe to raise concerns about unsafe clinical practice and that the organisation will address them. Although disappointing, the figure is still in line with national average figures for a Community & Acute Trust and reflects a national trend.

The Freedom To Speak Up Guardian has produced an annual progress report against the Trust's Freedom To Speak Up Strategy 2020-2024 which looked at the objectives set out in the strategy, progress made against them, and if additional actions are required to fulfil them. It is hoped that the majority of objectives set out in the strategy will be met by 2024 and no additional actions were identified at this stage.

2.3k Information about the Guardian of Safe Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training to oversee the process of ensuring they do not work excessive hours with inadequate breaks. The contract has stipulations on the length and frequency of shifts as well as rest breaks. Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the TCS and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

There are no trainees within the Dentistry service at the Trust and so the Annual Report applies only to doctors in training. Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to educational opportunities.

The table below, provides a breakdown by specialty of the total number of exception reports received during the period July 2021 to June 2022.

Department	Total number of exceptions submitted
Accident and emergency	1
Acute Medicine	25
Anaesthetics	15
Cardiology	4
Diabetes & endocrinology	3
Gastroenterology	44
General medicine	135
General surgery	29
Geriatric medicine	5
Obstetrics and gynaecology	12
Ophthalmology	1
Paediatrics	3
Respiratory Medicine	2
Rheumatology	2
Trauma & Orthopaedic Surgery	9
Urology	1
Grand Total	**291**

Targeted support is provided to support specialties in reducing exception reporting and provide a good learning environment for the doctors in training. The Trust was granted £60,000 of national funding in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed and upgraded rest areas are available on both sites.

Current numbers of Doctors in training within the trust is as follows (as of 1 January 2023):

Number of Training Posts (WTE)	302.74
Number of Doctors/Dentists in Training (WTE)	262.32
Number of Less than full time (LTFT) Trainees (Headcount)	20
Number of Training post vacancies (WTE)	40.42
Total number of trainees: SGH	155.74
Total number of trainees: DPOW	147
Total number of trainees: GDH	0

Fill rates remain high but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

There have been 2 fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors missing breaks, and for excessive working hours. This funding has now been spent on wellbeing resources for the doctors, after discussion at the Junior Doctors Forum.

The Guardian of Safe Working attends meetings between the Trust and Health Education England to monitor the learning environment. During the past year these meetings have concentrated on Medicine and Gastroenterology, following concerns raised in the GMC annual trainee survey.

The Guardian of Safe Working holds Junior Doctor Forums (JDF) every month. Issues addressed over the past year have included:

- Rota concerns
- Working conditions
- Continued progression on the Fatigue and Facilities Charter
- Attendance at the JDF

There is now a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors. The Trust continues to see an improvement in engagement with our doctors in training. We will continue to build on this during 2023/24.

Since returning rota coordination management to the divisions in May 2022 there has been an impression of them being more directly responsive to the divisions. Recruitment and training are ongoing in Medicine for Rota Coordinators. Medicine is now engaged in getting all additional hours onto e-Rostering and to getting job plans onto e-Rostering for senior clinicians. This is work in progress that will be completed in 2023/24. This will allow a greater level of visibility across the division of activities undertaken by all clinicians.

2.4 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. However, due to the impact of COVID-19 some national data collection was paused leading to delays in publication. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update.

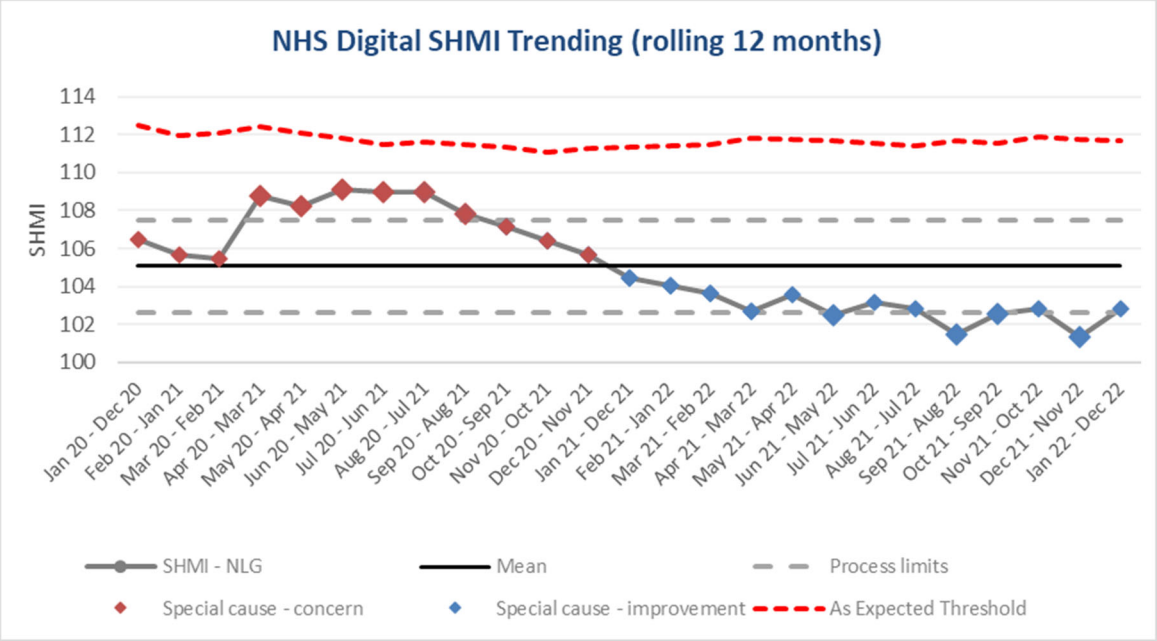
For each indicator, the number, percentage value, score, or rate (as applicable) for the last two reporting periods as well as the lowest and highest values and national average for each indicator for the latest reporting period will be represented in table format below. Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore, the following indicators reported on are only those relevant to the Trust.

2.4a Domain 1 – Preventing people from dying prematurely

Indicator	Trust value Jan 2021 – Dec 2021	Trust value Jan 2022 – Dec 2022	NHS (England) Jan 2022 – Dec 2022	National highest Jan 2022 – Dec 2022	National lowest Jan 2022 – Dec 2022
The value of the SHMI for the Trust for the reporting period*	1.04	1.03	1	1.22	0.71
The banding of the SHMI for the Trust for the reporting period*	2 (as expected)	2 (as expected)	2 (as expected)	1 (higher than expected)	3 (lower than expected)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	23%	23%	40%	65%	12%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts). *Reporting period January 2021 to December 2022

It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases. All values rounded to 2 decimal places.



- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths out-of-hospital (within 30 days of hospital discharge). The SHMI is a measure of observed deaths compared with 'expected deaths', derived statistically from the recording and coding of patient risk factors.

- NHS Digital guidance on SHMI interpretation states that the difference between the number of observed deaths and the number of expected deaths cannot be interpreted as 'avoidable deaths'. The 'expected' number of deaths is not an actual count but is a statistical construct which estimates the number of deaths that may be expected based on the average England figures and the risk characteristics of the Trust's patients. The SHMI is therefore not a direct measure of quality of care.

- The Trust, as demonstrated in the chart above, has demonstrated statistically significant improvement in the SHMI resulting in the Trust being categorised as having mortality that is 'as expected' and has maintained this position over the past two years. The rolling 12 month SHMI value for the Trust for the period December 2021 – November 2022 was 101.35 which is the lowest on record for the Trust.

- Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

- The SHMI does not exclude or make any adjustments for palliative care. Other Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) adjust for palliative care.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust continue with the processes to improve the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.

- Data continues to highlight a difference between hospital sites with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative care provision between both hospitals. This forms part of the End of Life improvement plan and is being addressed collaboratively between primary and secondary care. Funding has been secured and recruitment of a Palliative Care Consultant at Grimsby will be pursued in 2023/24.

The Trust has taken the following actions to improve the indicator and percentage in indicators a and b, and so the quality of its services by:

- Clinician led coding validation sessions and mortality screening reviews have continued throughout 2022/23. Key learning points around linking acute conditions to underlying problems have also been identified as follows:
  - Clinicians specifying electrolyte disorders or disturbances with the specific disorder, as each have a specific code. If the conditions are not specified only one code will be assigned, for the unspecified issue. If all conditions are specified, e.g. hypokalaemia, hypercalcaemia and hypernatraemia, all can be recorded which will improve the depth of coding and provides greater specificity around the conditions treated.
  - Multi-organ failure is also a 'catch-all' term used by clinicians to describe a patient's deterioration. When the individual organs that are failing are not specified only one ICD-10 code for unspecified multi-organ failure can be assigned. If each organ that has failed, each can be recorded individually (e.g. heart, respiratory, renal, liver). This accurately specifies the conditions that the patient is being treated for and improves depth of coding (Charlson comorbidities) and HRG assignment.
  - Heart failure diagnosed on diagnostic imaging e.g. chest x-ray requires diagnostic confirmation in the body of the medical record. Coders cannot code suggested diagnoses made on radiology reports and require confirmation for the condition to be coded.
- Teaching sessions and case study presentations have been shared at Divisions Quality & Safety meetings to share learning and reduce coding errors.

- The Trust is taking a pro-active approach to monitoring outcome risk of death for each SHMI diagnosis group and undertakes deep dive work with case reviews to learn from any early warning indicators to prevent future outlier alerts.

- The Community and Therapies Division works in partnership with the Northern Lincolnshire EoL Steering group to implement the Sub System EoL Improvement plan which focuses on delivering the National Ambitions for Palliative & End of Life care.

- The Trust is working in collaboration with Lindsey Lodge Hospice in Northern Lincolnshire to embed a single point of access 9am-5pm (7 days a week) where clinicians in the hospital and community can be directed to appropriate specialist palliative care team/professional for Face to face or virtual support. Outside of these hours on call specialist nurses and consultants can be contacted via Northern Lincolnshire Sigle Point of Access for phone or virtual support. This is underpinned by 7 days a week admission to the hospice and 7 day a week access to face to face specialist care nurses and consultants in Northern Lincolnshire. The Northern Lincolnshire Steering group continues to focus on the development of a consistent offer across Northern Lincolnshire, working with CPG and St Andrews Hospice to provide parity.

- The Clinical Coding team receive monthly palliative care contacts extract from North Lincolnshire Community and Therapy Services and North East Lincolnshire Care Plus Group. This is cross referenced against the patient coded data and any omissions are added for data quality purposes.

2.4b Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMS)

The data detailed in the table below was made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

a) Hip replacement surgery
b) Knee replacement surgery
c) Varicose vein surgery *(Not applicable as no longer performed by the Trust)*

The PROMs is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The table shows the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery. EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health). As participation is voluntary, patients can choose not to participate in PROMs.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average	National highest	National lowest
Hip replacement (Primary)	April 2019 – March 2020	0.447	0.459	0.539	0.352
	April 2020 – March 2021	0.410	0.472	0.574	0.393
Knee replacement (Primary)	April 2019 – March 2020	0.335	0.335	0.419	0.215
	April 2020 – March 2021	0.334	0.315	0.399	0.181

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

Patient-reported outcomes following primary hip replacement surgery (published in February 2022) showed a statistical difference to England rates where the Trust had fallen slightly outside the 95% control limit. The Trust scored 0.410, to be within the 95% control limit the Trust would have required a minimum of 0.421. The Trust remains within the 99.8% control limit of 0.392. This alert acts as a 'smoke alarm' and prompts the Trust to investigate processes surrounding primary hip replacement surgery.

The data period of April 2020 – March 2021 was during the peak of the COVID-19 pandemic and this resulted in some activity being cancelled altogether and limited restoration for the remainder of the period, the number of modelled records more than halved from the previous

year. Also, some lower risk patients were transferred to the independent sector which would likely influence the Trust's average patient reported outcomes scores.

Patient-reported outcomes following primary knee replacement surgery remain within the statistically calculated confidence intervals for EQ-5D measures, demonstrating no significantly different performance compared to the UK.

This release of data shows a potential impact from the Covid-19 pandemic which will have impacted upon planned surgery provision.

The Trust has taken the following actions to improve these outcome scores, and so the quality of its services by:

- Data made available from the PROMs dataset is presented within the division of surgery to support reflective practice and agreement of actions required for improvement. A summary report is presented at the Quality Governance Group and also the Quality and Safety Committee.

- Some lower risk patients were transferred to the independent sector to help reduce waiting lists.

- A deep dive investigation was carried out by the Quality and Audit Department and was presented at the Quality and Safety Committee in October 2022. Findings highlighted that although the Trust has fallen outside the 95% control limits for total hip replacements, the data for individual consultants does not highlight any issues that would need further investigation. The health records review further highlighted that over half of the patients for which a worsening in health was recorded had an American Society of Anaesthesiologists (ASA) grade of 3, which is defined as a patient with severe systemic disease. 62% of these patients were clinically classed as obese. This demonstrates that the 21 patients whose health scores deteriorated were high risk patients and may explain why the Trust's overall figures were below the England Average as the Trust does not impose exclusion criteria relating to high BMI and ASA grades.

Patients readmitted to a hospital within 30 days of being discharged

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged:

a) 0 to 15; and
b) 16 or over,

readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital during the reporting period.

Indicator	Trust value April 2020 – March 2021	Trust value April 2021 – March 2022	National average	National highest	National lowest
Percentage of patients aged between 0 to 15 readmitted to a hospital within 30 days of being discharged.	9.3	12.4	12.5	3.3	46.9
Percentage of patients aged 16 or over readmitted to a hospital within 30 days of being discharged.	12.7	12.1	14.7	2.1	142

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The Trust is below the England average for readmissions in both age groups. This is borne out by local performance reporting against peer benchmarked data.

The Trust intends to take the following actions to improve these percentages, and so the quality of its services by:

The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.

2.4c Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the Personal needs of patients

The Trust reviews its responsiveness to the needs of patients through monitoring responses to five specific questions:

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

There has been no new data made available to the Trust by NHS Digital about the Trust's responsiveness to the personal needs of its patients since 2020. Therefore, the table below shows the data up to the most recent entry covering hospital stays between 01 July 2019 to 31 July 2019 (data collected between 01 August 2019 to 31 January 2020). Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

Indicator	Trust value 2019 - 2020	National average	National lowest	National highest
Responsiveness to inpatients personal needs	62.5	67.1	59.5	84.2

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts).

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The data is provided by the national survey contractor.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

Working to ensure that patients can lead decisions in their care management. This is particularly evident in the outpatient transformation work that is ongoing within the Trust. Use of Patient Initiated Follow Up (PIFU) and Patient Knows Best (PKB) are two examples of how patients are encouraged to direct how they are managed according to their health needs.

The Trust continues to gather patient feedback about patient involvement in care and decisions through its monthly INSIGHT survey programme, which supports the national inpatient survey questions, and the 15 Step assurance programme. This feedback provides opportunity for divisions to work closely with areas where feedback indicates further improvement is required. A quality improvement collaborative is in progress focussing on discharge and ensuring patients are involved from the outset and are clear on ongoing care and treatment plans at discharge, including where to seek additional support after leaving hospital. This improvement piece of work also looked at medication at discharge, particularly in the discharge lounge and increased pharmacy support within this.

The most recent national inpatient and maternity surveys both highlighted that patients felt supported by staff, with reference to mental health in pregnancy. This improvement reflects the implementation of the mental health midwifery service. The Trust receives large amounts of positive feedback which references the impact good communication has on patients. Through cultural work, leadership development and training, such as national recognised Sage and Thyme communication workshop, the Trust continues to ensure effective and compassionate communication is a priority.

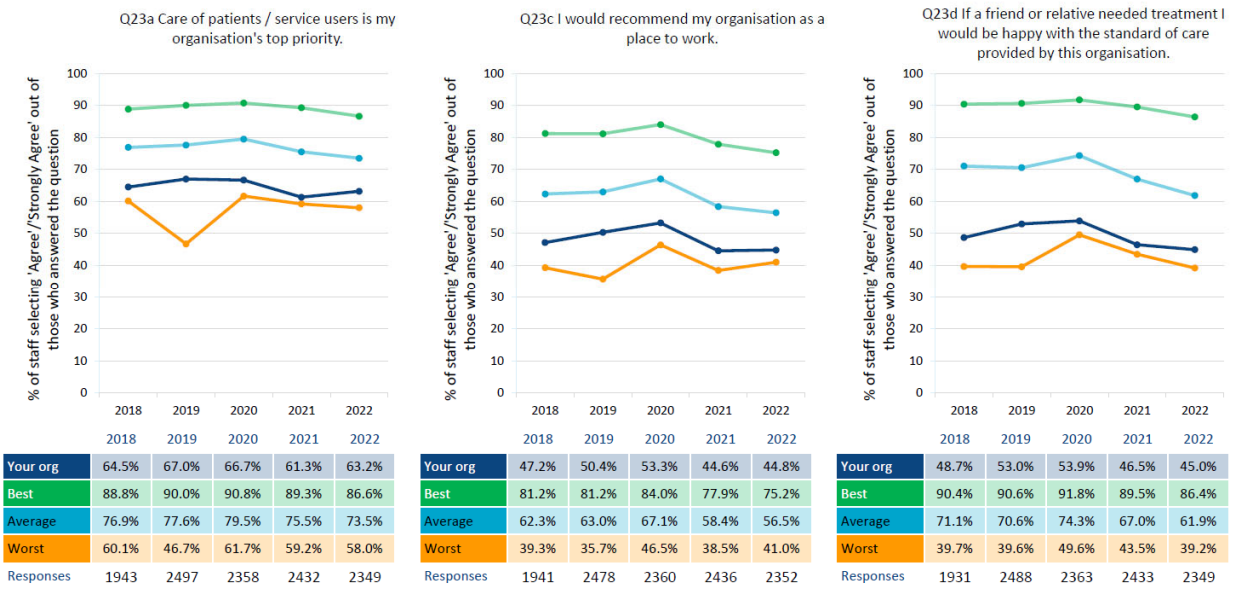
Whilst at times, the patient bedside is the only place to have a clinical conversation, due to the patient's clinical needs, there is further work required to revisit the use of our private spaces. Our charity partner, the Health Tree Foundation, supported a refurbishment programme of quiet rooms across the Trust and a review of this during 2023-24 will help identify the next steps.

The Trust recognises the worry that can arise around care and treatment following discharge. Patient Information leaflets are used within the Trust to provide valuable contact information and signposting. Use of social media platforms and helplines has been successful in our midwifery services, and this should be used to guide other areas wishing to develop this area further. The Trust Patient Advice and Liaison Service (PALS) team always provide a supportive signposting service for patients and families.

Staff recommending Trust as a provider to friends and family

The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends is taken from the Trust's NHS Staff Survey Benchmark report 2022 published on 09 March 2023.

Indicator	Trust value 2021	Trust value 2022	National average	National lowest	National highest
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	46.5%	45%	61.9%	39.2%	86.4%



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

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

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

Source: Northern Lincolnshire and Goole NHS Foundation Trust Staff Survey Benchmark Report 2022

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The above table illustrates the percentage of staff answering that they “Agreed” or “strongly agreed” with the question: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust” as published on the Staff Survey Coordination Centre website.

45% of staff surveyed would recommend the Trust (-1.6% since 2021); the reduction in the Trust’s score is not as big a decline compared with other organisations as this trend is system wide across the whole NHS and is likely as a response to the pressures and demands on public health presented post pandemic. It should be noted that the England average reduced from 67% to 61.9% in 2022 (-5.1% since 2001).

The unprecedented pressures and backlog of responses to health concerns and treatment the COVID-19 pandemic created continues to impact on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2022 compared to 2021. The Trust notes that there is much work to do across all staff survey themes. It should be noted that despite these pressures the Trust’s score in relation to “Care of patients/service users is my organisations top priority” improved in 2022 compared to the national trend which saw a decline.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

For the last three years significant work has gone into transforming the culture and supporting staff on front line services of the Trust. The Trust is taking the following strategic direction to improve our overall scores:

- The implementation of a Leadership Development Strategy focused on increasing line manager core skills, developing a values based leadership programme centred on improving leadership influence on culture and implementation of structured career pathways and education opportunities for clinical and non-clinical staff. As a result of

investment in leadership development the Trust has now piloted the first cohort with community and therapy and looks to run 6 more in 2023 to priority areas and management groups.

- The launch of a cultural transformation programme developed with our staff through the Big conversation of August 2022 to improve employee experience this resulted in high levels of staff engagement and voice: the Trust has since implemented a culture transformation working group and Board. 2023 will see the development of a culture change academy aimed at individuals, teams, leaders and a network of culture change ambassadors.

- Proactive career planning within nursing, including expanding the apprenticeship framework to enrich nursing career opportunities and retain good staff.

- Improved recruitment strategy and actions to become an Employer of Choice.

- implementation of an Equality, Diversity, and Inclusion action plan to strengthen our inclusion, diversity and equity. The Trust has launched 3 staff networks BME, Disability, LGBTQ+ in 2022 and is looking to launch the Women's network in 2023. A provision of educational programmes from 2023 onwards, ran with and through the staff networks, will support a more inclusive and equitable workforce and workplace.

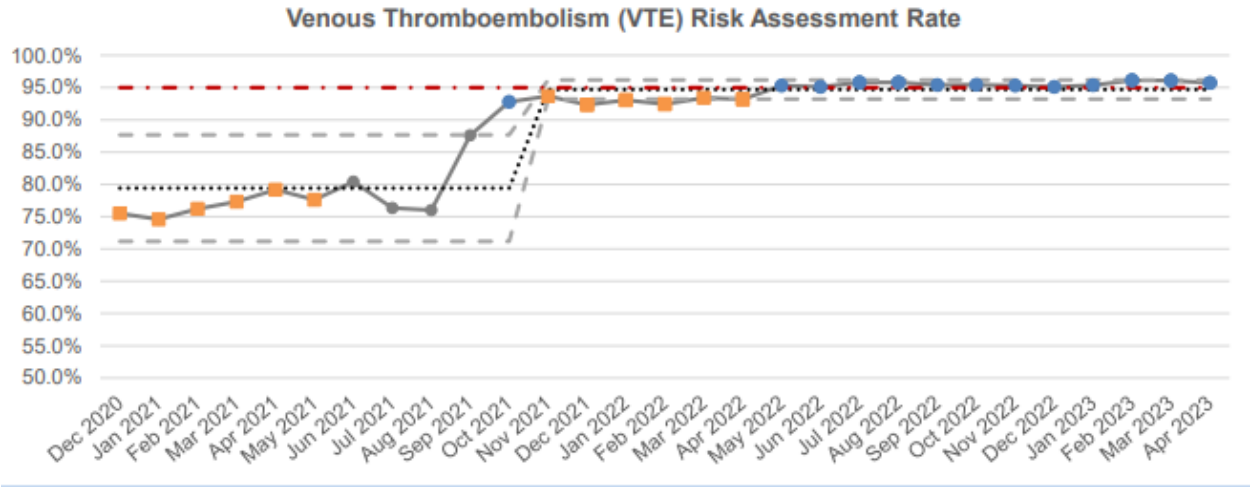
- The Trust has signed up to a two year health and wellbeing plan designed to build on progress made to date and embed effective leadership of our staff's health and wellbeing, introducing Schwartz rounds, growing a network of wellbeing champions and offering training in the field of Mental Health First Aid.

- The Trust aims to further develop this work in 2023 through leadership programme, culture programmes, coaching, mentoring and the development of a culture change academy aimed at individuals, teams, leaders, and a network of culture change transformation.

2.4d Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessed for Venous Thromboembolism (VTE)

The national VTE data collection and publication was paused to release NHS capacity to support the response to the Covid-19 pandemic. National data collection remains paused, so the below data only reflects local Trust performance data.



Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust reports on and oversees local VTE risk assessment compliance through the Trust's Performance Review meetings and in the Executive Governance reporting mechanisms. Compliance figures are also available at specialty level, allowing targeted support if indicated.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- The Trust completed the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system in November 2021. The system is having the desired effect in improving patient safety as built-in controls prompt doctors to undertake full VTE risk assessments in a timely manner, prior to prescribing or administering medications. Since the introduction of the EPMA system VTE risk assessment rate has significantly improved and remained above the Trust's 90% target since May 2022 with a 2023/23 year average of 95.3%.

- The Trust's Quality Governance Group receives a highlight report in relation to VTE screening performance.

Clostridium Difficile infection reported within the Trust

The data made available to the Trust by NHS Digital regarding the rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust (hospital onset) amongst patients aged 2 or over is shown in the table below. *(Most recent data published by NHS digital on 29 September 2022).*

Indicator	Trust value 2019/20	Trust value 2020/21	Trust value 2021/22	National average 2021/22	National lowest 2021/22	National highest 2021/22
The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	9.3	7.9	5.1	16.5	0	53.6

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The data shows that the Trust is beneath the UK average and one of the best performing acute hospitals in the UK which is a major achievement. This level of performance has been maintained in 2022/23.

The definitions for reporting Clostridium difficile cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital Onset Healthcare Associated (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Community Onset Healthcare Associated (COHA) if the patient was an in-patient within the previous 4 weeks.

Due to success of considerable reduction of cases in previous years, the trajectory for the year 2022 - 2023 of 21 cases was extremely challenging. The Trust had a Clostridium difficile infection objective of no more than 21 cases and ended the year on 24 reported cases combining Hospital-onset healthcare associated and Community-onset healthcare associated cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. Despite exceeding the threshold, The Trust performed exceptionally well for Clostridium difficile rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

- Capital and planning teams factored the need to increase isolation capacity in building schemes e.g. Emergency Care Centres and Ward 25.
- The Trust has an evidence-based Clostridium difficile policy and patient treatment care pathway.
- Multi-disciplinary team meetings are held for inpatient cases where required to identify any lessons to be learnt and post-infection review is conducted for hospital onset cases.
- For each case admitted to hospital, practice is audited by the infection prevention and control team based on the Department of Health Saving Lives' audit tools.
- Themes learnt from the Post-Infection Review (PIR) process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies.
- The development of a bespoke IPC alert that will inform the IPC team to previous cases of Clostridium difficile.
- GPs are sent an email to inform them of a patient's Clostridium difficile status again to help reduce the amount of antimicrobial use and prevent future Clostridium difficile cases; This is now incorporated into the patient discharge letter.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control group.
- PathLinks antimicrobial formulary reviewed with latest national standards.

- Updated antimicrobial Trust intranet site, the HUB, to make access to content easier for prescribers.

Patient safety incidents

The data made available to the Trust by NHS Digital represents acute (non specialist) trusts only, which is the Peer Group the Trust is benchmarked against for this indicator. Patient safety incident data is now published annually.

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Percentage of safety incidents that resulted in severe harm or death	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 100,00 population	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
October 2019 – March 2020	8,105	65.5	20	0.2	0.25%	0.3	1.95	0.00
April 2020 – September 2020	7,570	79.9	49	0.51	0.65%	Data not available	Data not available	Data not available
October 2020 – March 2021	7,547	69.7	94	0.86	1.25%	Data not available	Data not available	Data not available
April 2021 – March 2022	15,533	72.6	25	0.11	0.16	Data not available	Data not available	Data not available

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts). There have been no new publications of data by NHS digital since February 2021 which covered the reporting period Oct 2019 – March 2020.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- Due to Covid-19 and the lack of available data, the national indicators were not updated with new data periods. Therefore, the table has been populated with local data updates from April 2020 onwards from the National Reporting and Learning System.

- The lack of national data prevents the Trust being able to compare rates of patient safety incidents with other non-specialist NHS organisations. However, the Trust monitors and reports on numbers internally.

- The Trust continues to monitor incident rates locally and continues to actively promote and encourage staff to report all incidents as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness.

- The increase in numbers during April 2021 – March 2022 was due to incidents added retrospectively as severe harm/death for each patient who may have acquired COVID in hospital and then required treatment in ITU or who subsequently died with Covid-19. Letters of apology were sent to each patient's family.

The Trust has taken the following actions to improve this number and/or rate, and so the quality of its services by:

- The Trust continues to promote high levels of incident reporting, viewing this as a learning opportunity promoting a positive patient safety culture.
- The Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities.
- The Trust oversees Serious Incidents (SI) weekly at the SI panel ensuring that appropriate investigation is undertaken in line with agreed timescales.
- The Trust continually works towards improving learning in the organisation and has a learning strategy in place.
- The Trust have a SI Review Group to look back at older cases to determine if there is anything further that can be done to increase safety.

Part 3: Review of Quality Performance

3.1 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Oversight Framework (not already reported on within this document) are shown as follows for 2022/23.

Indicator	Quarter 1 22/23 (Percentage)			Quarter 2 22/23 (Percentage)			Quarter 3 22/23 (Percentage)			Quarter 4 22/23 (Percentage)			Target	Full year average
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	71.07	71.79	69.49	67.01	66.98	65.97	66.62	65.98	64.46	65.96	66.56	65.55	92%	67.29%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	58.90	65.50	63.30	62.10	59.10	62.20	61.20	62.30	53.10	57.60	55.80	56.50	95%	59.8%
All cancers: 62-day wait for first treatment from referral/screening	61.30	53.00	52.20	51.10	42.40	49.80	44.70	54.60	62.40	48.90	58.10	47.50	85%	52.17
Maximum 6-week wait for diagnostic procedures	23.80	20.00	24.40	29.80	32.50	31.40	28.40	29.80	38.60	39.20	33.30	34.40	1%	30.47%

3.2 Information on staff survey report

Summary of performance – NHS staff survey

Each year the Trust encourages staff to take part in the national staff survey. The survey results give each health Trust a picture of how its staff think it's performing as an employer and as an organisation.

Timeline

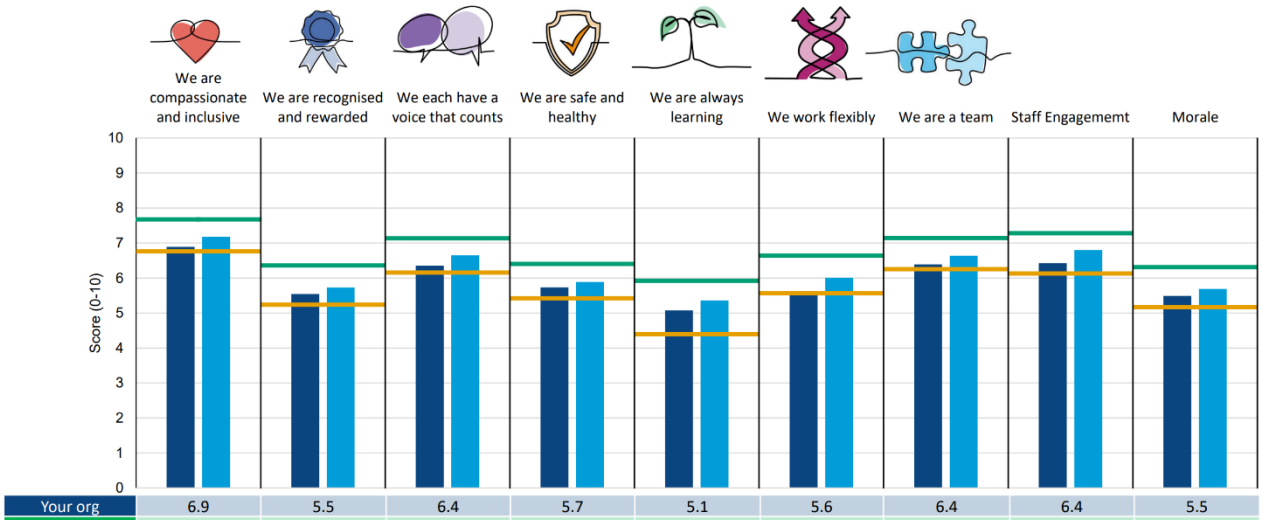
Survey Window: 4th October to 26th November 2022
Embargoed Findings: Received – 24th February 2023
NHSEI Publication: 30th March 2023

Key Facts

Benchmark Comparators: 126 Acute & Acute Community Trusts
Benchmark Response Rate: 46% (+0 % on 2021 survey)
NLaG Response Rate: 36% (-3% on 2021 survey)
NLaG Survey Mode: Online (2,415 completed / -138 on 2021)

Staff Survey 2022 findings

The 2022 survey questions are aligned to the seven themes of the People Promise. Staff Engagement and Morale remain included as in previous years.
The chart below demonstrates Trust results in comparison to peer organisations.



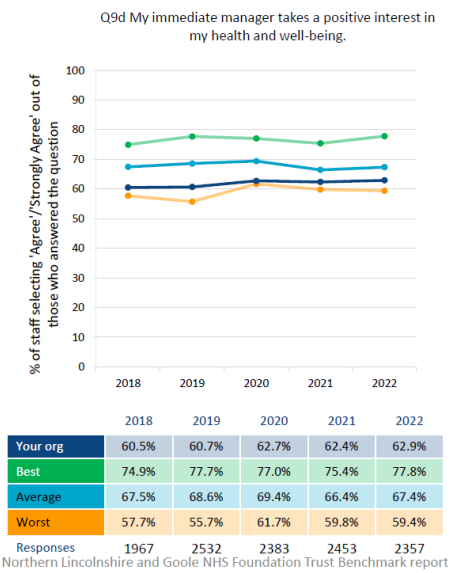
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.9	5.5	6.4	5.7	5.1	5.6	6.4	6.4	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7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

Health and Well-Being

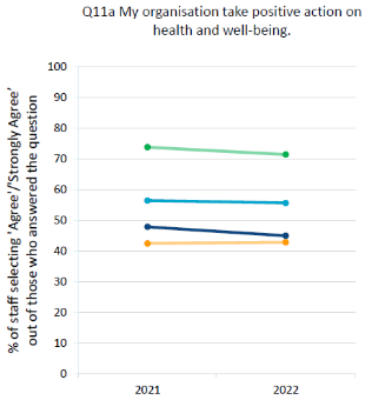
Since last year the Trust can evidence:

- Increased positive action being taken regarding health and wellbeing support
- The uptake of staff working agilely can be evidenced.

Note: Q11a with Trust taking positive action towards Health and Wellbeing is not felt by the respondents yet Q9d respondents felt immediate managers take an interest in health and wellbeing.

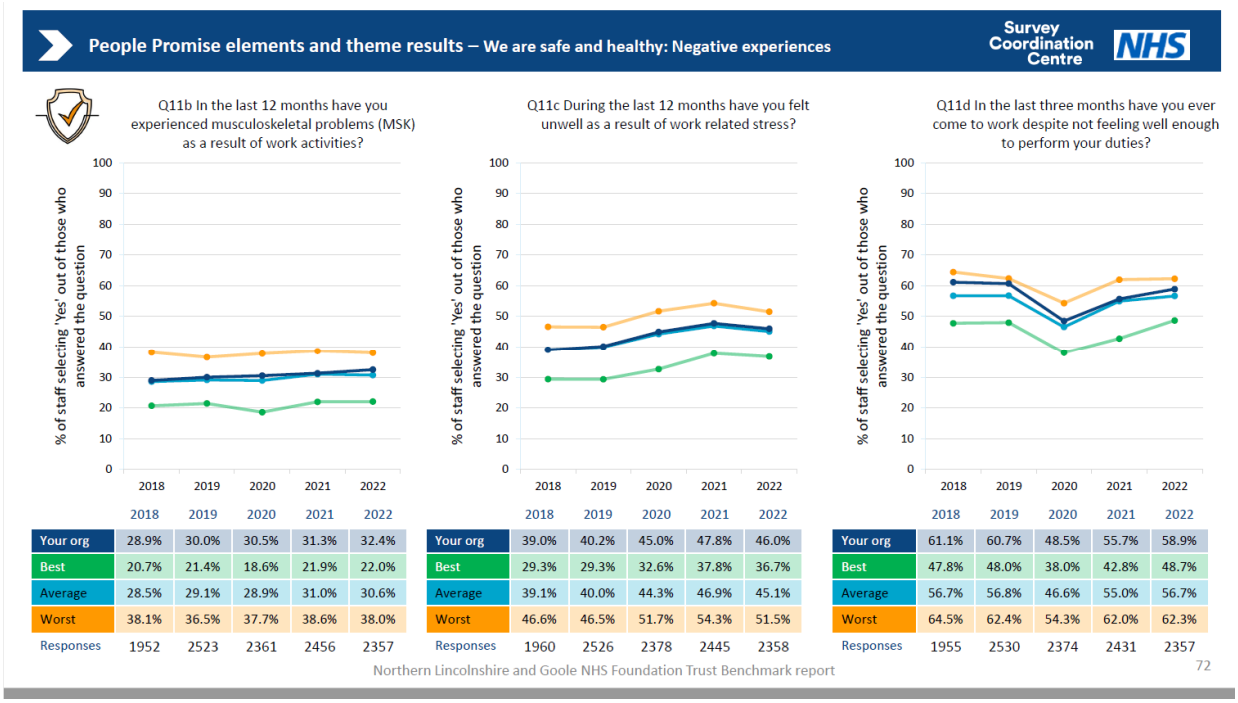


	2018	2019	2020	2021	2022
Your org	60.5%	60.7%	62.7%	62.4%	62.9%
Best	74.9%	77.7%	77.0%	75.4%	77.8%
Average	67.5%	68.6%	69.4%	66.4%	67.4%
Worst	57.7%	55.7%	61.7%	59.8%	59.4%
Responses	1967	2532	2383	2453	2357



	2021	2022
Your org	47.8%	44.9%
Best	73.8%	71.4%
Average	56.4%	55.6%
Worst	42.4%	42.8%
Responses	2426	2306

The Trust has retained a fairly consistent score on the value managers placed on staff health and wellbeing. This is largely due to a comprehensive and proactive pandemic response action plan implemented in 2020 and retained and enhanced in 2021/2 to support managers and staff through the challenges of the pandemic.



	2018	2019	2020	2021	2022
Your org	28.9%	30.0%	30.5%	31.3%	32.4%
Best	20.7%	21.4%	18.6%	21.9%	22.0%
Average	28.5%	29.1%	28.9%	31.0%	30.6%
Worst	38.1%	36.5%	37.7%	38.6%	38.0%
Responses	1952	2523	2361	2456	2357

	2018	2019	2020	2021	2022
Your org	39.0%	40.2%	45.0%	47.8%	46.0%
Best	29.3%	29.3%	32.6%	37.8%	36.7%
Average	39.1%	40.0%	44.3%	46.9%	45.1%
Worst	46.6%	46.5%	51.7%	54.3%	51.5%
Responses	1960	2526	2378	2445	2358

	2018	2019	2020	2021	2022
Your org	61.1%	60.7%	48.5%	55.7%	58.9%
Best	47.8%	48.0%	38.0%	42.8%	48.7%
Average	56.7%	56.8%	46.6%	55.0%	56.7%
Worst	64.5%	62.4%	54.3%	62.0%	62.3%
Responses	1955	2530	2374	2431	2357

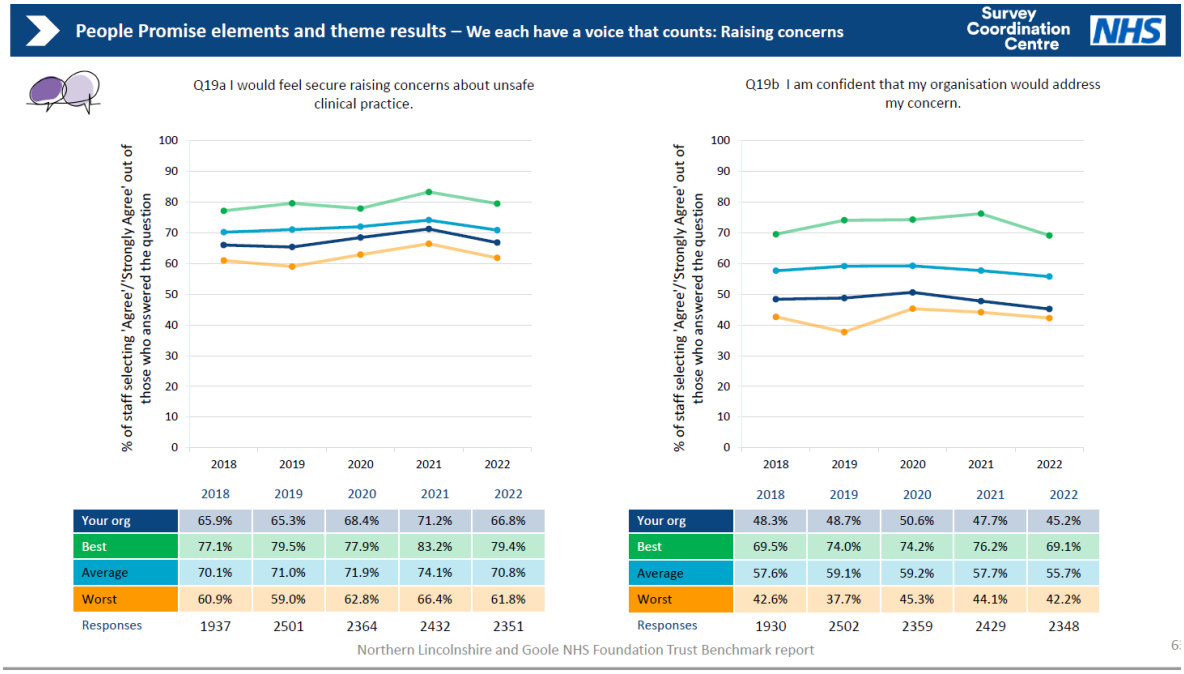
The Trust are committed to further work on health and wellbeing, as set out in our forthcoming two year health and wellbeing plan, and our Trust's recent participation in the NHSE Health and Wellbeing Trailblazer Pilot. The Trust was noted for its strategic perspective in the pilot, focusing on long term improvement of staff wellbeing and line manager capability to proactively support their staff. Further work is mapped to strengthen this including:

- The support of staff psychological wellbeing with skills training and sessions in CISM training, further funding of clinical psychologists, the introduction of Schwartz Rounds

and a series of pop up wellbeing Hubs planned for 2022/23 to continue well into 2023/24.

- Consideration given to supporting staff burnout is required given Q11d and staff continuing to work when unwell is increasing.

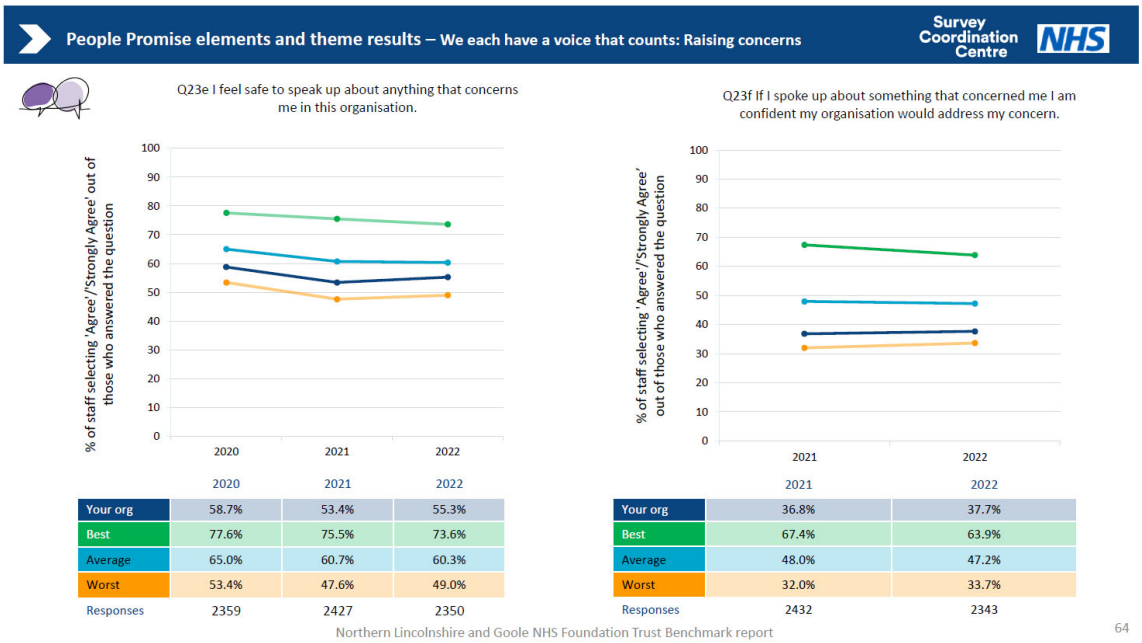
Safety Culture



	2018	2019	2020	2021	2022
Your org	65.9%	65.3%	68.4%	71.2%	66.8%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1937	2501	2364	2432	2351

	2018	2019	2020	2021	2022
Your org	48.3%	48.7%	50.6%	47.7%	45.2%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1930	2502	2359	2429	2348

Since 2018 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017 in 2021). However, we see an increase in loss of confidence in raising concerns and addressing these since last year (-4.4% for Q19a and -2.5% for Q19b)

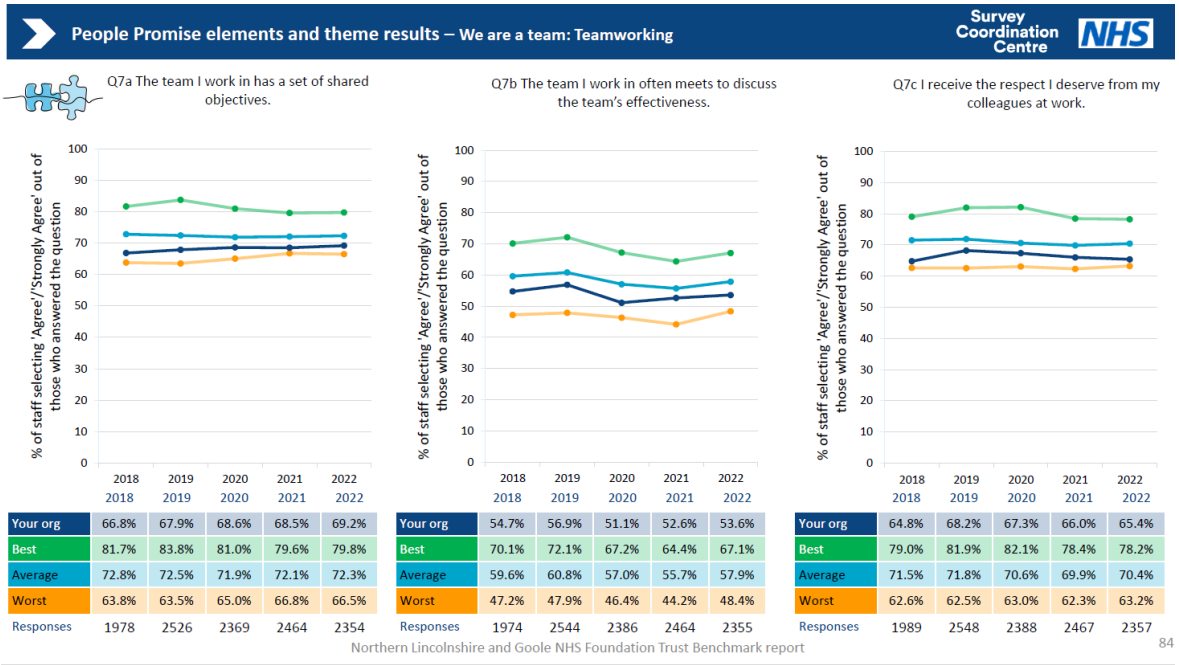


	2020	2021	2022
Your org	58.7%	53.4%	55.3%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	2359	2427	2350

	2021	2022
Your org	36.8%	37.7%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	2432	2343

Whereas 2021/22 saw a decrease in staff feeling they are able to speak up about anything that concerns them in the organisation there has been a marked improvement with the introduction of our Freedom To Speak Up Guardian and the Trust taking a proactive approach to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

Team Working



We see a small uplift in scores since last year as an indication that some small improvements have been made and felt by our staff. In addition to the Trusts approving the Leadership Development Strategy last year more Teamworking and Line management skills are required to achieve high levels of staff engagement. Our forthcoming core leadership skills programme of work will support improvement in this theme.

Next Steps:

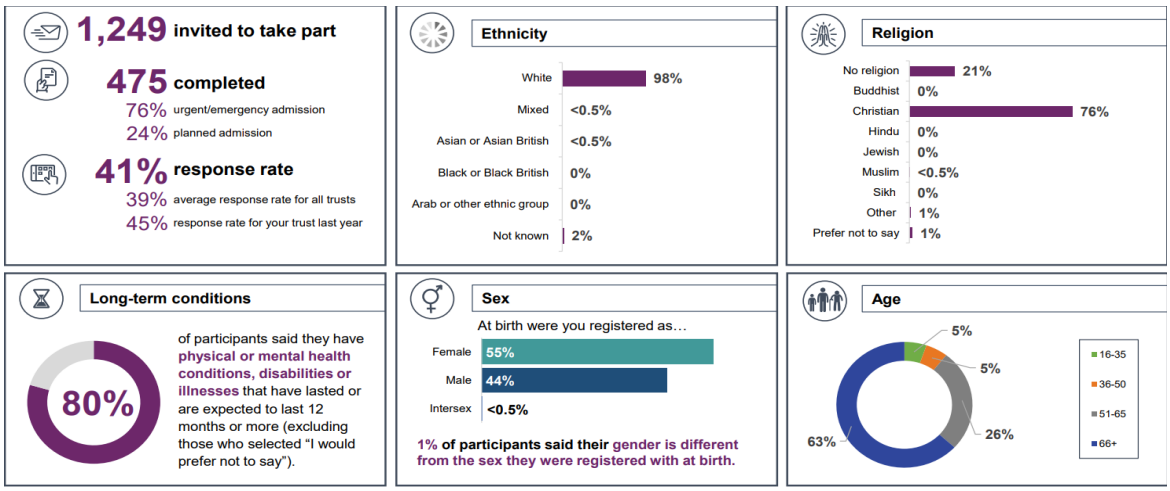
Begin delivery on revised cultural and leadership objectives aligned to Trust priorities and the Leadership Development Strategy. These are overseen by the Culture Transformation Board and the Workforce Committee.

3.3 Information on patient survey report

The national survey programme provides a year-on-year review of person-centred validated questions and responses. This data allows the Trust to monitor internal progress and benchmarking. During 2022/23 the Trust implemented a comprehensive action plan based on the 2021 national inpatient survey (2022 survey results are still being collated nationally), of which the headlines are detailed below.

The 2021 National Adult Inpatient Survey shows a significant internal improvement for Northern Lincolnshire and Goole NHS Foundation Trust, compared to the 2020 survey results from its survey provider, Picker.

All trusts then have their dated weighted and represented by the CQC. The demographical data indicates most people surveyed were over 66 years of age and had a long-term condition.



On release of the CQC data the Trust is rated in the same mid-range as the other 134 acute trusts surveyed for 46 of the questions asked. It also highlighted significant internal improvement in 5 questions, as shown below:

Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?
Q42. Before you left hospital, did you know what would happen next with your care?
Q29. Do you think the hospital staff did everything they could to help control your pain?

There has been an organisational quality improvement pain collaborative which has clearly impacted on the patient experience, reflected in the question responses, which provides added assurance to existing monitoring.

The celebration of improvements is shared across the Trust and the whole survey has been reviewed and discussed to determine the proposed improvement actions.

The areas for improvement from the CQC survey, as shown below, have

Where patient experience is best

- ✓ Quality of food: patients describing the hospital food as good
- ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had

Where patient experience could improve

- ○ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- ○ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ○ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ○ Information about medicines to take at home: patients being given information about medicines they were to take at home
- ○ After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went

The survey is shared divisionally, and any actions are designed collaboratively, following discussions around existing quality improvement pathways. This method avoids unnecessary duplication of actions, the overarching action is owned divisionally and monitored every quarter through the Trust's Patient Experience Group. Actions fall under the 4 main headings:

- Person centred care
- Information
- Environment and Facilities
- Discharge

This year's priorities are based on survey results, exiting quality improvement work streams and triangulation of other patient experience data. An example of this is, whilst medications at discharge featured on the CQC report as below the expected range, internally there has been no significant decline in scores and discharge is already a quality improvement priority.

Priorities are also based on which questions mattered most to patients, using the Picker Institutes research-based analysis during review.

Therefore, survey actions are now in place and being monitored around key areas:

- Did not have to wait long time to get to bed on ward
- Not prevented from sleeping
- Explained well how procedure had gone
- Family or home situation considered at discharge

Due to the time span of national surveys, they are, in effect, always year behind by the time results are analysed and shared, the Trust conducts its own ongoing inpatient survey programme. The INSIGHTS local survey programme surveys 10 patients on each adult inpatient ward monthly and monitors this feedback. It remains the Trust's commitment to listen and act on patient feedback and prioritise actions that matter to patients most.

3.4 Quality Improvement Journey

The Quality Improvement (QI) program for the trust has continued to develop in year with 656 staff trained in QI methodologies by the QI Academy during 22/23, including 327 Foundation Level Doctors from across the Integrated Care System at Applying QI level, where they are able to apply their QI skills by delivering a Quality Improvement Project (QIP). 23 Trust staff (and 1 Integrated Care Board staff member) have been trained in Leading & Coaching QI, enabling staff to not only enact their QI skills but lead larger programmes of change. A further 50 Trust staff undertook Applying QI level training with 37 either completing a QIP or in the process of doing so.

In addition, the Trust has run several trust wide QI collaborative events with measurable outcomes involving 38 wards from across the trust. These include the Safe and Secure medications QI collaborative which focused on increasing the compliance of the Safe and Secure Medications audit from a baseline 71.30% compliance to achieving the target of 85% compliance across all inpatient wards at the Trust. An ongoing QI Collaborative commissioned in year focused on the improvement of Pain Assessment and Reassessment, with the 5 pilot wards Increasing the number of electronic pain assessments completed from 497 in March 2022 to 3584 in March 2023. An 'Always' Event was also held during March 2023 to engage clinical colleagues, patients, and families to start a QI programme focusing on the trust End of Life pathways. This work will continue throughout 2023.

The Quality Improvement Showcase launched in Nov 2022 to capture, showcase, and celebrate QI initiatives from across the trust has over 160 QI project documented with over 40% showing a measurable improvement with the remainder at various stages of testing and measuring data.

The Trust will continue to build on its strong QI foundations to deliver outstanding quality of care to our patients in 2023/24.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 1.1: Statements from Commissioners

Feedback from:
Humber and North Yorkshire Integrated Care Board (ICB)
Lincolnshire ICB

This statement has been produced by Humber and North Yorkshire Integrated Care Board (ICB) and includes the reflections of Lincolnshire Integrated Care Board.

The 2022/2023 financial year has been particularly challenging for our health and care system. The Trust has accomplished significant advancements and sustained improvements within the year whilst also being open to opportunities to support the wider healthcare system. The ICB is delighted that the hard work and efforts of the Trust have been formally recognised in their latest CQC inspection and NLaG has moved out of the Recovery Support Programme formally known as Special Measures. The Humber and North Yorkshire Integrated Care Board would like to thank the Trust and all Staff working within the organisation for their significant contribution to supporting the health and care of our population.

The ICB would particularly like to recognise the sustained improvement of the Summary Hospital-level Mortality Indicator (SHMI). An indicator which demonstrates the efforts of the Trust within the organisation and that of the collaboration with health and care partners outside of the Trust to drive system improvement in this area. Additionally, other achievements of the Trust throughout 2022/2023 are highly commended, specifically the vast number of quality improvement initiatives undertaken throughout the year, the establishment of the Maternity Triage Telephone system, the excellent work around the personalisation agenda which is reflected in Gareth's story and the exceptional achievement of the Trust with regards to having some of the lowest Infection Control rates in the country.

The ICB are supportive of the Trust's Quality Priorities for 2023/24, recognising the need to continue to embed the excellent work commenced during 2022/2023 for some areas and the additionality of new quality priorities including End of Life and Mental Capacity which are fundamental to ensuring high quality care for all. With the development of more complex patient pathways, effective communication is key across health and care partners to ensure patient safety and the ICB is reassured that there will also be a specific focus on communication.

We will continue to support the Trust on its improvement journey and will be actively contributing to this by facilitating system health and care innovations within the local health and care system which will impact the quality of our health and care pathways. The two places in Northern Lincolnshire have prioritised Quality Improvement activity to support development in system flow and the quality of care in hospital avoidance and supported discharge. Support into and around care homes is the focus of North and North East Lincolnshire Health and Care Partnerships.

Once again we would like to commend all staff and the Trust on their hard work, resilience and achievements this financial year.

Annex 1.2: Statement from Healthwatch organisations

Feedback from:
Healthwatch North East Lincolnshire
Healthwatch North Lincolnshire
Healthwatch East Riding of Yorkshire

Healthwatch North East Lincolnshire
Suite 4 Alexandra Business Centre
Fisherman's Wharf
Grimsby
DN31 1UL

18.5.23

Dr Peter Reading
Chief Executive
Northern Lincolnshire & Goole NHS Foundation Trust

Dear Dr Peter Reading

Healthwatch response to the Annual Quality Accounts 2022/23

Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire and Healthwatch East Riding of Yorkshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust and have agreed to provide a joint statement.

The three local Healthwatch organisations recognise that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. The following is the joint response from Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire and Healthwatch East Riding of Yorkshire.

The summary clearly sets out what you have achieved during 2022/23 against your 6 priority areas and what still needs working on and where progress has been made. The Trust has also clearly indicated what the priorities will be for 2023/24 and how you hope to achieve them.

Here at Healthwatch we are pleased to hear that the Northern Lincolnshire & Goole NHS Foundation Trust achieved the targets that were necessary to leave the Quality Special Measures after your CQC inspections, these inspections have also shown that through the hard work you and your staff have put in during 2022/23 that your overall CQC rating has gone from 'Inadequate' to 'Requires Improvement'.

The highlight for patients across Northern Lincolnshire has been the opening of the 2 new Emergency Departments, with further developments consisting of Acute Assessment Units and Same Day Emergency Care Provision.

We at Healthwatch are pleased to see the personal account and the impact you have made to an individual with support from staff the young man received the treatment he needed in a caring and compassionate way and the difference this had made to him and his family.

In 2021/22 you reported that you intended to improve the figure for patients being discharged before 12pm. 2022/23 there has still been no statistical change to your position, we at Healthwatch would hope that during 2023/24, with new initiatives being in place that these figures improve. We are aware that you are often reliant on outside agencies to support you and to work collaboratively for the patient and that sometimes things are outside of your control, however improvement in this area is paramount for the wellbeing of patients.

Healthwatch is also pleased to see that the Friends and Family Test has resumed after being paused due to the Covid-19 pandemic, the Trust had set targets to increase the response rates, these may not have been achieved but plans are in place to continue with this action. Healthwatch offers support in this area, if you require it.

The Trusts work and future planning with regards End of Life is welcomed. During 2022/23 we are aware that you have started to roll out the Electronic Palliative care Coordination System (EPaCCs) and this should enable patient's wishes and feelings to written in one place, this will improve their journey and the care they receive. There is still progress to be made in the area of End of Life but the Trust has a clear plan in place to achieve the goals set out.

We would like to thank all of your staff for the hard work they have put in during 2022/23 to achieve a better CQC rating and for the developments that are happening within the Trust. We have still been in Covid-19 recovery, however you have continued to make improvements and to recognise were you still need to make progress.

Yours sincerely,

Tracy Slattery	Jennifer Allen	Cheryl Howley
Delivery Manager	Delivery Manager	Delivery Manager
Healthwatch North East Lincolnshire	Healthwatch North Lincolnshire	Healthwatch East Riding of Yorkshire

Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire

Introduction

The Health Scrutiny Committee for Lincolnshire is grateful to representatives from the Trust for presenting its draft quality account and enabling the representatives from the Committee to receive answers to their questions on its content.

Presentation and Clarity of the Quality Account

The Committee believes that the quality account is clearly presented, for example, progress on each of the metrics for the previous year's quality priorities is clearly indicated by colour-coding. The Committee notes that the glossary of terms was included in the draft quality account, and this would be expanded in the final version to cover the acronyms throughout the quality account.

Priorities for Improvement

Progress in 2022/2023

The Committee notes that improvements were made across the metrics for the six priorities for improvement, except antibiotic prescribing, where it was explained to representatives of the Committee that setting targets for reducing antibiotic prescribing may not always be appropriate. The following specific comments are recorded on three of the priorities:

- Priority 1 *(Mortality Improvement)* – Improvements in the Summary Hospital-level Mortality Indicator [SHMI] are particularly welcomed, as are the year on year reductions in the number of patients dying within 24 hours of admission.

- Priority 3 (*Sepsis*) – Although the targets were not met, the Committee accepts that there have been improvements in the percentage of patients screened for sepsis. The Committee looks forward to further improvements as this priority has been carried forward into 2023/24.

- Priority 6 (*Safety of Discharge*) - The Committee supports the contribution of weekend consultant ward rounds to enable the timely discharge of patients, thereby avoiding discharge peaks on Monday mornings.

Priorities for 2023/2024

The Committee supports the five quality priorities selected for 2023/2024, three of which are continuations of actions taken during 2022/23. The Committee looks forward to progress across all five priorities, including the two new priorities (*Improving End of Life and Palliative Care*; and *Increasing the Quality of Mental Capacity Act Compliance*). It was confirmed to the representatives of the Committee that all five priorities were selected with the involvement of patients and staff.

Achievements During 2022/23

The Committee welcomes the following achievements during 2022-23:

- external recognition of the Trust's end of life team and the training of 68 bluebell end of life champions;
- external recognition of the discharge improvement project;
- the development of two new emergency departments and adult assessment units in Grimsby and Scunthorpe; and
- the introduction of the maternity triage system.

Support for Patients with Mental Health Needs

The Committee is grateful for the representatives of the Trust who presented the quality account for outlining the Trust's support for patients needing mental health support, which include some 'in-reach' services provided by the two local mental health providers, as well as access to support from these providers outside the hospital setting. The Committee stresses the importance of mental health support, particularly in emergency departments, as these are places where patients go, when mental health crisis services are not available.

Staff Wellbeing

The number of staff recommending the Trust as a provider to their friends and family had fallen in 2022, and notes that this is likely as a result of staff fatigue and demands on them following the pandemic. Representatives of the Committee were reassured that staff wellbeing was important: the "Ask Peter" initiative, and the *Freedom to Speak Up Guardian* were key elements in valuing staff involvement and supporting their welfare. The Committee was pleased that a higher percentage of exit interviews were being conducted, so that the Trust could learn from staff leaving the service.

Engagement with the Committee

As the Trust engages regularly with three other health overview and scrutiny committees representing the local authority areas where its main sites are located, engagement with the Health Scrutiny Committee for Lincolnshire has previously been limited. The Committee is mindful that the Humber Acute Services Review, with its possible changes to the acute hospitals in Grimsby and Scunthorpe, will affect Lincolnshire patients, and as a result the Committee believes that its engagement with either the Trust or its commissioners is likely to increase.

Conclusion

The Committee is grateful for the opportunity of making a statement on the Trust's quality account for 2022/2023 and looks forward to the Trust continuing with its progress on its standards of care and continuing to provide the acute hospitals of choice for a significant number of patients in the administrative county of Lincolnshire.

Feedback from:
East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

Northern Lincolnshire and Goole NHS Foundation Trust has engaged with the Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee throughout its work programme 2022/23.

The Sub-Committee welcomes the quality priorities set for 2022/23 and feel these have been carefully considered and hopes the Trust can meet these priorities in forthcoming year and that these will help to improve the overall performance of the Trust.
Comments:

- Elective Waiting – In February 2023, the Sub-Committee were presented with a breakdown of NLaG's elective waiting backlog and note that the CQC identified an improvement. A continued commitment to reducing the backlog would be greatly supported by the Sub-Committee.

- Workforce – An approach to address staffing challenges is vital to future proof service delivery. Following on from its consideration of the health care workforce in November 2022, and the continued references throughout the year, the Sub-Committee are pleased to see that activity has been identified for upskilling pharmacists. Opportunities to improve the career prospects of staff, including career planning within nursing, is a positive step towards recruiting and retaining staff.

- Co-production - In preparation for quality priority planning for 2023/24, the Sub-Committee appreciate the engagement with service users as a means to co-produce areas of improvement.

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel

North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel note and welcome the Trust's Quality Account document, including the priorities for the forthcoming year. The Scrutiny Panel intends to work closely with the Trust throughout 2023/24 to discuss services for local patients and residents, to robustly scrutinise forthcoming proposals around acute care, and to hold local decision makers to account.

Feedback from:
North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel

No feedback was received for inclusion in the Trust's quality account.

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is pleased to have been given the opportunity to comment on the Trust's Quality Account for 2022/23. Despite the Covid pandemic aftermath, this demonstrates a continuation in the significant quality improvements that have been achieved over recent years through the herculean efforts of NLaG staff at all levels of the organisation. It was particularly gratifying that these measurable improvements were reflected in the Care Quality Commission's latest inspection report and the subsequent removal of the Trust from Quality Special Measures or the Recovery Support Programme as it is now known.

Throughout the year governors have continued to prioritise seeking robust assurance regarding the quality and safety of all hospital and community services provided by the Trust in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We receive regular reports at Council of Governors meetings on progress in implementing the Trust's quality priorities. We are represented at meetings of the Quality & Safety Committee in an observer capacity and the NED chair makes herself available to brief bi-monthly Governor Assurance Group meetings on committee highlights and to answer our searching questions.

Governors are pleased to see the progress that has been made against many of the Trust's 2022/23 quality priorities. Maintenance of a consistent downward in-hospital mortality trajectory has been particularly impressive although more work is required with integrated care system place partners to drive improvements to out of hospital mortality rates. It is also pleasing to see the improvements that have been achieved in the discharge process through much more timely despatch of discharge letters and outpatient clinic summaries to GPs.

The Council of Governors supports the five quality priorities identified for 2023/24. We were pleased that feedback was sought from Trust members and service users in identifying quality improvement areas. It is clearly right that priority is being given to improving palliative and end of life care. This is the one area of NLaG service provision still rated 'inadequate' by the Care Quality Commission, although bringing about the necessary improvements will require concerted action by all system partners. Governors were initially disappointed that communication improvement was not identified as a standalone quality priority as poor communication is too often at the heart of quality lapses. We have since been reassured that communication key performance indicators will be developed for each of the agreed quality priority areas.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 2022/23.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2022 to March 2023
    - Papers relating to quality reported to the board over the period April 2022 to March 2023
    - Feedback from commissioners
    - Feedback from governors
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2021
    - Latest national staff survey 2023
    - CQC inspection report published 2 December 2022
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is routinely quality checked to ensure it is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

30 June 2023
…… Date …… Chair

30 June 2023
…… Date …… Chief Executive

Annex 3: Glossary

Ceiling of Care: The course of treatment considered to be the predetermined highest level of intervention deemed appropriate by a medical team, aligning with patient and family wishes, values and beliefs. These crucial early decisions aim to improve the quality of care for patients in whom they are deemed appropriate.

Clostridium Difficile (C. Difficile): A species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora are wiped out by antibiotics.

CQUIN or Commissioning for Quality & Innovation Framework: The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Deteriorating Patient: Sometimes, the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

Electronic Palliative Care Coordination system EPaCCs: Single shared record for preferred place of care and advanced decisions.

EPMA stands for Electronic Prescribing and Medicines Administration and is the digital prescribing system used by Medics and Pharmacists at the Trust.

Family and Friends Test (FFT): From April 2013, all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of this friends and family test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Mortality Data: - How is it measured?

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

Summary Hospital-level Mortality Indicator (SHMI): The SHMI is a measure of deaths following hospital treatment based on all conditions, which occur in or out of hospital within 30 days following discharge from a hospital admission. It is reported at Trust level across the NHS in England using standard methodology.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD): NCEPOD promote improvements in healthcare and support hospitals and doctors to ensure that the highest possible quality of safe patient care is delivered. NCEPOD use critical senior and appropriately chosen specialists to critically examine what has actually happened to the patients.

National Early Warning Score (NEWS2): Nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Patient Advice & Liaison Service (PALS): The PALS service offers confidential advice, support and information on health-related **matters. They provide a point of contact for patients, their families and their carers.**

Patient Reported Outcome Measures (PROMS): Patient Reported Outcome Measures are questionnaires that ask patients about their health before and after an operation. This helps to measure the results or outcome of the operation from the patient's point of view. This outcome is known as the 'health gain'. All NHS patients undergoing planned hip replacement, knee replacement, varicose vein or groin hernia surgery procedures are invited to fill in PROMs questionnaires.

A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): Provides a summary for a person's clinical care and treatment in a future emergency in which they do not have capacity to make or express choices.

Same Day Emergency Care (SDEC): Same Day Emergency Care is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.

Sepsis: A medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 4: Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2022/23 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

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NLG(23) 097

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6th June 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 April & May)**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is to note the Quality and Safety Committee highlight report including the following recommendations: • a Board discussion takes place to better explore Bank and Agency usage, shift fill rates and subsequent impacts to the patient • Trust Management Board champion support to drive divisional engagement for the extensive program of work in End-of-Life activities	
Background Information and/or Supporting Document(s) (if applicable)	None	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	✓ Approval ✓ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Highlight Report to Trust Board

Report for Trust Board Meeting on:	6 June 2023
Report From:	Incorporating Quality & Safety Committees held on 25 April and 23 May 2023

Highlight Report:

Maternity transformation and improvement plans have been highlighted as priority topic to support the service in coming out of the Maternity Improvement Programme. Building on the series of initiatives taken forward including Ockenden action plans, Clinical Negligence Scheme for Trusts (CNST) etc., a sustainability plan is being progressed. The Maternity Voices Partnership lead role was currently vacant, with plans to fill this post. This vacancy carries some risk due to it being part of the (CNST) requirements.

To support and seek assurance on the Quality Priorities delivery, the Committee will receive deep dive reports for each of the Quality Priority areas from June 2023. A key part of this assurance is creating robust measures. Concerns were raised about delays to their establishment and reporting in the Integrated Performance Report (IPR) to enable sufficient oversight and monitoring. Limited resources for support were cited due to the significant program of work underway in Digital. Options are being explored with the Quality Assurance and Information departments and the Committee will continue to monitor progress.

As part of the Nursing Assurance report it was noted that shift fill rates had reduced although bank and agency usage rates remained unchanged since the bank incentive rate was withdrawn. The Committee recommends that a Board discussion takes place to better explore Bank and Agency usage, shift fill rates and subsequent impacts to the patient.

The Nursing Annual Safe Staffing review was received for information. The report demonstrated Ward establishments had been assessed using best practice tools and against the current bed base. It was highlighted that 2023/24 nursing establishment is subject to a pending bed configuration review. A referral to the Finance & Performance Committee has been created to better understand any resulting funding constraints.

End of life care updates to the Committee demonstrate further roll out of improved systems for communication, as part of the Bluebell workstream. A roll out of a pain assessment tool on WebV will enhance pain management supported by educational updates. The Committee recommend and request Trust Management Board (TMB) support in driving divisional engagement for the extensive program of work that has been developed.

The Committee received assurance that work to deliver the Patient Safety Incident Reporting Framework (PSIRF) within the statutory timescales are demonstrating progress. The Patient Safety Incident Response Plan is being developed with analysis of the Trusts patient safety profile. Planned changes to ways of working will release time with a clear package of investigation tools. This will reduce the number of lengthy investigations to a more focused approach, with more immediate investigations in most circumstances. The Committee were assured that the plans mitigate concerns from Divisional teams about the workload.

Care Quality Commission (CQC) reporting on action plan progression continues, with sufficient information provided through the revised report structure to provide assurance of effective processes.

The Annual Clinical Audit Forward Plan was presented, illustrating a large number of audit activities being supported across divisions, linking with initiatives for Quality Priorities, Commissioning for Quality and Innovation (CQUIN), National Audits, Confidential Enquiries, as well as Division priorities linked to a range of issues including serious incidents and clinician interest areas. Active encouragement for Divisions to register audits is expected to improve the cross-over of workstreams between Divisions. The Committee were assured the program of work can be delivered due to robust plans for improving audit processes.

The Committee was unable to reach agreement on proposed changes to the Terms of Reference. The subject has been escalated to the Chief Executive and Trust Chair for review.

The Annual Committee Effectiveness report was received and discussed with a plan of action to create improvement for the coming year agreed.

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

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

Action Required by the Trust Board:

The Committee recommend:

- a Board discussion takes place to better explore Bank and Agency usage, shift fill rates and subsequent impacts to the patient
- TMB champion support to drive divisional engagement for the extensive program of work in End-of-Life activities.

The Board is asked to note:

- the risk in delivering CNST if recruitment to the Maternity Voices Partnership lead role cannot be fulfilled
- the risks to the development of Quality Priority measures due to limited data provision resource in the Digital Services priorities.

Fiona Osborne
Non-Executive Director

NLG(23)098

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	6 June 2023
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee
Contact Officer/Author	Richard Peasgood, Executive Assistant
Title of the Report	**Finance & Performance Committee Highlight Report**
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Performance areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives. • Emergency Care continues to be a challenge, but there are some early signs of improvement to 12 hour waits and ambulance handovers • Improvements against the National Cancer Standards seen at the April meeting • There were nine 78 week wait breaches at the end of March 2023 • Changes to the national specification for mobile scanners meant that the units offered to the Trust to help reduce diagnostic waiting times were larger, heavier and required more power than previous units, resulting in the Trust being unable to accept them immediately
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other:
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working ☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 June 2023
Report From:	Finance & Performance Committee – 19-04-23 and 24-05-23

Highlight Report:

Unplanned Care

- Emergency Care and ambulance handover performance continued to cause concern due to the volume of admitted patients and the flow throughout the hospital. A 24-hour Urgent Care Service (UCS) would improve the performance, but it will take around three months to recruit the staff needed.
- There are early signs of improvement in both the Ambulance Handover position and 12-hour waits.

Planned Care Improvement and Productivity

- The Committee were pleased to note the improvement in Cancer Performance at the April meeting, with five of the nine metrics achieved, an improvement in the Cancer 62-day backlog and the achievement of the Faster Diagnosis standard.
- Improvements to in-session theatre utilisation data on WebV that were nearly ready for implementation and ongoing work with the Get It Right First Time (GIRFT) team on anaesthetic preassessments would enable improvements to be made in theatre productivity.
- Nine 78-week breaches had occurred at the end of March, which were mutual aid cases received in March. Plans were in place to clear those as the Trust focused on further improvements in waiting times.
- The expected increase in Diagnostic capacity had been delayed as the mobile trucks offered to the Trust were too large and heavy for the current pads; a solution is being sought.

Committee Self-Assessment and Action Plan

- The annual Committee self-assessment exercise was completed, along with the action plan agreed in response.

Confirm or Challenge of the Board Assurance Framework:

The Committee reviewed the Board Assurance Framework and agreed the current risk and the future planned risk scores for Strategic Objectives 1-1.2 and 1-1.6.

Action Required by the Trust Board:

The Trust Board is asked to note the key items highlighted above.

Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)099

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	06 June 2023	
Director Lead	Simon Nearney, Interim Director of People	
Contact Officer/Author	Liz Houchin, Freedom To Speak Up (FTSU) Guardian	
Title of the Report	**Freedom To Speak Up (FTSU) Guardian Q4 and Annual Report 2022-23**	
Purpose of the Report and Executive Summary (to include recommendations)	The Freedom To Speak Up (FTSU) Guardian Q4 and Annual Report for 2022-23 gives an update from the last Board report, including an overview of the number of concerns raised, national and regional updates, proactive work undertaken by the trust's FTSU Guardian, and future plans for FTSU. The report is for approval and assurance.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	✓ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Freedom to Speak Up (FTSU) Guardian - Q4 Report January to March 2023

and

Annual Report for 2022-2023

Liz Houchin
24 April 2023

Contents

1. Executive Summary

This paper provides an update regarding NLaG activity for Q4 2022-23 (which covers the period January to March 2023) and also provides an annual update for 2022-23. Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

This paper satisfies the Trust Strategic Objective of 'Being a good employer' and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

3. Introduction / Background

The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement. The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

4. Assessment of FTSU Concerns Raised

4.1 In Q4 2022-23 the number of concerns received were 64, 26 of those were closed on the same day after giving advice or signposting to other services. There were no concerns raised anonymously in Q4

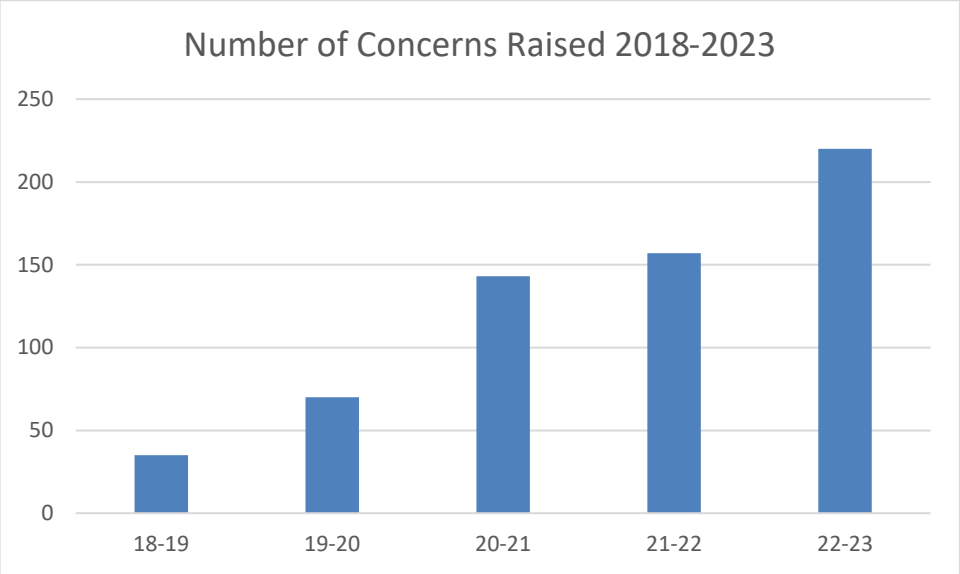
4.2 The total number of concerns raised in 2022-23 was 220, this will be the fifth consecutive year that the number of colleagues contacting the Guardian has risen. This could be due to several factors including an increased confidence that staff feel able to raise concerns.

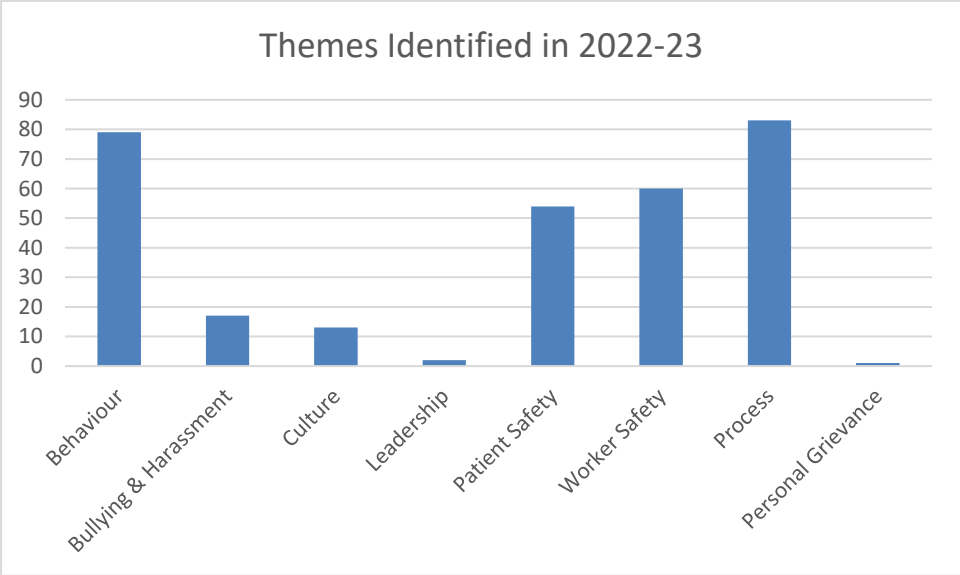
4.3 For the year 2022-23 (up to Q3), 6 concerns were raised anonymously, which is 2.7% compared with the national figure of 8% (Model Hospital data accessed April 2023)

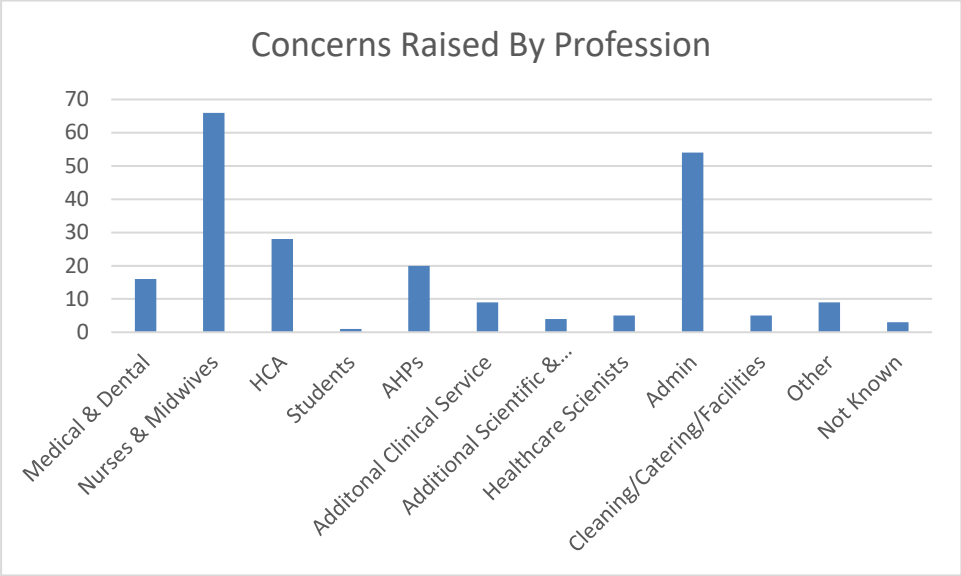
4.4 For the year 2022-23 (up to Q3), 20% of cases brought to the Guardian had an element of patient safety, this compares to 13% against peer providers.

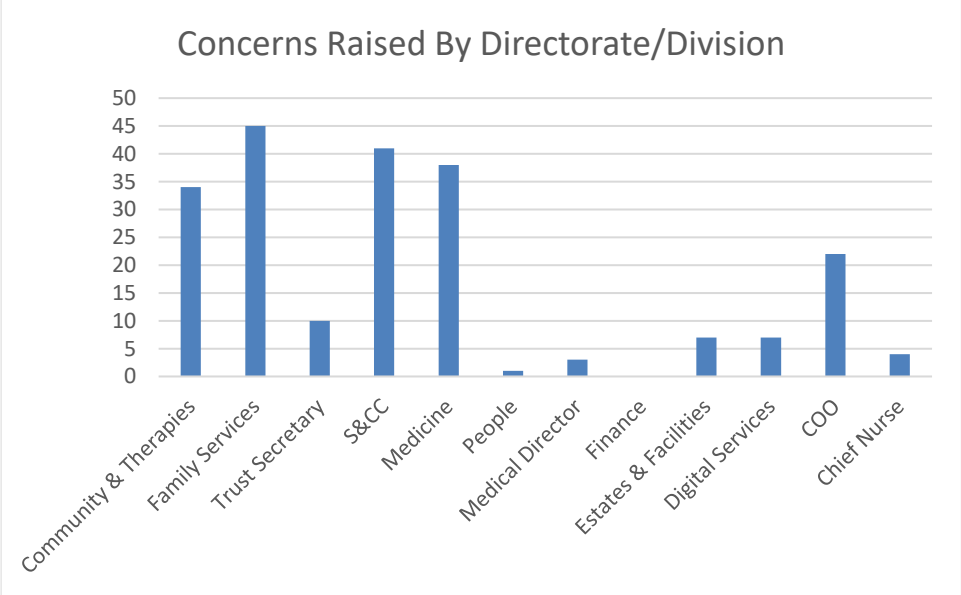
4.5 For the year 2022-23 (up to Q3), 6% of cases related to bullying and harassment, this compares to 22% against peer providers.

4.6 The main themes raised were around process, behaviours, worker safety and patient safety. The National Guardian Office (NGO) data indicates that 29% of cases raised nationally are linked to inappropriate behaviours, at NLaG for 2022-2023 there were 79 which is 35.9%, this is further evidence for the ongoing cultural transformation work.









The diversity of different professions across all divisions contacting the FTSU Guardian, continues to demonstrate an increased awareness of the Guardian role amongst staff in the Trust.

Area of Concern	No	Themes and Lessons Learnt
Behaviour	79	Most of these relate to behaviours that are not in line with Trust values or behaviour that is unprofessional.
Process	83	These are cases where staff were either unsure of how to proceed with a concern and needed help signposting/support to the appropriate services or around Trust policies and procedures not being followed.
Worker Safety	60	Various issues including staff levels, training, reasonable adjustments to support colleagues with disabilities and long-term conditions. Each concern looked into individually and escalated as appropriate.

4.7 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and most concerns were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the DOP /CEO for awareness and support if required.

4.8 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback has been provided by staff that have spoken up and has been predominantly positive.

2022-23	Feedback received	Would you speak up again? Yes
Total	40	39 Yes 1 Maybe

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

- ***I've been to management many times before because of bullying and not being given equipment. Nothing happened until Liz got involved, things are happening now.***
- ***I felt involving the Guardian gave an opportunity for the staff within my department to be heard by senior managers. I felt that as a division SMT were already aware of concerns raised and although change takes time, measures were already underway to address some of the challenges faced by the staff.***
- ***Liz listened and took action.***
- ***I just feel that the managers were doing their utmost to make matters worse for those who raised the concern. The feeling that they wanted us out just got worse.***

4.9 Case Studies

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

The FTSUG was contacted by a colleague on behalf of several others who were concerned that the MobilePass App would use their personal data allowance. They were working in the community and had to access systems several times a day. FTSUG contacted IT who confirmed that this wasn't the case. To reassure colleagues an 'all staff comms' email was sent telling staff that their personal data would not be used at all. Staff felt reassured and started using the app.

The FTSUG was contacted by several colleagues over a period of 2 months raising concerns about how they were being treated because they had neurodiverse conditions. There were also concerns raised from colleagues who had long term conditions that felt that the organisation was not supporting them. The FTSUG shared these themes with the HR team and the Equality & Diversity Lead. As a result of these concerns the Trust is now producing a Disability Policy.

5.0 Regional and National Information and Data

5.1 National update

The National Guardian's Office reported 20,362 cases were brought to Guardians in 2021-22 (on a par with previous year). Figures for 2022-23 have not been released yet.

Q4 data for 2022-23 will be submitted to the NGO by the Guardian when the portal opens and data for previous quarters will be checked and reconciled for accuracy.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included discussion around defining detriment, trauma and adversity and the impact this has on colleagues and how different organisations are supporting staff. The national staff survey was also discussed and how the NGO and Guardians can support organisations to increase confidence for staff to feel safe to speak up.

6.0 Proactive work of the FTSUG during 2022-23

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Quarterly attendance at Patient Safety Champion Meetings
- Walk round with Comms to access knowledge of Guardian role and future Comms plan
- Attendance at all network meetings

6.1 Future Plans

- Work to define the future work of combined Champions to include FTSU and Health and Wellbeing is ongoing by the People Directorate
- Continue to be a core member of the Cultural Transformation Working Group
- Continue to raise profile of the Guardian
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice
- Input into 'Be the Change' programme

7.0 Indicators of Success

The NHS Staff Survey results for the following questions are an indicator of how staff feel about 'speaking up' in the Trust.

The results from the 2022 survey indicate a reduction from staff in feeling able to raise concerns about unsafe clinical practice and that the organisation would address this concern, this mirrors the national picture.

There is an increase in confidence from staff saying that they feel safe to speak up about anything that concerns them in the organisation.

The FTSU Guardian will help support the organisation to improve staff confidence and is part of the Cultural Transformation Board.

NUMBER	QUESTION	NLAG 2021	NLAG 2022	National average combined Acute and Community Trusts (2022)
14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	43.5%	46%	47%
19a	I would feel secure raising concerns about unsafe clinical practice.	70.9%	66%	71%
19b	I am confident that my organisation would address my concern about unsafe clinical practice.	49%	45%	56%
23e	I feel safe to speak up about anything that concerns me in this organisation.	54%	55%	61%
23f	If I spoke up about something that concerned me, I am confident my organisation would address my concern.	39%	38%	48%
People Promise Overview	'We each have a voice that counts' – Raising concerns.	6.1%	6.4%	6.6%

8.0 Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

9.0 Recommendations

The Trust Board is asked to:

a) Note the report for assurance
b) Approve the report

Compiled By: Liz Houchin
Date: 24 April 2023

Agenda Item: NLG(23)100

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	06 June 2023
Director Lead	Simon Nearney, Interim Director of People
Contact Officer/Author	Karl Portz, Equality, Diversity, and Inclusion Lead
Title of the Report	**Equality, Diversity, and Inclusion Report and Strategy 2023 - 2027**
Purpose of the Report and Executive Summary (to include recommendations)	• To provide a progress report against our equality objectives • To refresh our Equality Diversity and Inclusion Strategy and our Equality Objectives • To explain going forward how NLaG intends to meet its Public Sector Equality Duty requirement and beyond
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)	To ensure the Trust are compliant with 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

Annual NLaG Equality, Diversity, and Inclusion Report May 2023	
1.0	**Introduction**
1.1	The report will provide the Workforce Committee/Trust Board with an update on Equality, Diversity and Inclusion, and its implications for the Trust in terms of our: • Legal duties • Contractual requirements • Social Responsibilities • Equality Objectives
1.2	The report aims to recognise the key achievements during 2022 – 2023.
1.3	NLaG aims to be an organisation that people want to access for high quality care and treatment. NLaG aims to be an organisation that people want to join and remain with as staff because it allows them to make their distinctive contributions and achieve their full potential. NLaG does not tolerate any form of intimidation, humiliation, harassment, bullying or abuse and will ensure that patients, staff, visitors, and the public are treated fairly, with dignity and respect. Our aim is to break down all barriers of discrimination, prejudice, fear, or misunderstanding, which can damage service effectiveness for service users and carers. NLaG is committed to compliance with the Public Sector Equality Duty as set out in the Equality Act 2010. NLaG will do this by eliminating unlawful discrimination, harassment, and victimisation, have due regard to advancing equality of opportunity and foster good relations, for the relevant protected characteristics: • Age • Disability • Gender re-assignment • Marriage and civil partnership • Pregnancy and maternity • Race • Religion and belief • Sex / Gender • Sexual Orientation
2.0	**CONTEXT - EQUALITY ACT 2010, LEGAL DUTIES & CONTRACTUAL REQIREMENTS**
2.1	The Equality Act 2010 was introduced as an umbrella piece of legislation bringing together all previously separate equality legislation into a single Act. As a public sector organisation we have both general and specific public sector equality duties.
2.2	General Public Sector Equality Duty: https://www.gov.uk/government/publications/public-sector-equality-duty
2.3	As part of the NHS Contract our contractual requirements state that we must:

	• Use the Workforce Race Equality Standard to effectively collect, analyse and use of workforce data to address inequalities within the workforce. • Use the Workforce Disability Equality Stand to effectively collect, analyse and use of workforce data to address inequalities within the workforce. • To use the Equality Delivery System framework to assist in identifying inequalities.
3.0	**Equality Objective's – Summary, Key Achievements and Impact**
3.1	**Reporting and Governance**
3.1.1	<u>Summary</u> The Equality and Diversity Strategy 2018 - 2023 is in place and has provided an orderly structure to enable the delivery of our legal and contractual Public Sector Equality Duties and our social responsibilities. Our local Equality, Diversity, and Inclusion action plan is in place and reflects our Equality Objectives which are embedded in the above strategy. Progress of which is reported as part of our annual report 2021/22.
3.1.2	<u>Key Achievements</u> Excellent relationships have been formed between our commissioners and the new integrated care systems, Humber and North Yorkshire, and our ICS colleagues. The Trust has published its annual Anti-Slavery Statement which was approved at the Trust Board in February 2023. To ensure our staff are aware of key equality, diversity, and inclusion events the Trust has organised a number of engagement events each month. These events give our staff an opportunity to meet the Trust EDI lead and ask questions. Each month different equality themes are explored.
3.1.3	<u>Impact</u> The Trust are legally compliant and meeting our Public Sector Equality Duties. A good relationship with our commissioners has been formed and we are actively engaging with them with the emerging EDI agenda.
3.2	**Equality Delivery System 2 (EDS2)**
3.2.1	<u>Summary</u> The EDS 2 implementation framework was halted due to the impact of COVID-19 and only self-assessments were carried out. However, planning has started to introduce the new Equality Delivery System 22 (EDS22). NHS England have agreed that due to the late introduction of EDS22 that this year can be used as a transition year.

3.2.2	Key Achievements We have continued to engage with our staff at monthly drop-in sessions exploring a wide range of equality themes. These events involved working in partnership with Health and Well-Being and Trade Union colleagues.
3.2.3	Impact The visibility and accessibility to EDI has substantially increased. Additionally, a valuable insight into staff experience has started to be developed which will be used to support the delivery of the People Promise to the diverse range of staff we employ at NLaG.
3.3	**Treating patients, carers and colleagues with dignity and respect**
3.3.1	Summary All staff are required to complete Equality, Diversity, and Inclusion training as part of their statutory and mandatory training. As part of our induction staff receive a face-to-face Equality, Diversity and Inclusion training session. Face-to-face Equality, Diversity and Inclusion training has also been reintroduced as part of our leadership and cultural awareness training. In addition, we have introduced a new support package for our internationally educated nurses which aims to help them feel welcome and valued. All of our recruitment panels now have an equality lead attending the recruitment process. A new programme has been introduced to NLaG which aims to give young people with learning disabilities an opportunity to experience work. This DFN Project Search has 5 internships who are all working at DPOW in the Estates and Facilities team.
3.3.2	Key Achievements A new EDI training package has been designed which includes cultural competence and unconscious bias awareness. This training package is being delivered to staff as part of the new leader training course. The support package we are co-delivering with our nursing team to our internationally educated nurses is already starting to grow green shoots of success. Through this engagement we have created a mechanism to identify concerns and where necessary challenge inappropriate behaviours. We are also working with a local charity organisation 'the Health Gospel' who provide pastoral support to people who move to our area from African countries. DFN Project Search has been a resounding success and, although is still in its first year, early feedback is positive: the interns will gain paid employment which achieves the programme end goal.
3.3.3	Impact Although at an early stage we are receiving positive feedback in relation to our EDI training.

3.4	**Report and deliver against workforce data**
3.4.1	Summary The Workforce Race Equality Standard (WRES) data was collected, analysed and an action plan for improvement developed. A report to reflect this information was approved by the Trust Board, and to meet our contractual requirements this information was published and shared with NHS England. The Workforce Disability Equality Standard (WDES) data was collected, analysed and an action plan for improvement developed. A report to reflect this information was approved by the Trust Board, and to meet our contractual requirements this information was published and shared with NHS England. The Gender Pay Gap (GPG) data was collected, analysed and a report presented to Trust Board. To comply with our legal duty under the Equality Act 2010 - Specific Duties and Public Authorities - Regulations 2017. This information was then published on the Government website and shared with our commissioners.
3.4.2	Key Achievements We reported our WRES and WDES data to NHS England, and GPG information to the Government website within the specified timescales. The data was analysed, and action plans developed which link in to fair recruitment, improving staff experience through developing staff networks and general staff engagement. We now have a dedicated disability and long-term conditions hub page which signposts staff to our reasonable adjustment policy and guidance on how to support staff who are neuro-diverse. This work has been completed by the newly developed NLaG Disability working group. We also have a small group of staff on the NHS Calibre Programme which has been designed to support disabled staff and give them the skills to develop as leaders.
3.4.3	Impact This work is helping the organisation to focus on diversity in our workforce and understanding the benefits which this can bring to our organisation. It is also helping our staff equality networks understand how they can impact on issues such as: • Recruitment and retention • Career progression • Staff experience • Flexible working • And policy development
3.5	**Develop and grow staff equality support networks**
3.5.1	Summary

	We recognise through the NHS Staff Survey and some of our engagement events that staff who belong to certain groups are more likely to have a poorer experience at work. Therefore, links have been established with HR colleagues, the Trust's Freedom to Speak Up Guardian and the Health and Wellbeing Business Partner. This has resulted in the development of four staff equality support networks. These are the Black, Asian and Minority Ethnic (BAME) staff network, the Lesbian, Gay Bi-Sexual and Transgender + (LGBTQ+) staff network, the Disabled staff network and the Menopause staff network. A number of sharing events took place recently with staff network members, to explain how the new approach to Culture and Engagement, and how the staff networks can influence organisational change, will unfold into 2022. However, through engagement we have identified that staff have high levels of time constraints and, whilst they see the benefits of staff networks, many of them prefer to engage through social media outlets. Therefore, we have a number of Facebook Staff Equality Network groups.
3.5.2	<u>Key Achievements</u> The Facebook Staff Equality Networks Membership as grown from very low numbers to April 2023: • BAME Staff Network 76 members • Disability Staff Network 38 members • LGBTQ+ Staff Network 52 members • Menopause Staff Network 215 Members We have draft terms of reference for our staff equality network face to face meetings. These groups have also grown during the last year. The most significant increase has been in the BAME staff equality network which has grown from less than 10 members to now over 40 members.
3.5.3	<u>Impact</u> They are giving the members an opportunity to have an organisational voice to raise any concerns they may have and also influence the Trust policies and ways of working to create a more inclusive and equitable workplace.
4.0	**Next Steps**
4.1	As part of the Equality, Diversity and Inclusion Strategy 2023-27 these equality objectives will be captured and taken forward to ensure the good work which has started will be carried forward and further developed, as reflected in the Trust's and the People &OD Directorate's yearly objectives.

Northern Lincolnshire and Goole NHS Foundation Trust

EQUALITY DIVERSITY AND INCLUSION STRATEGY 2023-2027

Executive Summary

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 carer's, 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, sex, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

Acting Chief Executive, Northern Lincolnshire and Goole NHS Foundation Trust

Sean Lyons
Chair, Northern Lincolnshire and Goole NHS Foundation Trust

1.0 Northern Lincolnshire and Goole NHS Foundation Trust – About Us

1.1 Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) serves a population in excess of 450,000 people across a catchment area covering North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and Lincolnshire.

1.2 **The Trust runs three hospitals:**

- Diana Princess of Wales in Grimsby
- Scunthorpe General Hospital
- Goole and District Hospital
- And provides a range of services in the communities of North East Lincolnshire, North Lincolnshire, East Riding of Yorkshire and Lincolnshire.

1.3 The Trust was established as a combined hospital and community Trust on 1 April 2001 and achieved Foundation Status on 1 May 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby, and Goole. In April 2011, it became a combined hospital and community services Trust for North Lincolnshire. As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to reflect that the Trust does not just operate hospitals in the region.

1.4 The Trust employs over 7,000 staff across all our sites, including nursing and midwifery staff, medical and dental staff, allied health professions, technicians and scientists, administration and facilities staff, and are always looking for a diverse range of skilled and caring people to join our organisation.

1.5 Our staff are supported by a thriving team of volunteers of over 75 people onsite, including the League of Friends, hospital radio, and people who help on the wards and in clinics, to those who provide our ‘meet and greet’ service.

1.6 As an NHS Foundation Trust, we also benefit from a membership of more than 11,000 staff, patients and members of our community, who are able to help guide our future plans and priorities through a range of channels, including our Council of Governors.

1.7 The communities that the Trust serves are very diverse population with a wide range of healthcare needs. See below for more details relating to the populations of North East Lincolnshire, North Lincolnshire, East Riding of Yorkshire and Lincolnshire:

- E06000012 (phe.org.uk)
- E06000013 (phe.org.uk)
- E06000011 (phe.org.uk)
- E10000019 (phe.org.uk)

2.0 The Trust Values are Kindness, Courage and Respect

2.1 We believe **kindness** is shown by caring as we would care for our loved ones

- will be compassionate, courteous, and helpful at all times
- I will be empathetic, giving my full and undivided attention
- I will show I care by being calm, professional and considerate at all times

2.2 We believe **courage** is the strength to do things differently and stand up for what's right

- I will be positively involved in doing things differently to improve our services
- I will challenge poor behaviour when I see it, hear it or feel it.
- I will speak up when I see anything which concerns me

2.3 We believe **respect** is having due regard for the feelings, contribution and achievements of others

- I will be open and honest and do what I say
- I will listen to and involve others so we can be the best we can be
- I will celebrate and appreciate the successes of others

3.0 Our Approach to Equality and Human Rights

3.1 The Trust is committed to ensuring that it carries out all its functions within the framework of the Human Rights Act 1998. The Act sets out the basic rights and freedoms of everyone in the UK regardless of citizenship or immigration status. Anyone who is in the UK for any reason is protected by the Act.

The Human Rights Act 1998 (HRA) came into force in 2000. Everyone in the UK is protected under the Act. As a public body we must at all times act in a manner compatible with the rights protected in this Act and safeguard these for patients and staff in our care and employment.

3.2 The FREDA principles make up the main structure of a human rights based approach. They summarise that **care must be based on Fairness, Respect, Equality, Dignity and Autonomy which will ensure that the needs of the individual come first, and their rights are protected**.

3.3 Consideration of Human Rights is also given in our Equality Impact Assessment process, to ensure that our policies, procedures and functions are compatible with the rights afforded by this Act.

3.4 The **NHS Constitution / Health and Social Care Act 2012** builds on the core principles and values of the NHS in terms of equality – a comprehensive service that is available to all, based on need and free at the point of use.

4.0 Scope

4.1 The strategy is designed to address equality and diversity between people from all backgrounds. This should be an integral part of our recruitment processes, service redesign and tendering processes. This will include any organisations contracted by the Trust who must be able to demonstrate their commitment and practice to the equality agenda. Their values should not be in direct conflict with this strategy or our vision and values.

5.0 Definitions

5.1 Equality – is not about treating everyone the same; it is about ensuring that access to services and opportunities are available to all by taking into account people's differing needs and capabilities and making appropriate adjustments to ensure equal opportunities for everyone.

5.2 Diversity – is the mosaic of people who bring a variety of backgrounds, styles, perspectives, values and beliefs as assets to the groups and organisations with whom they work and interact. It's about recognising and valuing differences through inclusion and service provision, regardless of age, disability, sex, race, religious belief, sexual orientation, gender reassignment pregnancy/maternity or marriage/civil partnership.

5.3 Inclusion - is the complete acceptance and integration of all, regardless of their diversity or background, this proactively leads to a sense of belonging, engagement, progression and full participation within the organisation.

6.0 Legal Responsibilities / Equality Act 2010

6.1 The Equality Act 2010 was introduced as an umbrella piece of legislation bringing together all previously separate equality legislation into a single Act.

6.2 The Equality Act 2010 provides protection for nine protected characteristics which are: age, sex, race, sexual orientation, religion & belief, disability, pregnancy and maternity, gender reassignment and marriage and civil partnership (Appendix 2).

6.3 The Act provides protection in relation to access to goods and services as well as employment. As a public sector organisation we also have both general and specific public sector duties. The general Public Sector Equality Duty, which forms part of the Equality Act 2010, requires us as an NHS public sector organisation, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation (Appendix 1)
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

6.4 The specific duties mean that the Trust must:

- Set meaningful and relevant equality objectives with a focus on "outcomes" as opposed to process. These should translate into core business planning process along with all other business objectives with regular performance monitoring
- Report on progress in achieving equality objectives
- Report on equality data in the workforce
- Demonstrate the impact on equality of policies and services using an equality impact assessment model which will include where necessary involvement and consultation with effected groups
- Take account of 'Buying better outcomes: mainstreaming equality considerations in procurement' www.equalityhumanrights

6.5 In order to demonstrate 'due regard' for the General Duties of the Equality Act 2010, the Trust will complete an Equality Impact Assessment on all policies, projects, functions and services to understand the impact they may have on different equality groups.

6.6 Gender Pay Gap

To comply with our legal duty under the Equality Act 2010 - Specific Duties and Public Authorities - Regulations 2017, we are required to publish our Gender Pay Gap data on the Government website and develop an action to address gaps on an annual basis.

6.7 Modern Anti-Slavery Statement

In accordance with the Modern Slavery Act 2015 which is designed to consolidate various offences relating to human trafficking and slavery we must publish a Modern Slavery Statement annually. The Modern Slavery Act makes provision to demonstrate transparency in supply chains, prohibit slavery, servitude and forced or compulsory labour and human trafficking and includes provision for the protection of victims.

7.0 Contractual Responsibilities

7.1 Workforce Race Equality Standard (WRES)

From 1 April 2015, the WRES has been introduced by the NHS Equality and Diversity Council for all NHS Trusts and Clinical Commissioning Groups. This was in response to 'The Snowy White Peaks' a report by Roger Kline which provided compelling evidence that barriers to progression, including poor data, are deeply rooted within the culture of the NHS.

7.1.1 The WRES is a mandatory requirement embedded within the NHS Contract to ensure effective collection, analysis and use of workforce data to address the under-representation of Black, Asian and Minority Ethnic (BAME) staff across the NHS.

7.1.2 The WRES requires the Trust to demonstrate progress against 9 standard indicators specifically focused at race equality.

7.1.3 The 9 indicators cover:

- 4 workforce metrics – data provided showing comparison of the experience of Black, Asian and Ethnic Minority (BAME) employees and white candidates
- 4 NHS Staff Survey findings – Key Findings 18, 19, 23a and 27 all specifically focus on the experience of employees from an Equality and Diversity perspective
- A Board that is broadly representative of the population they serve

7.2 Workforce Disability Equality Standard (WDES)

From 1April 2019, the WDES was introduced by the NHS Equality and Diversity Council (EDC) for all NHS Trusts.

7.2.1 This introduction of the WDES links to the NHS Long Term Plan, where respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. Therefore, NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare.

7.2.2 The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS. The WDES follows the NHS Workforce Disability Equality Standard (WDES) as a tool and an enabler of change.

7.2.3 The WDES has a set of ten specific measures that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used to develop local actions to enable them to demonstrate progress against the indicators of disability equality.

7.3 NHS Equality Delivery System 22 (EDS22)

The refreshed EDS22 system has arisen out of NHS England's commitment to an inclusive NHS that is fair and accessible to all.

7.3.1 EDS22 is a national equality toolkit designed for the NHS. The framework provides an overarching approach to enable the monitoring of equality and

fairness across service delivery, workforce and leadership issues. NHS providers are required to use EDS22 to help them improve their equality performance for patients, communities and staff, as well as helping them to meet their Public Sector Equality Duty.

7.3.2 EDS22 comprises 11 outcomes spread across three domains:

Domain 1 Commissioned or provided services – outcomes

- Reference access to a service
- Whether health needs are met
- That users are free from harm
- They report positive experiences

Domain 2 Workforce health and wellbeing – outcomes:

- Reference support for staff to manage obesity, diabetes, asthma, COPD, mental health
- Prevalence of and associated support for staff experiencing abuse, harassment, bullying and physical violence
- Recommending organisation as a place to work
- Recommending organisation as a place to receive treatment.

Domain 3 Leadership – outcomes:

- Board and line managers' routinely demonstrating understanding of/commitment to equality and health inequalities
- Board papers identifying equality/health inequalities impacts and risks
- Board/senior leaders ensuring levers are in place to manage, monitor performance and progress.

7.3.3 EDS22 cannot be implemented without the involvement and engagement of key stakeholders. Our stakeholders are required to be representative of the views of people who share protected characteristics under the Equality Act 2010. These cover: age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, sexual orientation and religion or belief.

7.3.4 Stakeholders engagement will be internal (our workforce) and external (our communities).

7.4 Accessible Information Standard

From 1st August 2016 onwards, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard.

7.4.1 The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services

7.4.2 In implementing the Standard, applicable organisations are required to complete five distinct stages or steps leading to the achievement of five clear outcomes:

- Identification of needs
- Recording of needs
- Flagging of needs
- Sharing of needs
- Meeting of needs

7.5 Additional standards may be developed and introduced during the course of this strategy and these will be implemented as required.

8.0 Engagement (Workforce and Community)

8.1 It is recognised as part of the strategy and taking into account the dynamic equality, diversity and inclusion agenda a continuous engagement model will be used as part of the EDS22 framework. This will involve both workforce and community engagement.

8.2 The engagement events will include

8.2.1 Externally NLAG will work with our partner organisations and our communities to gain an improved understanding of our community needs and look to create a whole systems approach to addressing health inequalities in the areas we provide services too.

8.2.2 Internally NLAG will work with our staff equality networks to gain an improved understanding of the communities they represent. Additionally, throughout the year the NLAG EDI team in partnership with the People Directorate teams and our Trade Union colleagues will run a number of themed engagement events.

9.0 Priorities and Local Ambitions and Links to NHS England's National EDI High Impact Actions (HIA)

*** Please Note** NHSE will be publishing a new Equality, Diversity and Inclusion improvement plan in due course, it will include the HIA's, but any further actions will be included within our strategy going forward.

9.1 Use EDS22 as an overarching service improvement tool:

- To identify inequalities experienced by our patients and within our workforce by:
  - Engaging with our diverse patient groups and supporting our patient experience team
  - Engaging with our staff at monthly themed events which focuses on celebrating the benefits diversity brings to NLaG
- To create an EDI action plan to address or mitigate identified inequality
- To ensure inclusivity within the NLaG leadership

9.2 Improved knowledge, understanding and action plan to address health inequalities within the local population (HIA 4) and within our workforce by:

- Increasing data collection for protected characteristic to understand the disparities better
- Developing health inequalities baseline information covering all protected groups (**1.7**)
- Engaging with communities that are underrepresented and disadvantaged in healthcare (one annual event in Scunthorpe and one annual event in Grimsby)
- Attending our local PRIDE events annually
- Engaging communities through our staff equality networks
- Developing action planning to address health inequalities
- Ensure our policies, procedure and function comply with our Public Sector Equality General Duties using our Equality Impact Assessment Policy and Procedure EIA (Link here)

9.3 As part of our EDI education package we will deliver:

- Face to face equality awareness training as part of our corporate induction (at least one course each month HIA5)
- As part of the NLaG Leadership programme we will deliver equality, diversity, inclusion and unconscious bias training bi-monthly
- Bi-spoke EDI training will be delivered as required
- Trust Board develop training will be delivered as required to support HIA1 which requires Trust Board members to have specific and measurable EDI objective to which have individual and collective accountability

9.4 We will report and develop action plans against the Workforce Race Equality Standard (WRES), the Workforce Disability Standard (WDES) and the Gender Pay Gap report (GPG). But also monitor other protected groups.

- Strengthen recruitment practices to require greater diverse recruitment panel membership (HIA2):
  - Continue to have an EDI representative on all interview panels
  - Explore having visible diversity on recruitment panel
- Develop targets to:
  - Monitor workforce diversity (all protected groups) in recruitment and retention of staff
  - Make year on year improvements against the WRES, WDES and GPG (HIA3)
  - Explore collecting, analysing and action planning in relation to the Disability and Race Pay Gaps (HIA3)
- Analyse and make improvements on our NHS staff survey data relating to all equality group with a focus on fairness, bullying, discrimination and harassment (HIA6)
- Maintain our Disability Confident status
- Monitor the effectiveness of our new disability policy and the reasonable adjustment policy

- Continue to support the DFN Project Search Programme which gives young people from our community who have learning disabilities an opportunity into employment

9.5 To support, enhance and strengthen our staff equality networks to increase their maturity level to develop their reach and effectiveness:

- To introduce and develop new staff equality networks so that all groups have a recognised voice
- To agree staff equality network terms of reference
- Focus on improving staff experience (HIA6)
- To grow our on-boarding support programme for our internationally educated/recruited staff (HIA5)

10.0 Equality Objectives (2023 – 2027)

Our Equality Objectives are mapped against national and local EDI priorities but are only a starting point as they will through the course of this strategy evolve both internally and externally informed by consultation to address health and workforce inequalities.

10.1 Implement the **NHS Equality Delivery System 22** (EDS22) within NLaG (7.3).

10.2 To improve our understanding of **health inequalities data** and how this impacts on our local health economy, to identify gaps and consider solutions.

10.3 Ensure that all staff have the skills and knowledge **to treat patients, carers and colleagues with dignity and respect.**

10.4 Report and deliver against **Workforce Equality Standards** and develop action plan for improvement.

10.5 Develop and Grow our **Staff Equality Networks**.

11. Monitoring

11.1 An Equality, Diversity and Inclusion action plan will be developed to support the delivery of these Equality Objectives. Progress against this plan will be monitored by the Trust's Equality and Diversity Team and progress reported annually to the Workforce Committee, the Trust Board and to our commissioners.

11.2 The Workforce Race Equality Standard, the Workforce Disability Equality Standard, the Equality Delivery System 22, Gender Pay Gap report and additional standards as they are introduced during the course of this strategy will be reported as required to meet our contractual and legal responsibilities.

12. References

- Equality Act 2010
  www.gov.uk/guidance/equality-act-2010-guidance

- Equality and Human Rights Commission
  https://www.equalityhumanrights.com/en/publication-download/buying-better-outcomes-mainstreaming-equality-considerations-procurement-guide

- Human Rights in Healthcare Care Quality Commission
  www.cqc.org.uk/sites/default/files/20150416_our_human_rights_approach.pdf

- NHS Equalities Office
  www.england.nhs.uk/about/equality/

- Public Health England
  www.gov.uk/government/organisations/public-health-england

Appendix 1 - Definitions of Discrimination (Equality Act)

1. **Direct Discrimination** – occurs when a person is treated less favourably than another on the grounds of a protected characteristic. **Example** – an employer does not interview a job applicant because of the applicant's ethnic background.

2. **Indirect Discrimination** – occurs when a rule, policy or way of doing things has a worse impact on someone with a protected characteristic than someone without one, when this cannot be objectively justified. **Example** – requiring all patients to call up to book an appointment. This could have a negative impact on patients with hearing or speech impairments if they are not given an alternative method of booking an appointment.

3. **Direct discrimination by association** – means treating someone less favourably than another person because they are associated with a person who has a protected characteristic. **Example** – an employer offers flexible working to all staff. Requests are supposed to be considered based on business need. A manager allows a man's request to work flexibly to train for a qualification but does not allow another man's request to work flexibly to care for his disabled child. If the manager's decision is because the child is disabled, this is likely to be direct disability discrimination because of the man's association with his child.

4. **Direct discrimination by perception** – means treating one person less favourably than someone else, because you incorrectly think they have a protected characteristic. **Example** – a bed and breakfast hotel owner falsely tells a man that there are no rooms available because the owner believes the man is gay. Even if the man is not gay, the owner is discriminating on grounds of perception.

5. **Victimisation** – means treating someone unfavourably because they have taken some form of action relating to the Equality Act, e.g. made a complaint, raised a grievance or supported somebody who is doing so. **Example** – a non-disabled worker gives evidence on behalf of a disabled colleague at an Employment Tribunal hearing where disability discrimination is claimed. If the non-disabled worker were subsequently refused a promotion because of that action, they would have suffered victimisation in contravention of the Act.

6. **Harassment** – unwanted behaviour related to a protected characteristic which has the purpose or effect of violating someone's dignity or which creates a hostile, degrading, humiliating or offensive environment. **Example** – a builder addresses abusive and hostile remarks to a customer because of her race after their business relationship has ended. This would be harassment.

7. **Discrimination arising from disability** – means treating a person with a disability unfavourably because of something connected with their disability when this cannot be objectively justified. **Example** – an employer dismisses a worker because she has had three months' sick leave. The employer is aware that the worker has multiple sclerosis and most of her sick leave is disability-related. The employer's decision to dismiss is not because of the worker's disability itself. However, the worker has been treated unfavourably because of something arising in consequence of her disability (namely, the need to take a period of disability-related sick leave).

Appendix 2 - Definitions of Protected Characteristics (Equality Act)

1. **Age** – Where this is referred to, it refers to a person belonging to a particular age (e.g. 32 year olds) or range of ages (e.g. 18 - 30 year olds).

2. **Sex** – A man or a woman.

3. **Disability** – A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

4. **Gender Reassignment** – The process of transitioning from one gender to another. A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. ‘Non-binary gender people’ are those who identify outside of the gender binary of male or female and may include terms such as: genderqueer, bi-gender, pangender, genderless, agender, neutrois, third gender and gender fluid people.

5. **Marriage and Civil Partnership** – In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple. [1] This will also be true in Scotland when the relevant legislation is brought into force. [2] Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act).

6. **Pregnancy and Maternity** – Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

7. **Race** – It refers to a group of people defined by their race, colour, nationality, ethnic or national origins.

8. **Religion and Belief** – Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

9. **Sexual Orientation** – Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

NLG(23)101

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	06 June 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: • Revision and update of the Trust's Equality Diversity and Inclusion Strategy and Objectives for 2023-2027. • The Trust's Recruitment Strategy progress. • Drivers influencing the Trust's Agency spending. • Q4 Freedom to Speak Up Guardian Update and Annual Report for 2022-2023. • Receipt of the Annual Committee Effectiveness Report. The Board is asked to receive and note the content of this highlight report.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	06 June 2023
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee
Highlight Report: Workforce Committee – 21 March 2023	

1. Introduction

The aim of this report is to provide an update and prompt discussions and scrutiny of the work of the Workforce Committee and Board Assurance.

2. Equality Diversity and Inclusion (ED&I)

The Committee received an ED&I progress report against equality objectives 2022-2023. A number of key achievements and areas of impact were noted. An area of note was the steady growth of membership of the Ethnic minority, Disability, LGBTQ+ and Menopause staff networks. These networks are an important staff engagement mechanism and are giving members an opportunity to have an organisational voice to raise any concerns and influence Trust policies and ways of working to create a more inclusive and equitable workplace. In addition, the refresh of Trust ED&I Strategy and Objectives for 2023-2027 was received and approved by the Committee.

3. Recruitment

Recruitment and retention are keys areas of focus for the Committee. The overall recruitment plan is designed to attract staff to a range of roles and reduce the reliance on bank and agency staff. The Trust staff turnover position has seen significant improvement over the last 6months with a steady decrease in vacancy positions. However, except for medical vacancies, other staff groups remain over their specified targets. For example, Registered Nursing vacancy positions continue to be high at 10.2% against a target of 8%, however is on a reducing trend. The Unregistered Nursing vacancy rate has reduced consecutively for the last 9 months but remains above target at 10.25% however, is also on a reducing trend. The Director of People and his team have recruitment and retention as a high priority area of work.

4. Agency Spending

The Trust spent circa. £30m on agency usage during 2022/23. The Committee undertook a deep dive to gain a better understanding of the drivers for the utilisation of agency staff. The primary driver for agency usage is staff vacancy followed by sickness absence. Factors that will positively reduce the spend are improving recruitment, retention, and changes to establishment. It was noted the main reason for medical sickness absence is seasonal colds, and flu, however for nursing staff it is anxiety, stress, and depression. It is acknowledged that a reduction in agency spend is a Trust priority.

5. Q4 Freedom to Speak Up Guardian (FTSUG) Update and Annual Report for 2022-2023

The Committee noted the FTSUG update and approved the annual report. The total number of concerns raised in 2022-23 was 220. This is an increase in the reporting trend when viewed over the last five years. Main reporting themes are centred around process, behaviours, and patient safety.

Behaviour themes are those actions not in line with Trust values, process concerns are where staff are unsure on how to proceed with a concern. and worker safety relate to staffing levels training and the need for reasonable adjustments. Each concern is investigated individually and escalated when required. Learning is fed back into the Culture Transformation Programme and Organisational Development planning and design.

6. Annual Committee Effectiveness

The Annual Committee Effectiveness report was received. Consideration of the report will contribute to the planning and shaping of the proposed Workforce Committee in Common to be formed within the Group structure.

Confirm or Challenge of the Board Assurance Framework:

No changes were recommended for the Board Assurance Framework.

Action Required by the Trust Board:

The Board is asked to receive and note the content of this highlight report.

Sue Liburd
Non-Executive Director and Chair of Workforce Committee

NLG(23)102

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 June 2023	
Director Lead	- Shaun Stacey, Chief Operating Officer - Lee Bond Chief Finance Officer	
Contact Officer/Author	- Ashy Shanker, Deputy Director of Planning and Performance - Brian Shipley, Deputy Director of Finance	
Title of the Report	Operational and Financial Plan 2023-24	
Purpose of the Report and Executive Summary (to include recommendations)	To provide the final version of the Operational and Financial Plan for 2023-24.	
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 currently	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A currently	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

Northern Lincolnshire and Goole NHS Foundation Trust

NLAG Operational Plan 2023/24 – 30.03.23 Submission

Ashy Shanker – Deputy Director of Planning and Performance
Brian Shipley – Deputy Director of Finance

Northern Lincolnshire and Goole NHS Foundation Trust

Activity and Performance

Summary

Northern Lincolnshire Goole NHS Foundation Trust

Summary of Impacts of Key Service Changes on Activity Plan Performance against 1920

Activity Type2		1920 Activity	Impact of 1920 Theatres WLIs in 1920 Activity	Locums over establisl	Core 1920 Activity	v2 CORE 2324 Plan	Externally monitored %	Impact of Closed Theatres	Impact of Cons of Week	Impact of Acute Ward Rounds	2324 Plan before Impact Factors	Mitigated % of 1920	ERF invest in WLI / IS
	Surgery and Critical Care	25,199	- 872	- 248	24,326	23,403	93%	1,681	827	-	25,911	107%	4,047
	Medicine	14,212	-	-	14,212	14,689	103%	-	-	-	14,689	103%	-
	Family Services	4,168	-	-	4,168	3,006	72%	275	-	-	3,281	79%	362
	Surgery Endoscopy	14,704	- 2,667	-	12,037	11,394	77%	-	-	-	11,394	95%	2,799
Elective and Daycase Total		58,913	- 3,539	- 248	55,374	53,106	90%	2,144	827	-	56,077	101%	7,209
	Surgery and Critical Care	57,763	- 3,933	-	53,830	54,465	94%	-	2,640	-	57,105	106%	5,038
	Medicine	20,884	-	-	20,884	29,122	139%	-	-	11,839	40,961	196%	5,450
	Family Services	21,953	-	-	21,953	32,582	148%	-	-	-	32,582	148%	3,125
	Surgery Endoscopy	989	-	-	989	460	47%	-	-	-	460	47%	-
Outpatient New Total		101,589	- 3,933	-	97,656	116,629	115%	-	2,640	11,839	131,108	134%	13,613
	Surgery and Critical Care	123,983	- 158	-	123,825	102,145	82%	-	3,664	-	105,809	85%	7,697
	Medicine	60,148	-	-	60,148	69,729	116%	-	-	-	69,729	116%	-
	Family Services	33,663	-	-	33,663	29,507	88%	-	-	-	29,507	88%	-
Outpatient Review Total		217,794	- 158	-	217,636	201,381	92%	-	3,664	-	205,045	94%	7,697
% based on Financial Value	Surgery and Critical Care												100%
% based on Financial Value	Medicine												122%
% based on Financial Value	Family Services												123%
% based on Financial Value	Surgery Endoscopy												97%
% based on Financial Value	Community and Therapies												97%
% based on Financial Value	Trust Total						94%					106%	107%

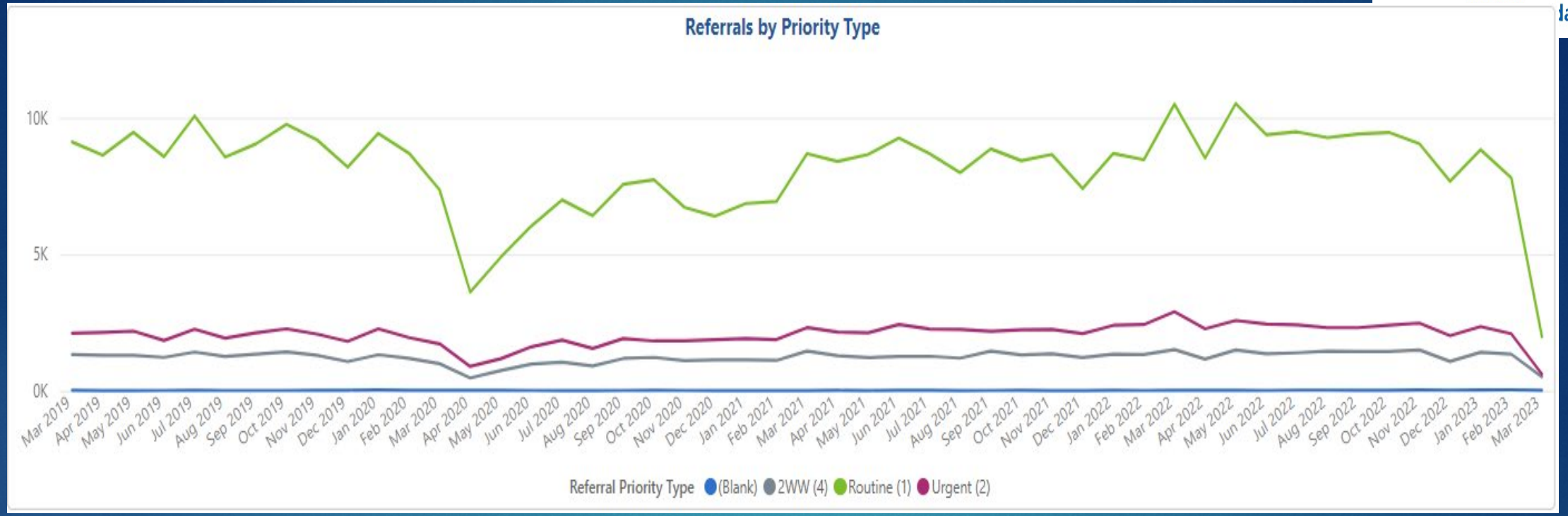
- 94% core capacity (106% including mitigating factors)
- 107% including ERF related activity

Counting & coding changes

Northern Lincolnshire and Goole NHS Foundation Trust

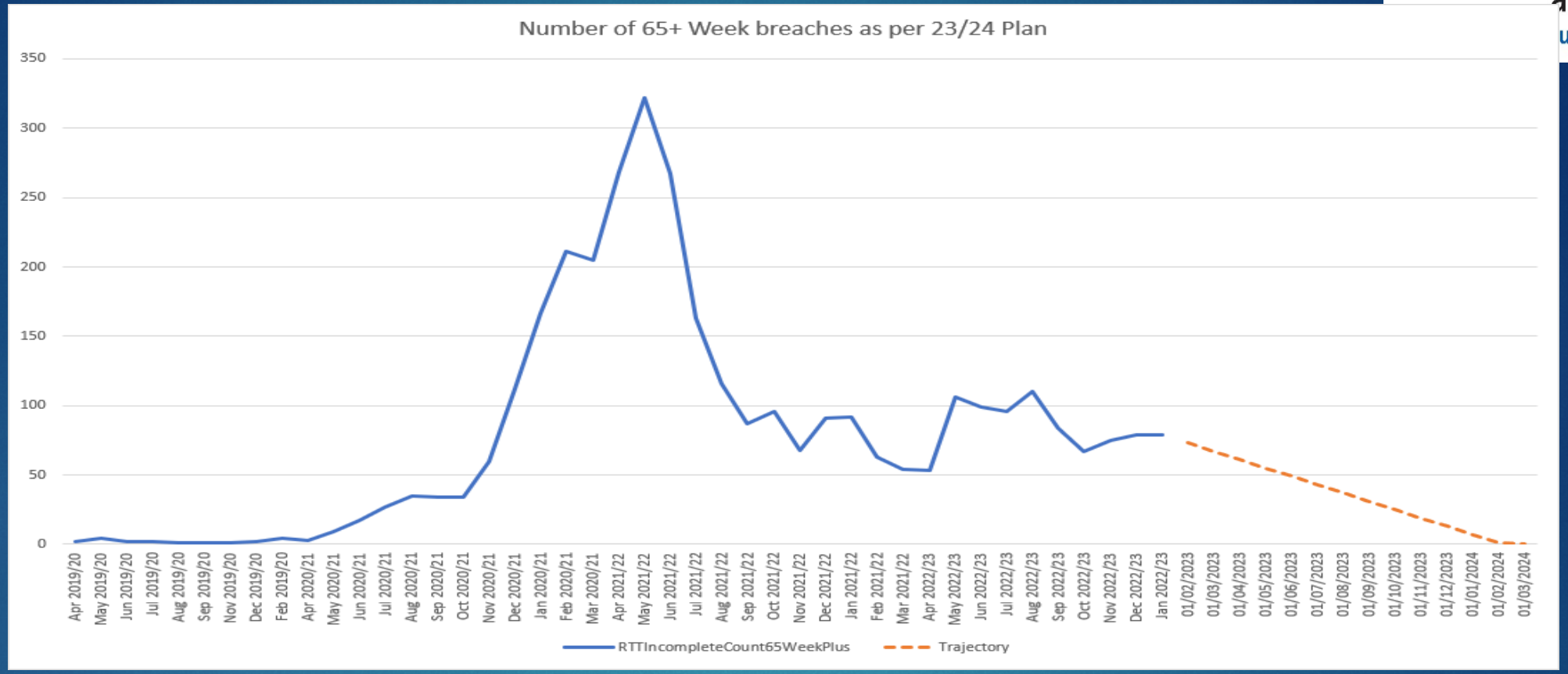
TFC (Specialty)	(All)					
	Values	Provider_C				
	Sum of activity change		Sum of value change		Total Sum of a	Total Sum of v
Counting and Coding Changes Description	RJL	RWA	RJL	RWA		
Transfers to Neuro-Rehab at Goole were previously coded as an emergency discharge and elective re-admission, now they are coded as a ward transfer.	- 642		- 233,769		- 642	- 233,769
All ED Elective return activity is ceased	- 683		- 133,990		- 683	- 133,990
Liver Biopsies DC replaced with Fibroscans in OP F/Up	- 50		- 31,050		- 50	- 31,050
Complex Haem now treated at HUTH	- 275	275	- 169,585	169,585	-	-
Clinical Immunology Service Ceased	- 58		- 18,490		- 58	- 18,490
Activity transferred to Connected Health Network under local currency	- 2,352		- 435,120		- 2,352	- 435,120
Dermatology service transferred to HUTH	- 4,428	4,428	- 520,025	520,025	-	-
Neurology OP service transferred to HUTH	- 1,427	1,427	- 274,633	274,633	-	-
Haematology restructure as HUTH/NLAG joint service	- 1,562	1,562	- 412,055	412,055	-	-
Pain Management service ceased	- 452		- 279,413		- 452	- 279,413
Paeds Assess Unit recording to Acute admission	- 4,862		- 1,161,184		- 4,862	- 1,161,184
Significant Provider Capacity Issue - 3 theatres closed for refurbishment	- 2,028		- 4,217,398		- 2,028	- 4,217,398
Grand Total	**- 18,819**	**7,692**	**- 7,886,712**	**1,376,298**	**- 11,127**	**- 6,510,414**

Referrals



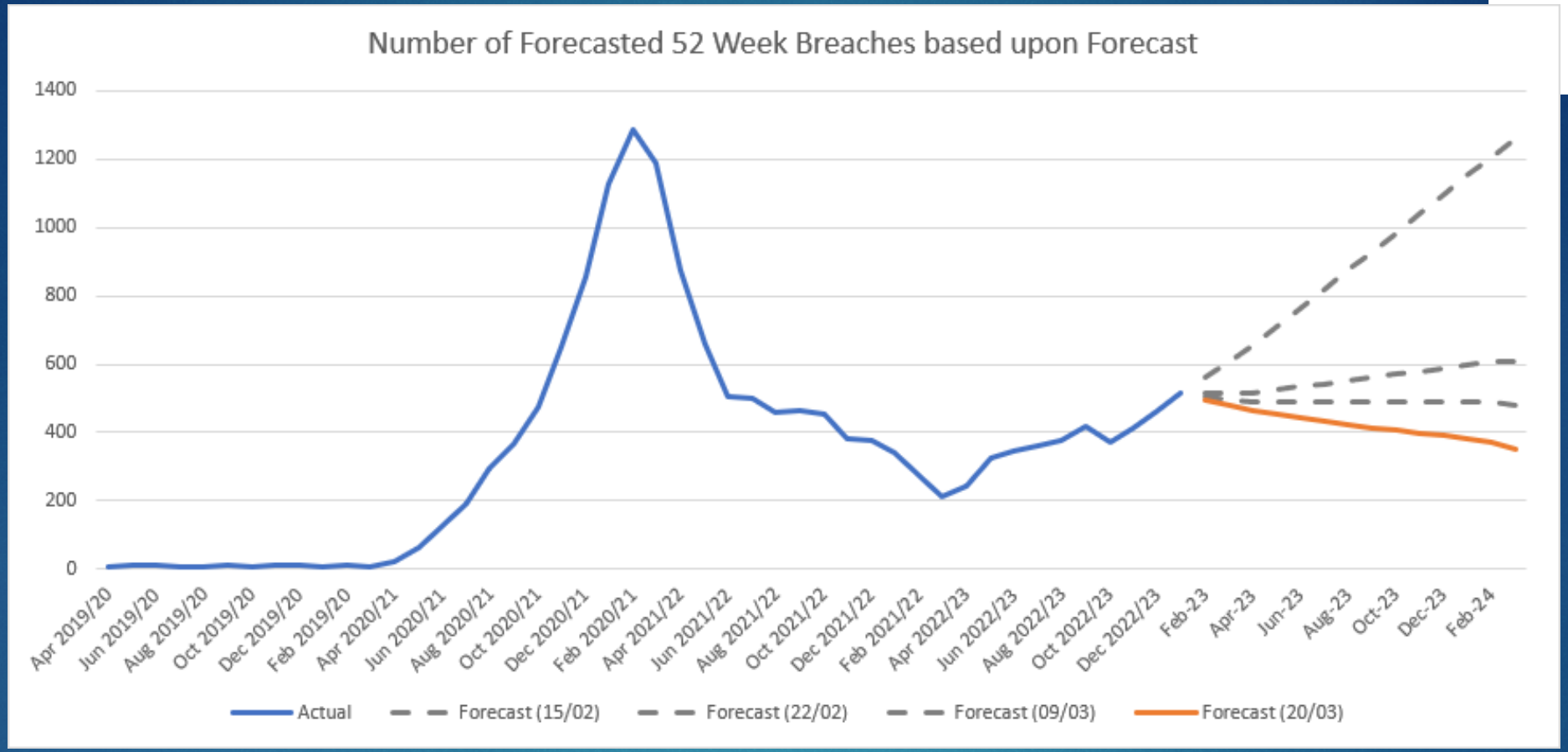
- Referral levels have remained the same since the pandemic showing so significant increases

Waiting Lists – 65 weeks



- We are planning to have zero 65 weeks plus waits by the end of March 2024

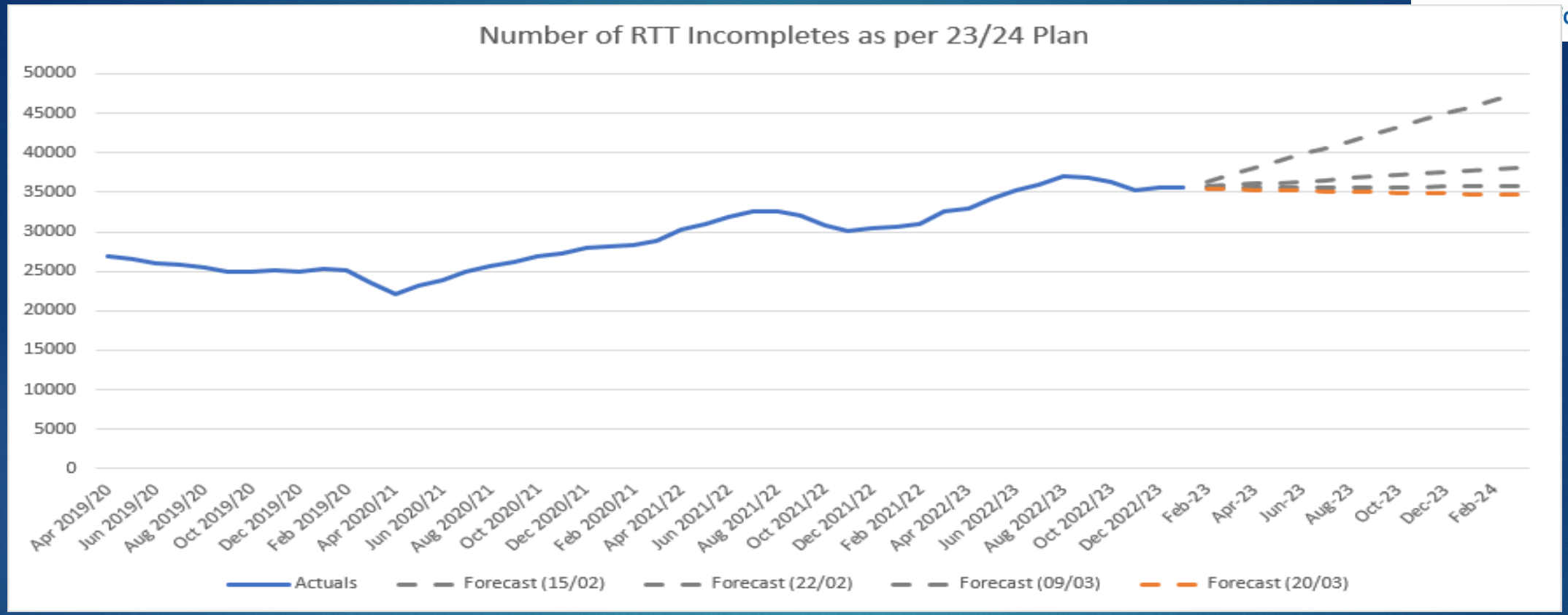
Waiting Lists – 52 weeks



- Referral levels have remained the same since the pandemic showing so significant increases

Waiting Lists – RTT total

Northern Lincolnshire and Goole NHS Foundation Trust



- We aim to bring our RTT waiting lists back under control and reduce the 35k of patients waiting

Approach

- Minimum of 85% Theatre utilisation (current is 88%)
- Minimum of 85%-day case rates (current is 79%)
- 25% reduction in follow ups
- 5% PIFU (current is 2%)
- A&G 16% (current is 8%)
- Virtual appointments 35 %
- Improved DNA rates to per/national benchmarks – 6% (current is 6.3%)
- Phased plans
- GIRFT LOS at specialty level , theatre scheduling incorporates TIF2 assumptions
- Cancer 13% increase in treatments
- 25 % increase in cancer Diagnostics
- Delivery of key Cancer timed pathways
- Delivery of Outpatient Transformation programme
- Non SDEC LOS reduction from 4 days (current is 5 days)
- Virtual wards existing and additional
- Home first
- Community Rehab beds

Levers

- Planning and Performance Group – overall trust level
- Northern Lincolnshire Planning (and delivery) Forum
- Patient Flow Improvement group - Urgent and Emergency care delivery/implementation
- Planned Care Improvement Group – Efficiently and productivity development
- Performance Review and Improvement Meetings - Divisional
- Sub- committees of Trust Board
- QI structure
- Cancer improvement programme
- Outpatients transformation programme
- Theatres systems and processes
- New PAS implementation – in subsequent years

TIF 2 – Theatres refurb

Option 2 – Preferred Option– Refurbishment of Theatres 7, 8 and A inc Laminar Flow – Existing Workforce Model with revenue for temporary staffing to cover vacancies and sickness						
Max Sessions	Utilisation	Additional Sessions	Procedures per list	Additional Procedures over (50 wks)	LOS	Additional Beds
30	30	15	3.5 (1.5 bed)	2625	2	4*

- 2 sessions per theatre, 6 in total per day for 5 days equates to 30 sessions
- GIRFT standard working practices, the case mix of In Patients and Day Case are agreed for every 3.5 session the assumption of 2 In Patients and 1.5 Day Case.
- 4 additional beds required managed by improving LOS through implementation of GIRFT plans at specialty level, Enhanced Recovery, Increasing Day Case activity.
- Manged through current workforce model, plus additional agency premiums to deliver activity whilst the trust addressed vacancy and sickness levels.

A&E & Amb HO trajectories

Northern Lincolnshire and Goole NHS Foundation Trust

Patients seen within 4hours of arrival

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
A&E performance	60%	61%	62%	64%	66%	68%	70%	71%	72%	74%	75%	76%

Against a mean target of 100 % being seen within 30 minutes of arrival

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	20%	25%	30%	35%	40%	45%	50%	60%	70%	80%	90%	100%

A&E & Amb HO trajectories

Northern Lincolnshire and Goole NHS Foundation Trust

- Current performance approx. 60%
- Delivery of our UEC system improvement plan agreed with our PLACE , Local authority and other partners
- Admission avoidance schemes 2 hr urgent care response expansion, Single point of access expansion ,
- Streaming of patients that come to our Urgent care centre and Emergency department
- Providing a 24/7 Urgent care service easing the pressure on Emergency departments
- Two new emergency departments
- Direct access to Same day emergency care
- Expanding our Integrated Acute Assessment unit
- Reducing Non-SDEC length of stay for patients
- Implementing our Discharge to Assess pathways robustly
- Implementing our community capacity expansion schemes (Homefirst, Paediatric Virtual wards, OPAT & Virtual wards)
- Working with partners to maximise stepdown and intermediate care capacity and care home placements - robust commissioning ,spot purchase of beds

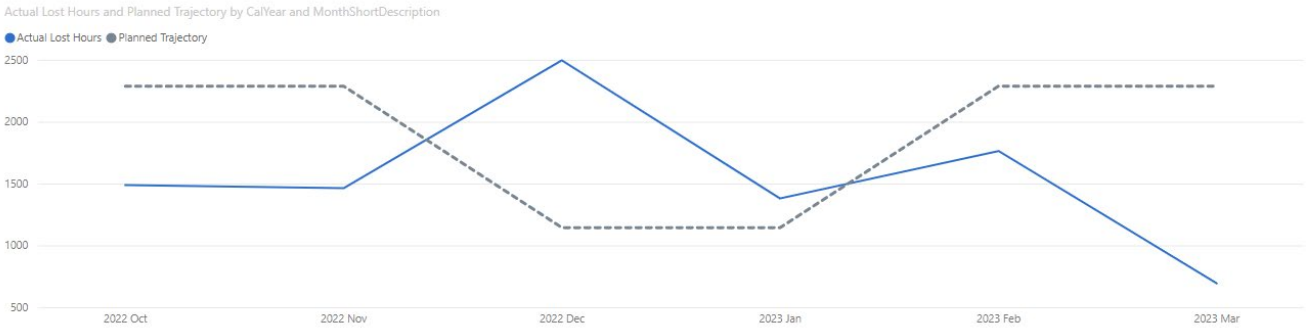
Ambulance waiting times

Northern Lincolnshire

Ambulance Actual Lost Hours Against Planned Trajectory (HNY Activity)

Includes all EMAS Activity Where Lost Minutes are Supplied

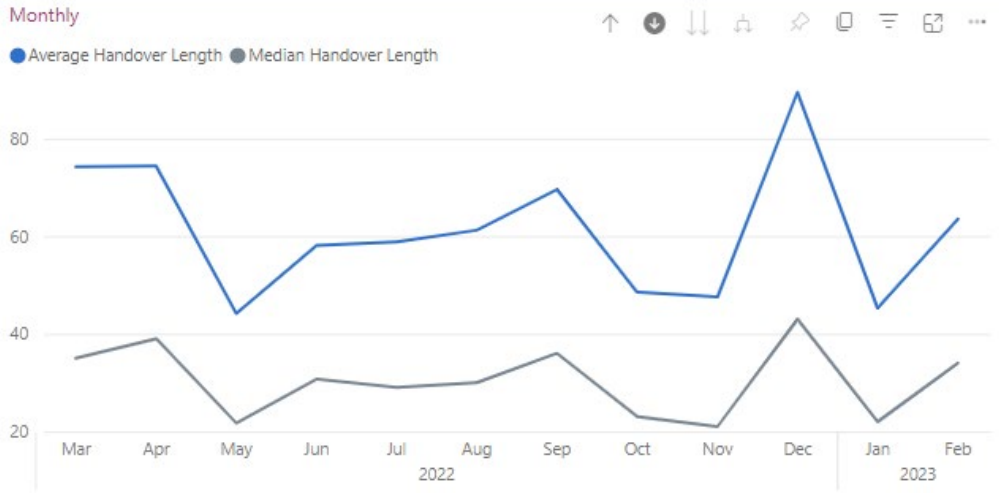
Northern Lincolnshire and Goole NHS Foundation Trust



CalYear	2022			2023		
	Oct	Nov	Dec	Jan	Feb	Mar
Actual Lost Hours	1488	1462	2496	1380	1763	693
Planned Trajectory	2,287.40	2,287.40	1,143.70	1,143.70	2,287.40	2,287.40
Planned Trajectory minus Lost Hours	799.18	825.07	-1,352.23	-236.07	524.55	1,594.30

Ambulance Handovers - Averages

Includes all EMAS and YAS where a handover time is provided



Number of Ambulance Handovers - Split by Handover Time Bracket

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
0-15 Minute Handover	418	748	545	470	497	458	662	875	380	835	526	263
15-30 Minute Handover	576	891	631	705	674	561	805	763	468	790	572	323
30-60 Minute Handover	410	409	429	411	415	435	462	342	375	465	408	218
60 Minute or More Handover	906	536	771	699	738	851	540	570	869	608	820	361
Total Ambulance Handovers	2310	2584	2376	2285	2324	2305	2469	2550	2092	2698	2326	1165

- RAT Model – SGH
- QI Project – focus from front end to whole pathway
- Site, Nurse in charge and EPIC – better integration
- One plan - ambulance HO and Patient flow improvement

Bed occupancy

Northern Lincolnshire and Goole NHS Foundation Trust

NLAG beds 2023/24 plan at 92% Occupancy	Trust
Beds funded (including critical care X14 and excluding paediatrics x40)	581
Beds required (including critical care X14 and excluding paediatrics X40)	670
Difference beds required	89

- Robust Bed capacity modelling based on last 9 months worth of actual activity – moving beyond historic comparisons
- 92% occupancy , 94% critical care occupancy – need 17 beds , currently 17 – A deep dive required to bring down occupancy
- Bed configuration – Critical care, High dependency, seasonal profiling
- Community rehab beds and initiatives in place partly for 6 months , incorporated
- Reduction in Non-SDEC LOS Non-Elective – 4.3 days , Elective - 2.6, Total 4.2. Currently performing better than peers and national averages.
- Robust D2A implementation and reduction in NCTR
- non-elective demand -growth of 2.5 % based on 8 months (April 22 to October 22).
- ED conversion rates- admission rate remains consistent in 2023/24 (Current approx. 25%)
- 1+ LOS - 97% of 22/23 activity (April to September)
- Zero + LOS - 112% of 22/23 activity (April to September)

Cancer and Diagnostics

Northern Lincolnshire and Goole NHS Foundation Trust

- 62 days plus - NHSE/I trajectory delivers finite target of 102 (-54%)
- Also delivers 6.4%to the internal stretch target of 6% PTL by end March 24
- Reflects the compilation of the 62-day backlog, e.g. urology > 50% of the backlog is a result of treatment capacity at HUTH
- Cancer FDS

June 2023	67.5%
Sept 2023	70%
Dec 2023	72.5%
Mar 2024	75%

- STT pathways are being introduced in Q1 in Gastro, additional consultant staff appointed to support delivery in Respiratory and Surgical specialties
- Targeted lung health checks
- achieve a DMO1 performance of 10% in 23/24 and 5% in 24/25
- incorporated 25% additional capacity at modality level

Workforce

Northern Lincolnshire and Goole NHS Foundation Trust

	Baseline Mar 31		Plan - March 24	
	Staff in Post	Establishment	Staff in Post	Establishment
Workforce (WTE)	6597.77	6660.0	6615.36	6794.30
Substantive	5907.87	6660.0	6077.72	6794.30
Bank	434.58	0.00	357.64	0.00
Agency	255.32	0.00	180.20	0.00

- Excludes trainees
- Increase in establishment – 134.3 WTE
- Staff in post
  - Total increase of 17.6 WTE
    - Substantive : +170
    - Bank : - 60
    - Agency : - 75

Workforce- recruitment

Northern Lincolnshire and Goole NHS Foundation Trust

- International nurse recruitment, utilising existing pipelines and diversifying pipelines further
- Nursing apprenticeship programmes further, including ACP and nurse associate programmes
- Developing relationships with universities and newly qualified nurses to maintain existing recruitment performance, and introduce rotational NQN roles
- HCA mass recruitment, including "new to care" candidates, and continue to develop widening participation programmes
- Talent Acquisition Team for sourcing candidates for hard to fill roles, and broaden remit to include focus on medical staff
- Develop medical training initiative to support medical recruitment
- develop relationships and processes with Lincolnshire Refugee Doctor project to grow pipeline of local doctors
- Expand use of the Specialist grade – as a means of increasing senior clinical capacity and provide career pathways for existing SAS grades
- Formalise CESR programme – explore appointing formal CESR lead for the Trust,
- Explore expanding career pathways – explore local training programme taking career from junior, through SAS, to supporting with CESR –working closely with organisations in region to provide rotational posts and exposure to procedures
- Implement the Occupational Health Interface to ensure all frontline healthcare workers transfer all vaccination and immunisation records for new starters between organisations to speed up the recruitment process.
- Encourage our former people to return to practice as a key part of recruitment drives

Workforce- recruitment

Northern Lincolnshire and Goole NHS Foundation Trust

- Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave.
- Identify and proactively support staff when they go off sick and support their return to work
- Every member of staff should have a health and wellbeing conversation. Health and Wellbeing induction for new starters. Discuss equality, diversity and inclusion as part of the health and wellbeing conversation.
- Make staff aware of the working carers passport to support people with caring responsibilities.
- Requesting flexibility – whether in hours or location, should as far as possible be offered regardless of role, team or grade.
- Ensure people working from home can do safely and have support to do so, including having the equipment they need.
- Prevent and tackle bullying, harassment and abuse against staff and create a culture of civility and respect.
- Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles
- Bespoke Appraisals which can be used to assist organisations talent management processes
- Focus of developing skills and expanding capabilities to create more flexibility, boost morale and support career progression. Develop local Talent Management conversation templates within ESR.
- Launch new Leavers policy and robust checklist for managers to help support the retention of staff.
- Launch the new external link to support the Exit Questionnaire to identify trends or areas of concern

Risks

- Mutual aid – our plans do not include mutual aid provision. Any activity accepted will be facilitated through Waiting list initiatives funded in addition to submitted plan
- Capacity in the Independent sector and tertiary centres
- Workforce plan delivery – recruitment, retention and sickness
- Surge in acute activity – infections
- Ringfencing of elective capacity
- 8 + 4 esc beds at SGH, 18 + 4 esc beds at DPoW,15 at Goole.
- Goole elective HVLC Hub in 2023/24, is included in plan
- Clinical engagement
- Evidence base of service developments/ improvements
- System level delivery – Primary care performance, local authority performance and community care performance
- Implementation of Lorenzo PAS

Quality and Safety

What are quality and safety impacts on individual scheme non delivery including failing to find workforce?	Increased waits for patient care delivery and associated clinical risks/harm Non delivery of operational plan targets Reduction in Staff and patient experience Financial risk of not meeting income targets Legal and reputational risk associated with non-delivery of constitutional targets
What are the most significant quality and safety risks that relate to specific elements of the plan such as the following (won't all apply):-	Integrated service transformation and improvement programmes are in place to deliver improvements. These include UEC improvement plans Elective efficiently and productivity plans - GIRFT, OP transformation, LOS reduction Community service development and capacity improvement plans Discharge to asses and reduction of NCRT plans Reduction of non-elective non SDECLOS plans EPRR policies and processes
What are the support measures around ongoing quality and safety issues in relation to ambulance handover delays, 12 hour trolley breaches and waiting times?	We have a robust risk stratification policy and process in place that reviews, assesses and prioritises risks of overdue patients on the waiting list
What is the assurance around plans for Harm Minimisation in approach to waiting list management?	NLAG's Children's strategy developed and approved by trust Board incorporating the requirements of facing the future standards and impact of SEND.
What plans are in place to improve Children Services across HCV, especially Humber, given SEND and wider children's services position? Are there any CQC implications to be aware of?	None

Health inequalities

Has data been used to the drive the plans/actions and identify health inequalities so these can be addressed in a practical way, ensuring there is no adverse impact to the current position?

Are we clear who is at risk, vulnerable groups or excluded groups including but more than those in the protected characteristics? If not, how we are going to understand any shortfall?

If we are using a patient facing digital solution are we clear how we ensure digital inclusion?

Have you assessed your waiting list in terms of ethnicity and deprivation to understand if any health inequalities across the population? What action, if any, has/will be taken as a result?

The next milestone for elective recovery s achieve 65 weeks by the end of March 2024. What the plans for risk stratification and supporting patients on the waiting list? How will waiting well be accomplished in your provider and supported by the wider system?

How do the plans address equity for accessing elective service across the population groups. How do these plans support population groups from the Core20 (based on HNY deprivation index value) and those listed under the proceed characteristics under the quality act
How do the plans reflect how patients will be provided a choice to ensure they received the treatment as quickly as possible. How will this be addressed at:
The point a referral is made
Any Point during the elective pathway (i.e. both non admitted / Admitted)
Have you factored in a consideration regarding digital inclusion to minimise any further health inequalities re access?

Health Inequalities
Alcohol and tobacco dependence programmes – no funding for programme manager

NLAG elective waiting lists analysed, current average waits of patients in lowest deprivation shows no variation against all patients.
Analysis of the quantity of patients shows more patients on our waiting lists in lower quintiles, meaning there is a greater health need for those patients.
NLAG elective waiting lists analysed, current average waits of patients who are BAME show no variation of wait against those that are not BAME.
The split of ethnicity in the population against the waiting list is similar, however data sources for ethnicity are less reliable due to old census data.
More work need to be done at PLACE and ICS level to scrutinise waiting lists and provide equity of access and clinical outcomes for our deprived populations.

Waiting well program is part of the outpatient transformation programme and is progressing well

Digital inclusion
We provide a range of communication methods to help patient consultations and mitigate risks of Digital Exclusion in certain demographic groups. Our approach utilises existing systems and capabilities to record and monitor the utilisation of remote monitoring solutions.
Communication methods recorded against a consultation can be mapped against the demographics of those patients, providing a clearer breakdown of profiles and the impacts on inclusion.

Analysis will identify the uptake of different methods across various demographic profiles and can be used to target engagement and marketing for utilisation of various engagement methods

Ensure datasets are complete and timely:
Plan to map key demographics to the consultation data to allow analysis of different communication methods by demographic group
Gaps analysis will provide evidence to refine marketing for digital offerings, whist also communicating alternative methods
Continue to provide returns in an accurate and timely manner as per reporting schedules
Review and aim to provide new requirements where possible

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Draft Income and Expenditure Plan 2023/24

Kindness · Courage · Respect

Draft Income and Expenditure Plan

Northern Lincolnshire and Goole NHS Foundation Trust

This table shows the high-level I&E account, mapping the move from 22/23 to 23/24 £20.1m deficit plan (3.9% of Operating Income):

Income & Expenditure £'000	22/23 FOT	23/24 Draft Plan	Change
Clinical Income	457,515	464,350	6,835
Other Income	44,977	44,087	(890)
Total Operating Income	**502,492**	**508,437**	**5,945**
Clinical Pay	(279,922)	(273,296)	6,626
Other Pay	(59,656)	(74,708)	(15,052)
Total Pay	**(339,578)**	**(348,004)**	**(8,426)**
Clinical Non Pay	(75,298)	(78,760)	(3,462)
Other Non Pay	(67,399)	(75,079)	(7,680)
Total Non Pay	**(142,698)**	**(153,839)**	**(11,141)**
Operating Expenditure	**(482,276)**	**(501,843)**	**(19,567)**
EBITDA	**20,216**	**6,594**	**(13,622)**
Depreciation	(15,788)	(20,558)	(4,770)
Interest Expenses & Other Costs	755	398	(357)
Dividend	(5,933)	(7,398)	(1,465)
Total Post EBITDA Items	**(20,966)**	**(27,558)**	**(6,592)**
Remove Capital Donated I&E Impact	751	906	155
Remove Gains on Disposal	0	0	0
I&E Surplus / (Deficit)	**0**	**(20,058)**	**(20,058)**

This table summarises the movements from the 22/23 balanced outturn to the current 23/24 deficit updated from the draft plan submission:

	Draft Plan	Final Plan	Movement
2022/23 Forecast Outturn @ Month 10	**0**	**0**	**0**
22/23 Reduced Income	(24,865)	(28,508)	(3,644)
22/23 NR Expenditure	14,814	16,829	2,015
22/23 NR Technical B/S Planned	(6,800)	(6,800)	0
22/23 NR Technical B/S Additional	(12,792)	(12,873)	(81)
22/23 NR Underspends (Midwifery/Community Nursing)	(2,870)	(2,870)	0
22/23 NR CIP Savings Delivery	(3,112)	(3,112)	0
22/23 Investments	(6,029)	(4,019)	2,011
2022/23 Underlying Deficit	**(41,654)**	**(41,354)**	**301**
Tariff Uplift (2.9%)	12,070	12,393	323
Inflation Expenditure	(16,115)	(16,808)	(693)
Tariff Efficiency Deflator (1.1%)	(4,578)	(4,577)	0
Convergence Efficiency Deflator	(2,991)	(2,993)	(1)
Cost of Capital & PDC	(6,768)	(6,768)	0
Depreciation Support Funding	0	1,200	1,200
ICB Stretch Improvement CIP	0	10,058	10,058
Savings Efficiency Target	17,303	25,678	8,375
2023/24 Underlying Deficit post inflation	**(42,734)**	**(23,171)**	**19,563**
ERF Funding	8,694	12,041	3,347
ERF Expenditure	(8,694)	(12,041)	(3,347)
Activity Growth Funding	3,729	9,396	5,667
Activity Growth Expenditure	(3,729)	(4,984)	(1,255)
New Investments (Internal Funded)	0	(1,299)	(1,299)
Investment Funding	1,432	8,671	7,239
Investment Expenditure	(2,864)	(8,671)	(5,807)
2023/24 Planned Deficit	**(44,166)**	**(20,058)**	**24,108**
NR CIP		(23,317)	
FYE Investments		(6,423)	
2023/24 Planned Underlying Deficit	**(44,166)**	**(49,798)**	**24,108**

Issue 1 – Lost Income & Non Recurrent Expenditure

Northern Lincolnshire and Goole NHS Foundation Trust

Moving between years the Trust has lost COVID Funding plus other non recurrent income. This totals £28.5m.

Scheme	£000's
Non Recurrent COVID-19 Funding	(9,331)
Non Recurrent ERF Income*	(8,816)
SDF - Cancer Alliance / VW	(1,367)
NR Bed Capacity Funding*	(1,296)
National Insurance Contribution	(1,264)
Contributions From Charity	(1,182)
Service Changes	(1,151)
Pay Award Cost Pressure Support	(773)
Depreciation Support	(600)
Migration Support Workers	(477)
The Grange	(376)
NHSE HCD Rebase	489
Deferred Income	(244)
NR Education Income Adjustments	(232)
QSM Intensive Support	(177)
Alcohol Team	(152)
NHSE Slippage Support	(122)
AHP Investment	(114)
Tobacco Service	(100)
Other Schemes < £100k	(759)
NR System Smoothing Support	(466)
Total	**(28,508)**

We used this resource to meet non-recurrent costs of £16.8m.

Scheme	£000's
Non Recurrent ERF Expenditure*	8,184
Contributions From Charity	1,162
National Insurance Contribution	1,357
SDF - Cancer Alliance / VW	1,291
NHSE HCD Rebase	(514)
NR Bed Capacity Funding*	1,296
Non Recurrent COVID-19 Expenditure	1,505
Migration Support Workers	477
The Grange	376
Incentives	320
Service Changes	301
QSM Intensive Support	177
Alcohol Team	152
Education Income Adjustments	141
AHP Investment	114
Tobacco Service	100
Other Schemes < £100k	391
Total	**16,829**

*ERF funding and expenditure has been re-provided for 23/24 see Slide 30
*Bed Capacity funding and expenditure has been re-provided for recurrently in 23/24 see Slide 29

Issue 1 – Lost Income & Non Recurrent Expenditure

Northern Lincolnshire and Goole NHS Foundation Trust

- COVID funding reduces by £9.3m year on year. Expenditure has stabilised at £6.2m predominantly driven by Ward Reconfiguration quality investments. Testing income and expenditure is removed awaiting further clarification on funding mechanism for 23/24.

- In addition the Trust is forecast to release **£19.7m** in non recurrent Technical Support in year (£6.8m was included in the 22/23 plan).

- The Trust is forecast to deliver £3.1m in non recurrent CIP in year.

- We also carried significant underspends further supporting the in year position, predominantly within Midwifery and Community Nursing of £2.87m

- Full year effects of committed investments of £4.0m (See Issue 5) create an underlying **deficit of £41.35m** as we exit 22/23

Issue 2 – Growth and Inflation

- Inflation funding has been received at 2.9% (£12.4m). We currently assess the impact of inflation to the cost base to be £16.8m. Incremental pay pressures are calculated at 2.89% v's 2.1% provided in tariff. Initial workings suggest Utilities will rise by £1.5m, £1.2m over inflation provided for in tariff. Other inflation is currently accounted for using planning guidance % uplifts which could result in additional pressures as we are seeing inflation of >10% as contracts come up for renewal.

- The Trust has received growth and investment support funding of £9.4m with a corresponding expenditure assumption for non pay growth as witnessed in 22/23 of £4.9m.

Issue 3 – Implications of Increased Capital

- Due to increased capital spend the Trust will incur an additional £1.5m of PDC charges (interest paid on Govt capital).

- In addition depreciation will increased as a result of the additional capital received into the Trust by £5.3m. The Trust is expected to receive £1.2m in support funding and is included in the plan at this stage but is still tbc.

- Whist this is welcome for the capital programme this places further pressure on balancing the I&E position.

Issue 4 – CIP

Northern Lincolnshire and Goole NHS Foundation Trust

- The national 22/23 CIP requirement has been set at 1.1% (£4.6m) plus a convergence factor requiring further savings requirement of £3.0m, £7.6m in total.
- Currently included in the plan is a 6.4% efficiency target of £35.7m. This consists of a baseline 3% CIP target (£14.9m) applied across Divisions and Directorates plus a stretch target to fund the AAU investment of £2.4m to give a core CIP programme of £17.3m, 3.4%.
- In addition, technical savings have been identified of £8.4m, predominantly through anticipated planned release of annual leave accrual.
- In order to close the financial gap, an as yet unidentified stretch target of £10.1m is included in the plan.

		CIP REQUIREMENT						CIP IDENTIFICATION	
	Allocations for CIP	Initial CIP at 3%	AAU	Core Programme	Technical	Unidentified Stretch	CIP Target	Scoped	Unidentified
Medicine	124,055	3,722	1,500	5,222			5,222	5,222	0
Surgery & Critical Care	121,015	3,630	350	3,980			3,980	3,383	597
Family Services	47,939	1,438	577	2,015			2,015	1,360	655
Community & Therapy Services	35,857	1,076		1,076			1,076	1,076	0
COO's Directorate	40,090	1,203		1,203			1,203	1,203	0
Total Operations	**368,955**	**11,069**	**2,427**	**13,496**		**0**	**13,496**	**12,243**	**1,253**
Chief Executive's Office	673	20		20			20	20	0
Chief Medical Officer's Directorate	5,579	167		167			167	167	0
Chief Nurse Directorate	3,619	109		109			109	109	0
Digital Services	10,490	315		315			315	315	0
Finance	5,034	151		151			151	151	0
People & OE	5,291	159		159			159	159	0
Strategic Development	1,298	39		39			39	39	0
Total Corporate	**31,983**	**960**	**0**	**960**		**0**	**960**	**960**	**0**
Estates & Facilities	33,672	1,010		1,010			1,010	852	158
Trust	57,048	1,838		1,838	8,375	10,058	20,271	10,071	10,200
Total By Division	**491,658**	**14,876**	**2,427**	**17,303**	**8,375**	**10,058**	**35,736**	**24,125**	**11,611**

PROJECT RECURRENCE	2. RISK	Recurrent	Non Rec.	Total
Recurrent	High	6,288	10,200	16,488
Non-Recurrent	Medium	3,909	730	4,639
Unidentified	Low	2,218	12,392	14,610
Total By Recurrence	**Total Risk**	**12,414**	**23,322**	**35,736**

Issue 5 – Investments

Northern Lincolnshire and Goole NHS Foundation Trust

- Currently included within the plan are committed investment schemes of £7.0m but these have been reduced by £1.7m for anticipated in year slippage.

	PYE	Slippage	23/24 Expenditure	FYE
Scheme	**£000's**	**£000's**	**£000's**	**£000's**
PYE AAU	2,427	(1,214)	1,214	4,729
SGH ED FYE	1,899	0	1,899	0
DPoW ED FYE	906	0	906	0
Nursing Apprenticeship	480	(480)	0	0
Total Pre-Committed Investments	**5,712**	**(1,694)**	**4,019**	**4,729**
International Nurse Recruitment	133	0	133	0
Extended Discharge Lounge	308	0	308	0
Pathology Cancer Standards	349	0	349	0
Paediatric Diabetes Peer Review	228	0	228	0
Medical Talent Acquisition	70	0	70	0
Vulnerabilities Nurse	64	0	64	0
CQUIN Admin Support	45	0	45	0
QI Facilitator	42	0	42	0
Occupational Health	41	0	41	0
ACP	19	0	19	0
Total New Investments	**1,299**	**0**	**1,299**	**0**
Total Committed Investments	**7,012**	**(1,694)**	**5,318**	**4,729**

- Additional investments funded by the ICB are included below of £8.7m. (Highlighted are agreed in principle to be transacted in year)

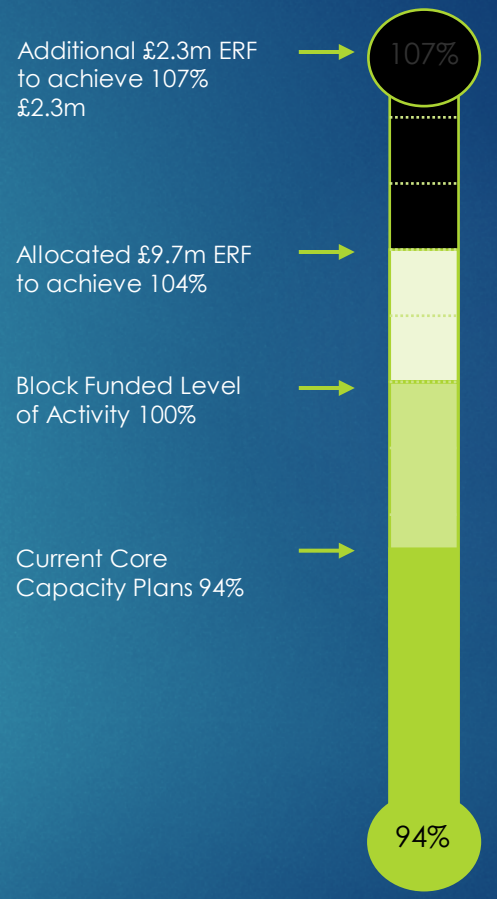
Scheme	**£000's**
Lung Health Checks	1,968
Acute Bed Capacity	1,840
Cancer Alliance	1,104
Virtual Ward Funding	1,005
Homefirst	382
Hospital @ Home (Paeds)	374
OPAT	350
24/7 UCS	330
NR RSPF Support	321
Extended SDEC to 10pm	306
Tobacco Cessation Service	290
Ockenden Phase 2	203
Alcohol Care Team	150
Continuity of Carer	48
Total Income	**8,671**

Issue 6 – Activity Plans and ERF

Northern Lincolnshire and Goole NHS Foundation Trust

- The Trust's draft activity plan is currently at 94% of the 19/20 baseline from within its core funded capacity.
- Division's plan to increase capacity through internal WLI's or through IS capacity that increases the activity levels to 107%.
- The Trust has been initially allocated £12.0m of additional funding for ERF. £4.3m is required for additional CT/MRI Diagnostic capacity leaving £7.7m available for premium capacity via IS/WLI sessions.

Elective Recovery Funding	£000's
ERF Funding 104%	9,733
ERF Funding 107%	2,308
Total Funding	**12,041**
Extended CT/MRI Capacity	4,300
Capacity Reserve WLI	4,692
Capacity Reserve IS	3,049
Total Expenditure	**12,041**



Underlying Position

Northern Lincolnshire and Goole NHS Foundation Trust

The Trust is heavily reliant on non recurrent slippage and savings in order to achieve its 2023/24 planned deficit of £20.1m.

- The Trust savings programme currently includes non recurrent CIP plans of £23.3m (this includes the £10.1m stretch target)

- FYE of Investments total £4.0m

The above adjustments reflect an underlying deficit at plan stage of **£47.4m.** (This is dependent on how the £10.1m stretch target will be delivered in year and is therefore worse case).

Key Risks

Northern Lincolnshire and Goole NHS Foundation Trust

- CIP Delivery – The Trust has an extremely challenging CIP target. Current assessment of the scoped plan has £16.5m as high risk with £10.9m currently unidentified.

- ERF – The Trust has a core capacity plan of 94% and would therefore be heavily reliant on premium capacity either via IS or internal WLI payments in order to deliver the activity plan. It must look to maximise its core activity nearer to 19/20 base levels and reduce its reliance on premium capacity.

- Inflation – Known inflationary pressures for incremental pay and energy are currently included within the plan. However, other expenditure inflation is currently provided for using planning guidance % uplifts. Any deviation to these assumptions would present additional cost pressures not included within the plan.

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Thank You

NLG(23)103

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 June 2023	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance	
Title of the Report	**Finance Report – M01**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 1 of the 2023/24 reporting period. The Trust Board are asked to note: • The Finance Report, Month 1 • The Trust reported an in month deficit for month 1 of £2.3m	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: F&P Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

Northern Lincolnshire and Goole NHS Foundation Trust

Finance Report Month 1

April – 2023/24

Finance Overview

In month I&E Performance – pages 4 to 6	
(£2.3m)	The Trust reported an in month deficit for month 1 of £2.3m, £0.6m favourable versus plan.

YTD I&E Performance – pages 4 to 6	
(£2.3m)	The Trust reported an in month deficit for month 1 of £2.3m, £0.6m favourable versus plan.

YTD CIP Delivery – page 7	
£0.3m	The Trust delivered £1.0m in CIP against a target of £1.3m. Non-recurrent technical reserves were £0.2m below plan, with the core programme £0.1m below plan.

Underlying I&E – page 8	
(£41.5m)	The Trust underlying position included in it plan submission is estimated at circa £41.5m

System Financial Performance – page 10	
£0.7m	The ICS reported a £0.7m surplus for 2022/23.

Capital Expenditure – page 12	
£1.2m	The Trust reported capital spend of £1.2m below plan, due to delays on schemes including ED/AAU, DPOW and SGH theatres and SGH Fire Alarms.

Balance Sheet & Cash – page 14	
£41.5m	The Trust cash balance at 30th April 2023 was £37.9m.

Elective Recovery Performance – page 15	
TBC	The Trust is ahead of its plan in April. However, Elective Recovery Funding baselines and profile are still to be agreed. No penalties were assumed in month 1.

Temporary Staffing – page 16	
(£0.45m)	The Trust has spent £5.8m on agency, bank and locum pay. This is £0.45m more than the same period in 2021/22.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Income and Expenditure Performance

Financial Performance Summary

The Trust reported a £2.3m in-month deficit in April, £0.6M favourable to plan.

- The Trust reported a £2.3m deficit in April 2023, £0.6m ahead of plan. **However, the position is supported by non-recurrent benefits including slippage on independent sector expenditure, reserves and on depreciation and interest received due to capital plan delays.**
- Income was £0.15m below plan. Clinical Income was £0.29m below plan due to tranche 2 of virtual ward funding and depreciation support both awaiting confirmation, and reduced lung health check activity. This was partly offset by Path Links Income (£0.15m above plan) and Private Patient Income (£0.03m above plan).
- Clinical Pay was £0.14m overspent. £0.67m Medical Staff overspends included £0.3m strike costs, reliance on premium temporary staffing covering vacancies, sickness, AAU phase 3 extra shifts, RAT extra shifts, premium waiting list capacity and weekend ITU cover. These were partly offset by £0.4m nursing and £0.13m AHP underspends due to vacancies across several areas including Maternity, NICU, Pharmacy and Community. Overall escalation bed costs amounted to £0.3m in month for circa 43 beds, partly offset by acute bed capacity funding of £0.15m.
- The above pressures were offset by slippage on investment and elective recovery reserves.
- Non-pay was £0.29m underspent in month mainly due to slippage on Independent Sector expenditure, which offset an overspend of £0.12m on energy costs.
- Depreciation and Non-operating Items were £0.3m underspent due to AAU, ED and SGH Fire Alarm scheme delays, and due to interest received from cash balances.

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical Income	39.3	39.0	(0.3)	39.3	39.0	(0.3)
Other Income	3.5	3.7	0.1	3.5	3.7	0.1
Total Operating Income	**42.8**	**42.6**	**(0.1)**	**42.8**	**42.6**	**(0.1)**
Pay Costs						
Clinical Pay	(24.3)	(24.5)	(0.1)	(24.3)	(24.5)	(0.1)
Other Pay	(6.4)	(6.2)	0.2	(6.4)	(6.2)	0.2
Total Pay Costs	**(30.8)**	**(30.7)**	**0.1**	**(30.8)**	**(30.7)**	**0.1**
Clinical Non Pay	(6.5)	(6.5)	0.0	(6.5)	(6.5)	0.0
Other Non Pay	(6.2)	(6.0)	0.3	(6.2)	(6.0)	0.3
Total Non Pay Costs	**(12.7)**	**(12.4)**	**0.3**	**(12.7)**	**(12.4)**	**0.3**
Total Operating Expenditure	**(43.5)**	**(43.1)**	**0.4**	**(43.5)**	**(43.1)**	**0.4**
EBITDA	**(0.7)**	**(0.5)**	**0.2**	**(0.7)**	**(0.5)**	**0.2**
Depreciation	(1.6)	(1.5)	0.1	(1.6)	(1.5)	0.1
Non Operating Items	(0.5)	(0.3)	0.2	(0.5)	(0.3)	0.2
Surplus/(Deficit)	**(2.8)**	**(2.3)**	**0.6**	**(2.8)**	**(2.3)**	**0.6**

Financial Performance – Divisions

See Appendix A on page 15 for a summary of the in month and YTD positions for all Divisions and Corporate Directorates.

Divisions	YTD Performance	Key Actions
Operations Directorate **£(0.0m)** In-month Variance **£(0.0m)** YTD Variance **£0.1m** YTD CIP Variance	• £(0.2)m Pathology overspends due to activity over-performance netted off by £0.1m additional income (note circa 50% CCG activity on block) . • £0.1m pay underspend due to vacancies in Pathology and Pharmacy.	• Conclude Site Management restructure. • Monitor costs of Path Links Over-performance on activity on block.
Family Services **(£0.24m)** In-month Variance **(£0.24m)** YTD Variance **(£0.07m)** YTD CIP Variance	• Medical staff (£0.16m deficit): high locum costs of cover (inclusive of £0.9m Strike costs) and increased additional sessions. Failure against CIP targets for agency and OP capacity. • Nursing £0.02m Surplus: Significant vacancies in paediatrics and midwifery, which have overachieved against the non recurrent CIP targets set against these. • CIP (£0.07m) adverse variance in month against unmet CIP target.	• Manage down rota cover costs, reduce sickness and special leave, implement cross site working, address exempt from on call where possible. Reduce F/UP Op activity. • Continue to recruit to substantive posts in order to reduce reliance on bank and agency. • Continue working to replace non recurrent benefits with sustainable recurrent CIP plans.
Surgery & Critical Care **(£0.7m)** In-month Variance **(£0.7m)** YTD Variance **(£0.1m)** YTD CIP Variance	• (£0.6m) overspent on Medical Staff mainly due to pay premiums covering vacancies alongside restricted duties and on-call cover. Includes (£0.1m) in April due to covering Junior Dr's strike. • (£0.03m) nursing overspend. (£0.07m) due to escalation beds.	• 14 medical staff on restricted duties . Meetings with Quad regarding pathways to ending restrictions • Recruitment of medical staff to vacancies 30 wte a key priority alongside staff retention • Focus on theatre productivity in line with GIRFT targets

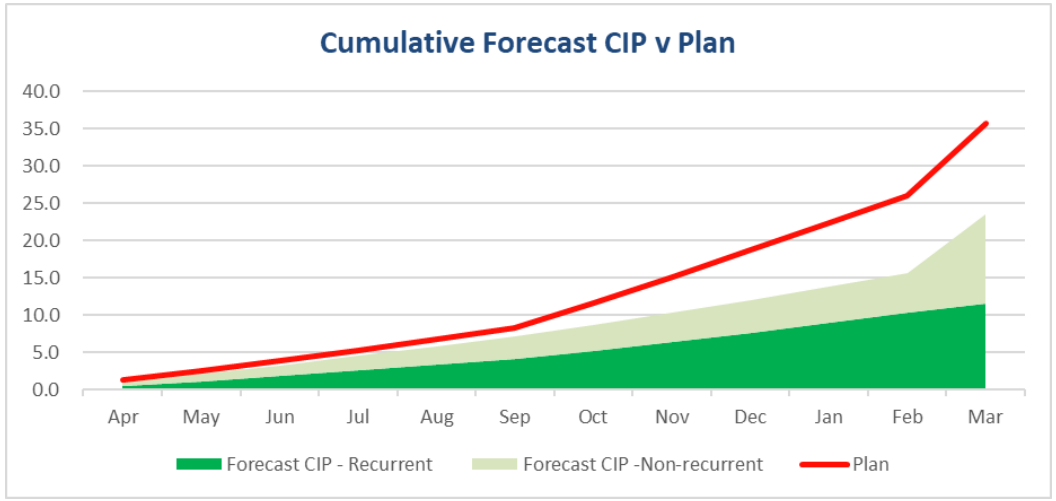
Financial Performance – Divisions continued

Divisions	YTD Performance	Key Actions
Medicine **(£0.47m)** In-month Variance **(£0.47m)** YTD Variance **£0.00m** YTD CIP Variance	• Medical Staff (£0.49M deficit) ; 40wte vacancy premium ; (£0.14m) unfunded strike cover costs ; (£0.22m) additional ED / UCS shifts , (£0.21m) Acute vacancies & GIM oncall gaps; LT Sickness cover & GI bleed oncall gaps • Nursing Staff (£0.20m deficit of which £0.14m is ED); vacancy premium 129wte RN & 64wte HCA ; escalation beds part funded (£0.06m); additional allocation on arrival shifts • Drugs underspent £0.17m ; Pacemakers (£0.02m) (activity>plan)	• Review ED rotas ; confirm Acute AAU FBC funding; continue recruitment & retention & mitigate gaps with floaters • Regular ED monitoring; reduce agency spend ; review escalation beds, continuation of recruitment & retention; review OOH agency authorisation
Therapy & Community Services **£0.02m** In-month Variance **£0.02m** YTD Variance **£0.03m** YTD CIP Variance	• Community Equipment Services (£0.02m deficit): Team struggling to cope with demand. Use of bank to cover vacancies and create additional capacity. Equipment spend funded to outturn but overspending. • GDH Medical Staffing (£0.03m deficit): Almost entirely vacant posts – covered by locums with high premium cost. • CIP: heavy reliance on non recurrent plans – targets against AHP & nursing vacancies.	• Work to streamline processes and maximise collections and refurbishments to reduce pressure on equipment spend. • Recruitment efforts suggest vacancies could be addressed by the autumn. • Continue working to replace non recurrent benefits with sustainable recurrent CIP plans.
Corporate Directorates & Central Reserves **£2.0m** In-month Variance **£2.0m** YTD Variance **(£0.24m)** YTD CIP Variance	• Estates & Facilities was (£0.1m) overspent due to increased energy costs and unidentified CIP. All other Corporate Directorates were break-even or in surplus mainly due to non-recurrent CIP over-delivery. • Central Income was (£0.3m) under plan across lung health checks, and due to awaiting formal agreement on tranche 2 virtual wards and depreciation support. • The position is supported through slippage on Investment & ERF reserves and centrally held agency premium reserves plus positive variances on interest and depreciation due to capital plan delays and high cash balances.	• Deep dive into non-pay – postage and text reminder cost drivers and overspending areas including electricity, water, sewerage and provisions. • Review of recurrent CIP gaps by individual Corporate Directorates, working up plans to close the gaps. • Review Investment and ERF reserves and expenditure plans.

Financial Performance – CIP delivery

The Trust has delivered £1.0m CIP against a month 1 target of £1.3m. This has been driven by unidentified plans within the core programme as well as a £0.2m under-delivery on non-recurrent technical reserves.

£million	Current Month			Year to Date		
	Plan	Actual	Var.	Plan	Actual	Var.
CLINICAL WORKFORCE						
Medical Staff	0.1	0.1	(0.0)	0.1	0.1	(0.0)
Nursing and Midwifery	0.2	0.2	0.1	0.2	0.2	0.1
AHP Staff	0.0	0.1	0.1	0.0	0.1	0.1
TOTAL CLINICAL WORKFORCE	**0.4**	**0.5**	**0.1**	**0.4**	**0.5**	**0.1**
Corporate and Non-Clinical	0.1	0.1	0.1	0.1	0.1	0.1
Non-Pay and Procurement	0.1	0.1	0.0	0.1	0.1	0.0
COVID Expenditure Reduction	0.0	0.0	0.0	0.0	0.0	0.0
Other CIP	0.5	0.2	(0.3)	0.5	0.2	(0.3)
TOTAL CORE PROGRAMME	**1.1**	**1.0**	**(0.1)**	**1.1**	**1.0**	**(0.1)**
Non-recurrent Technical Efficiency	0.2	0.0	(0.2)	0.2	0.0	(0.2)
ICS Stretch	0.0	0.0	0.0	0.0	0.0	0.0
TRUST TOTAL EFFICIENCY PLAN	**1.3**	**1.0**	**(0.3)**	**1.3**	**1.0**	**(0.3)**



- The Trust is £0.1m behind its £1.1m core CIP programme at the end of April 2023. The shortfall is primarily driven by unidentified plans of £0.2m across the Surgery and Family Services Divisions and the Estates & Facilities Directorate.
- These have been partially mitigated by over deliveries on Corporate and AHP vacancies and Pathology Income schemes.
- It was expected that £0.2m of non-recurrent technical reserves would be required in-month however this has not been the case and is reflected in the CIP delivery with the total Trust efficiency position £0.3m short of the £1.3m plan for the period.

Underlying Position

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

£million	
2023/24 - Surplus/(Deficit) Plan	**(13.4)**
Non-recurrent Adjustments	
Non Recurrent Savings Delivery	(24.1)
FYE Investment Programme	(4.0)
Underlying Deficit	**(41.5)**

- The Trust's underlying position reported within its 2023/24 plan submission is an estimated deficit of £41.5m.
- The Trust 2023/24 plan included £24.1m of non recurrent CIP delivery assumptions. This includes the unidentified stretch target of £10.0m, It is currently assumed will be delivered as non recurrent whilst recovery mitigation schemes are developed.

Northern Lincolnshire and Goole NHS Foundation Trust

System Financial Performance

System Financial Performance – February 2023

The Humber and North Yorkshire ICS delivered a £0.7m surplus for the year ending 31st March 2023.

£million	Full Year		
	Plan	Forecast	Variance
East Riding of Yorkshire Place	0.0	0.0	0.0
Hull Place	0.0	0.1	0.1
Hull University Teaching Hospitals NHS Trust	0.0	0.1	0.1
Humber Teaching FT	0.0	0.0	0.0
Hull and East Riding	**0.0**	**0.2**	**0.2**
North East Lincolnshire Place	0.0	0.0	0.0
North Lincolnshire Place	0.0	0.0	0.0
Northern Lincolnshire and Goole NHS FT	0.0	0.0	0.0
North and North East Lincolnshire	**0.0**	**0.0**	**0.0**
North Yorkshire Place	0.0	0.0	0.0
York Place	0.0	0.0	0.0
York and Scarborough Teaching Hospitals NHS FT	0.0	0.1	0.1
Harrogate and District NHS FT	0.0	0.2	0.2
North Yorkshire and York	**0.0**	**0.3**	**0.3**
ICB-Wide Expenditure	**0.0**	**0.1**	**0.1**
Total ICS Surplus/(deficit)	**0.0**	**0.6**	**0.6**
Summary			
ICB Total	0.0	0.1	0.1
ICB-Wide Expenditure	0.0	0.1	0.1
Provider Total	0.0	0.4	0.4
Total ICS Surplus/(deficit)	**0.0**	**0.7**	**0.7**

Northern Lincolnshire and Goole NHS Foundation Trust

Capital and Balance Sheet

Capital Expenditure

Year-to-date capital expenditure is £0.2m against a £1.4m YTD plan, including IFRS16 and donated spend.

£million	Year to Date		
	Plan	Actual	Var.
Estates Major Schemes			
Emergency Department/AAU	1.0	0.0	(1.0)
DPOW & SGH Theatres TIF	0.1	0.0	(0.1)
SGH Fire Alarm	0.2	0.0	(0.2)
Discharge Lounge	0.0	0.0	0.0
N Lincs CDC	0.0	0.0	0.0
Unallocated	0.0	0.0	0.0
Total Estates Major Schemes	**1.3**	**0.1**	**(1.2)**
Other Estates Schemes	0.0	0.0	0.0
IM&T Programme	0.1	0.1	0.0
Pathology LIMS	0.0	0.0	0.0
Equipment Renewal	0.0	0.0	0.0
Facilities Maintenance	0.0	0.0	0.0
Other Capital Expenditure	0.0	0.0	0.0
Total Capital Programme	**1.4**	**0.2**	**(1.2)**
Funded By:			
Internally Generated	1.4	0.2	(1.2)
PDC Funded	0.0	0.0	(0.0)
Donated	0.0	0.0	0.0
IFRS16	0.0	0.0	0.0
Total Funding	**1.4**	**0.2**	**(1.2)**

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

The actual spend to 30th April was £0.2m, all of which related to Trust funded schemes. Key variances are detailed below:

- The AAU schemes are progressing, further delays have been reported with both schemes now forecasting to be completed by the end of November 2023. The ED/AAU schemes in total are currently forecasting additional costs and risks of **£4.09m,** of this only £3.06m has been included in this years capital plan.
- DPOW and SGH theatre schemes are continuing, the schemes are currently on plan to be operational by the end of quarter 1.
- The Trust has successful secured funding of £19.4m over 2 years for North Lincs Community Diagnostic hub, designs and procurement have commenced with building works planned be completed this financial year.
- Facilities maintenance – the water improvements are continuing to be undertaken this year to complete the scheme. SGH Fire alarms is progressing as planned.
- IM&T implementation of PAS and single sign on is progressing.
- Equipment plans have been agreed, divisions are now working with procurement to agree specifications and obtain quotes.

Balance Sheet

£ million	Actual 31-Mar-22	Actual 31-Mar-23	Actual 30-Apr-23	In month movement
Fixed Assets	268.9	278.9	277.6	(1.3)
Current Assets				
Inventories	3.3	4.0	4.2	0.3
Trade and Other Debtors	20.0	25.4	26.5	1.1
Cash	31.9	41.5	37.9	(3.6)
Total Current Assets	**55.2**	**70.8**	**68.6**	**(2.2)**
Current Liabilities				
Trade and Other Creditors	37.1	64.8	57.3	(7.5)
Accruals	20.1	16.0	19.5	3.5
Other Current Liabilities	6.9	5.3	8.1	2.8
Total Current Liabilities	**64.1**	**86.1**	**85.0**	**(1.2)**
Net Current Liabilities	**(8.9)**	**(15.3)**	**(16.3)**	**(1.1)**
Debtors Due > 1 Year	1.25	0.98	0.98	0.00
Creditors Due > 1 Year	0.00	0.00	0.00	0.00
Loans > 1 Year	6.88	6.88	6.88	0.00
Finance Lease Obligations > 1 Year	14.86	12.29	12.29	0.00
Provisions - Non Current	5.44	4.04	4.04	0.00
Total Assets/(Liabilities)	**234.1**	**241.3**	**239.0**	**(2.4)**
TOTAL CAPITAL & RESERVES	**234.1**	**241.3**	**239.0**	**(2.4)**

Key Movements:

Current Assets

- Stock balances have increased in month, following an increase in pharmacy stock.
- Debtors have increased, United Lincs April block invoice is still outstanding.
- The Trust cash balance has reduced in month, as creditor invoices are now being paid.

Current Liabilities

- The deferred income has increased, the Trust received quarter 1 Health Education income in April.
- Trade and other creditors have reduced in month as year end invoices/creditors are paid. Accruals have increased following the receipting of April orders.

The total BPPC figures for the Trust continue to be above 90%; 96.0% for value of NHS invoices paid with 30 days and 92.4% for number paid. Non NHS invoices is 95.3% for value paid within 30 days and 94.9% for number paid. Monitoring of BPPC and communication to staff of the importance of authorising invoices will continue.

Northern Lincolnshire and Goole NHS Foundation Trust

Appendices

Appendix A – Divisional Financial Performance & Reserves Summary

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Operations						
Operations Directorate	(3.3)	(3.4)	(0.0)	(3.3)	(3.4)	(0.0)
Family Services	(3.8)	(4.1)	(0.2)	(3.8)	(4.1)	(0.2)
Surgery & Critical Care	(9.9)	(10.7)	(0.7)	(9.9)	(10.7)	(0.7)
Medicine	(10.2)	(10.7)	(0.5)	(10.2)	(10.7)	(0.5)
Therapy & Community Services	(3.1)	(3.0)	0.0	(3.1)	(3.0)	0.0
Total Operations	**(30.4)**	**(31.8)**	**(1.4)**	**(30.4)**	**(31.8)**	**(1.4)**
Corporate Directorates						
Trust Management	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
Chief Medical Officer Directorate	(2.0)	(1.9)	0.0	(2.0)	(1.9)	0.0
Chief Nurses Office	(0.5)	(0.5)	(0.0)	(0.5)	(0.5)	(0.0)
Finance	(0.4)	(0.4)	0.0	(0.4)	(0.4)	0.0
People Directorate	(0.4)	(0.4)	0.0	(0.4)	(0.4)	0.0
Estates & Facilities	(3.2)	(3.3)	(0.1)	(3.2)	(3.3)	(0.1)
Strategic Development	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
Digital Services	(0.9)	(0.8)	0.0	(0.9)	(0.8)	0.0
Technical Central & Capital Charges	(2.2)	(1.7)	0.4	(2.2)	(1.7)	0.4
Central Income	40.6	40.3	(0.3)	40.6	40.3	(0.3)
Central CIP	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Trust Reserves	(3.7)	(1.6)	2.1	(3.7)	(1.6)	2.1
Total Corporate Directorates	**27.5**	**29.5**	**2.0**	**27.5**	**29.5**	**2.0**
Excluded Items	0.1	0.1	0.0	0.1	0.1	0.0
Trust Total	**(2.8)**	**(2.3)**	**0.6**	**(2.8)**	**(2.3)**	**0.6**

£million	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
Investment Reserves	9.3	0.4	0.0	**0.4**
Inflation Reserve	18.6	1.4	1.6	**(0.2)**
Agency Premium Reserve	6.1	1.3	0.0	**1.3**
Elective Recovery Reserve	11.3	0.7	0.0	**0.7**
TOTAL	**45.3**	**3.7**	**1.6**	**2.1**

Appendix B – Elective Recovery

Elective Recovery Funding baselines and profiling are still to be agreed with NHSI. Performance against plan is detailed in the following table.

Elective Recovery Price (£k)																		
Specialty	DAYCASE			ELECTIVE			OP FIRST ATTENDANCE			OP FIRST PROCEDURE			OP F/UP PROCEDURE			ALL ACTIVITY TYPES		
	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance
Community and Therapies	26,232	9,316	(16,916)	-	-	-	-	-	-	-	-	-	-	-	-	26,232	9,316	(16,916)
Medicine	383,881	499,568	115,687	42,462	65,016	22,554	553,012	378,416	(174,595)	12,615	7,990	(4,625)	55,480	53,342	(2,138)	1,047,449	1,004,333	(43,117)
Surgery and Critical Care	813,792	970,359	156,567	803,482	927,535	124,053	564,237	530,722	(33,516)	113,038	119,561	6,523	217,418	305,687	88,269	2,511,967	2,853,863	341,896
Family Services	128,881	121,108	(7,773)	160,845	179,436	18,591	385,815	315,249	(70,566)	136,233	140,603	4,369	47,829	52,298	4,469	859,603	808,694	(50,910)
Surgery Endoscopy	542,473	648,067	105,594	-	-	-	-	-	-	8,984	22,235	13,251	-	-	-	551,457	670,301	118,844
Grand Total	**1,895,259**	**2,248,417**	**353,159**	**1,006,788**	**1,171,987**	**165,198**	**1,503,064**	**1,224,387**	**(278,677)**	**270,870**	**290,388**	**19,518**	**320,728**	**411,328**	**90,600**	**4,996,709**	**5,346,507**	**349,798**

Spells/Attendances	2019/20	2020/21	2021/22	2022/23	2023/24	Variance to 2019/20
Elective	546	148	371	345	379	(167)
Daycase	4,362	1,403	3,952	3,990	4,251	(111)
OPD New	7,553	4,874	7,495	9,064	6,581	(972)
OPD New Procedures	2,248	467	1,722	1,718	1,820	(428)
OPD Follow Up	15,653	12,560	15,156	16,546	15,030	(623)
OPD Follow Up Procedures	4,450	1,281	3,395	3,804	3,990	(460)
Total	**34,812**	**20,733**	**32,091**	**35,467**	**32,051**	**(2,761)**

Spells/Attendances	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Elective	345	400	353	397	417	426	482	474	356	389	455	411	379
Daycase	3,990	4,747	4,248	4,538	4,633	4,356	4,456	4,897	4,338	4,668	4,435	5,092	4,251
OPD New	9,064	10,146	9,682	9,304	9,048	9,847	9,491	9,538	7,949	8,940	7,846	8,826	6,581
OPD New Procedures	1,718	1,978	1,702	1,795	1,806	2,081	2,022	2,139	1,762	2,140	1,931	2,136	1,820
OPD Follow Up	16,546	18,993	18,350	16,929	17,418	18,173	18,737	20,669	16,334	19,741	17,626	18,055	15,030
OPD Follow Up Procedures	3,804	4,374	3,790	3,865	3,980	4,419	4,563	5,243	3,808	5,263	4,678	4,592	3,990
Total	**35,467**	**40,638**	**38,125**	**36,828**	**37,302**	**39,302**	**39,751**	**42,960**	**34,547**	**41,141**	**36,971**	**39,112**	**32,051**

Appendix C – Temporary Staffing Summary

Subjective Sub category	2022/23	2023/24	Variance
Medical Staff	2,617	2,945	(328)
Nursing Staff	2,242	2,302	(61)
Scientific, Therapeutic & Technical Staff	162	231	(69)
Admin & Clerical Staff	220	183	37
Maintenance Staff	-	-	0
Other Staff	- 0	0	(0)
Support Staff	139	170	(30)
Grand Total	**5,380**	**5,831**	**(451)**

Division / Directorate	2022/23	2023/24	Variance
Operations Directorate	309	273	36
Community + Therapy Services	269	260	10
Family Services	538	627	(89)
Medicine	2,576	2,792	(216)
Surgery + Critical Care	1,499	1,684	(186)
Sub Total Operations	**5,191**	**5,637**	**(446)**
Chief Medical Officer Directorate	1	1	(0)
Chief Nurses Office	12	6	7
Digital Services	36	16	20
Estates And Facilities	137	159	(22)
People Directorate	3	12	(9)
Sub Total Corporate	**189**	**194**	**(5)**

Grand Total	**5,380**	**5,831**	**(451)**

Type	Subjective Sub category	2022/23	2023/24	Variance
Agency	Medical Staff	1,320	970	350
	Nursing Staff	1,052	1,303	(251)
	Scientific, Therapeutic & Technical Staff	131	139	(8)
	Admin & Clerical Staff	26	10	16
	Maintenance Staff	-	-	0
	Other Staff	- 0	0	(0)
	Support Staff	-	0	(0)
Agency Total		**2,528**	**2,423**	**106**
Bank / Locum	Medical Staff	1,297	1,975	(678)
	Nursing Staff	1,189	999	191
	Scientific, Therapeutic & Technical Staff	32	92	(60)
	Admin & Clerical Staff	194	173	21
	Maintenance Staff	-	-	0
	Other Staff	-	-	0
	Support Staff	139	169	(30)
Bank / Locum Total		**2,852**	**3,408**	**(556)**
Grand Total		**5,380**	**5,831**	**(451)**

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(23)104

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	6 June 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Finance and Estates and Facilities areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives. • The trust ended 2022/23 in a balanced financial position • There remains concern over the level of spending on temporary staffing, as the Trust had spent £0.4million more in Month 1 than last year's Month 1 record level of spending. The Committee recommend a Board level discussion on ways of reducing this spend • The Ventilation systems in the Trust are a significant risk due to age and lack of capital to replace them • Lack of assurance due to lack of funding to address Backlog Maintenance requirements • The Committee have approved the Premises Assurance Model and recommend that the Board approves for submission (see pages 9-18 on appendix 1)	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	

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

HIGHLIGHT REPORT TO TRUST BOARD

Report for Trust Board Meeting on:	6 June 2023
Report From:	Finance & Performance Committee – 19-04-23 and 24-05-23

Highlight Report:

Review of NLaG Month 12 2022-23 Financial position (Finance Report) (SO3.1/SO3.2b)

- The Trust's adjusted performance was a break-even position, although that included a material level of non-recurrent savings and technical adjustments which would not be available to support achievement of the 2023-24 financial plan.

Review of NLaG Month 1 2023-24 Financial position (Finance Report) (SO3.1/SO3.2b)

- Concerns about the level of spend on temporary staffing remain as the Trust spent £0.4million above last year's record level of spend in Month 1. In view of the risk to the achievement of the 2023/24 financial plan, the Committee recommend a Board level discussion on ways of reducing these costs.

Financial and Operational Plan Update

- The Trust's plan includes savings of £35.7million including a £10million challenge which was still to be underpinned. Achieving the financial plan would be dependent on divisions delivering their planned savings and workforce plans.

Recovery Support Program for finance (RSPf)

- The Trust had been offered support to look at ways of improving productivity.
- A meeting was due to take place on 25 May to confirm whether the Trust could exit from the Recovery Support Programme for Finance.

Ventilation

- The average life of a ventilation system is 20 years and 86 of the Trust's units are over 20 years old. Units are being run to failure due to lack of capital funding and other critical infrastructure priorities. To mitigate the risk, systems are being 'over-serviced' in an attempt to keep them running and avoid lost activity due to unit failure. When units failed and could not be repaired, replacements are being hired at a cost of £6,000 per month per unit.

Entonox

- The Trust was acting in response to the new NHSE guidance on the use of Entonox issued on 3rd March 23, including checking ventilation in areas where Entonox is used, assessment of Entonox cylinders and the purchase of personal monitoring devices to record exposure, which was likely to require capital funding

Backlog Maintenance

- The Trust Backlog Maintenance is a high-level risk for the Trust and no assurance can be given against a major infrastructure failure in the future due to aging equipment and estate.

Premises Assurance Model

- The model has been completed for the 7th year and the Committee have approved and recommend that the Board approves for submission (see pages 9-18 on appendix 1).

Confirm or Challenge of the Board Assurance Framework:

The Committee reviewed the Board Assurance Framework and agreed the current risk and the future planned risk for Strategic Objectives 1-1.4 and 3-3.1.

Action Required by the Trust Board:

The Trust Board is asked to note the key points highlighted above and to consider a Board level discussion about ways of reducing the level of spend on agency staffing.
The Board is also requested to approve the Premises Assurance Model for submission.

Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

Appendix 1

Premises Assurance Model

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Number: 9.1

Name of the Meeting	**Finance & Performance Committee**
Date of the Meeting	24 May 2023
Director Lead	Jug Johal – Director of Estates and Facilities/Health Inequalties Lead
Contact Officer/Author	Mark Edgar (BLM) and Ron Gregory (PAM)
Title of the Report	Backlog Maintenance (BLM) and Premises Assurance Model (PAM)
Purpose of the Report and Executive Summary (to include recommendations)	**BLM -** This report provides the Finance and Performance Committee with an update on the Estates and Facilities Back Log Maintenance programme delivered in 2022/23 and outlines the 2023/24 programme. **PAM –** To present to Trust Board representatives the 2022/23 end of year E&F PAM report, noting no inadequate (red) ratings this year. Key areas for improvement are our Policy and Procedure, Risk Assessment, Maintenance, and EPRR.
Background Information and/or Supporting Document(s) (if applicable)	PAM – is a NHSe mandated and standardised compliance assurance system for all E&F divisions to complete and submit online their judgements.
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 P 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)	**BLM:** The committee is asked to note the report, in particular the capital BLM spend for 2022-23 and the draft BLM programme for 2023-24. **PAM:** Capital investment required for water and ventilation systems

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

Section A

Estates and Facilities

Backlog Maintenance Report 2022-2023

1.0 Aim

This report provides an update for the Finance and Performance Committee on the Estates and Facilities Back Log Maintenance Programme delivered in 2022/23 and outlines the plans for 2023/24.

2.0 Estates & Facilities Assurance Model

The E&F directorate provide assurance with the following tools:

- Formal governance meeting structure: there are meetings that cover all the estates specialist systems which report into the E&F Governance Group. E&F Governance Group has oversight of all risks including a monthly review/update of the E&F related Board Assurance Framework (BAF) risks. The table below details the E&F risks that are on the BAF and the latest E&F BAF is included as Appendix A. BLM Capital Group has full oversight on delivery of the BLM programme.

Narrative: Strategic Objective 1 – 1.4 Risk	**Score**
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.	20

- Risk Register: E&F has a number of risks on the Trust's Risk Register. These are reviewed monthly by the Deputy Director of E&F and the Head of Safety and Statutory Compliance. Oversight of all the risks is by the E&F Governance Group. A copy of the current E&F Risk Register is included as Appendix B.

- Authorising Engineers (AEs): these are external specialist engineers that are appointed to offer independent advice to the Trust. The AEs carry out audits, normally one per year per site, and recommend APs for appointment.

- Staff Compliance Framework: this lists all the AEs, Authorised persons (APs) and Competent Persons (CPs) for each engineering specialist and is included as Appendix C.

- PLACE assessments: these assessments feed into the NHSI Model Health platform and aid the identification and updating of risks to the patient environment.

- Estates Return Information Collection (ERIC): the national mandatory annual return that feeds into the Model Health platform and enables the E&F Directorate to understand costs to provide services and benchmark against similar organisations.

- NHS Premises Assurance Model (PAM): The NHS
  PAM is a management tool designed to provide a standardised approach to evaluating NHS premises performance against a set of national indicators, and provide NHS Boards with assurance on the management of their premises. Additionally, this assessment also ensure premises-related performance improvements are driven throughout the system and ensure a greater understanding of the vital role that premises play in the delivery of improved clinical and social outcomes.

  The latest 22/23 PAM report is included with this Paper as a separate document under Section B.

- NHSI Model Health platform: this is a benchmarking platform that supports the NHS to provide the best patient care in the most efficient way. This is a free digital tool provided by NHS Improvement that enables trusts to compare their productivity and identify opportunities to improve. It is a database for PLACE and ERIC information to be held and analysed to facilitate benchmarking against other NHS acute providers both nationally and regionally.

3.0 Backlog Maintenance (BLM) Programme 2022/23

3.1 The BLM is developed using the following information:

- Estates Strategy
- Risk Register
- External '6 Facet Survey' report
- Roofing surveys [inspections; thermal scans; core samples]
- NHSI Model Health
- Authorising Engineer audit reports
- External validation reports e.g. theatre ventilation test results
- Clinical scheme priorities
- Results of Planned Preventative Maintenance (PPM)
- External Engineering Inspection Reports e.g. lift service contract
- Authorised Persons professional knowledge of hospital site and associated engineering systems.

3.2 At the start of the 22/23 FY, the funding available for the BLM programme was **£1.83m**. This was increased to include Fire Alarm Replacement at SGH, funding for Chillers and funding for Fire Door Replacement, bringing the overall total to **£5.9m.**

3.3 The delivered 2022/23 BLM programme is summarised below:

DPoW Fire Alarm Strip-Out	£164,400
SGH Fire Alarm Replacement	£3,110,681
SGH CIR Water Infrastructure	£945,621
DPoW CSSD Substation Design	£17,030
DPoW Medical Air Desiccant Filter	£26,923
DPW C3 Saniflow System	£10,032
DPW Boiler Feed Pipework	£93,173
GDH Generator Control Panel	£7,325
SGH Endoscopy Chiller Replacement	£58,581
SGH & GDH Chiller Replacement	£359
DPoW Oxygen Phase 3	£298,538
DPW Oxygen Phase 4	£104,513
SGH DNO Connection	£60,983
SGH Ward 26 Flooring	£48,897
Trustwide Fire Door Survey	£351,784
PSDS	£481,110
Disabled Access SGH	£4,311
Chiller Replacement DPoW	£129,131
TOTAL	**£5,913,392**

3.4 The Trust provides a Capital to Revenue allocation to cover minor items, survey work and feasibility studies. Those in 22/23 are listed below:

6-Facet Survey (including roof survey)	£13,921
Micad systems consultancy implementation	£83,872
TOTAL	**£97,793**

4.0 BLM Programme 2023-24

4.1 The draft BLM Programme for 23/24, along with funding allocated, is as follows (subject to approval of CIB):

BLM Funding (CIR Water; CSSD1 S'Stn DPoW)	£415,000
Theatre UPS	£160,000
Theatres TIF	£200,000
SGH Fire Alarm Replacement	£2,200,000
Disabled Access	£50,000
TOTAL	**£3,025,000**

4.2 The £415,000 allocation is reserved initially for CIR Water Infrastructure. When concluded, the remaining funds will be allocated to DPoW CSSD substation, with the remainder required for completion of the substation to be requested from the 2024-25 BLM programme.

5.0 Conclusion

This report provides details on how BLM funding was spent in 2022-23 and outlines the draft BLM programme for 2023-24.

6.0 Recommendations

The committee is asked to note the report, in particular the capital BLM spend for 2022-23 and the draft BLM programme for 2023-24.

Apendices:

- Appendix A: E&F BAF.
- Appendix B: E&F Risk Register.
- Appendix C: E&F Staff Compliance Framework.

Section B

Estates and Facilities
Premises Assurance Model 2022-2023

End of Year Report

Contents

Purpose

The purpose of this report is to provide an end-of-year summary of the main findings of completing the mandatory NHSE 2022/23 Premises Assurance Model (PAM), which is required to have Trust Board oversight/sign off.

Background Information

Regulated by NHSE, the PAM is a national, mandatory standardised approach to self-assessing assurance levels within Estates & Facilities[1]. Through the coordinated engagement with both internal and external stakeholders, there are six domains comprising of 47 self-assessment questions that provide the assessment structure:

1. Safety Hard (Estates) - x19 assessment categories
2. Safety Soft (Facilities) - x10 assessment categories
3. Organisational Governance - x3 assessment categories
4. Patient Experience - x6 assessment categories
5. Effectiveness - x4 assessment categories
6. Efficiency - x5 assessment categories

Additionally, there are a small number of new sections for 2022-23 of the assurance model which specifically look at:

- Helipad (N/A for NLaG)
- FM Maturity (optional this year, but expected to be mandatory in future)
- Contacts for focus areas (Food, Medical Gas, board representative)

Contained within each domain are:

- Self-assessment questions (SAQ's) which are answered through a series of sub-questions based on NHSE set criterion.
- National Metrics: a standardised method of determining levels of adherence to healthcare and government legislation requirements with regards to Estate and Facilities. The judgement metrics are: *Outstanding, Good, Requires Minimal Improvement, Requires Moderate Improvement, Inadequate, Not Applicable.*

[1] Although categorised as *Estates and Facilities* departments/services are assessed which do not sit within Estates and Facilities in the structure of NLaG.

NLaG was one of the first voluntary adopters of PAM and for the past 7 years, NLaG's Estates and Facilities Directorate has actively engaged in the PAM self-assessment process with the E&F Safety and Statutory Compliance team facilitating the process. Additionally, the Trust is represented at a national level consulting every quarter at the NHSE Premises Assurance Model development steering group.

The PAM programme has only recently become a mandatory requirement - appearing for the first time in the 2021 NHS Standard Contract.

Northern Lincolnshire and Goole NHS Foundation Trust's PAM Model

NLaG's annual self-assessment commences each September and concludes at the end of March in the following calendar year. The period between April and August enables internal and external reporting to be completed.

The existing model has been presented previously, and is deemed suitable for the organisation, resulting in transparent and credible assurances.

This model was devised to best utilise the significant resources required to complete a 360° self-assessment. Therefore, a full stakeholder review is conducted every other year with a management desk-top review being carried out in the interim years.

Inherently, the self-assessment process is a subjective process therefore, underpinning this process is an annual programme of internal auditing activities conducted by the E&F Safety and Statutory Compliance team. Utilising the PAM Safety Hard (Estates) and Safety Soft (Facilities) self-assessment categories; a risk-based approach is employed to direct auditing activities to maximise targeted resource allocation. The primary objective is to determine assurance levels from suggested evidence provided by Estates and Facilities departments as to their justifications of:

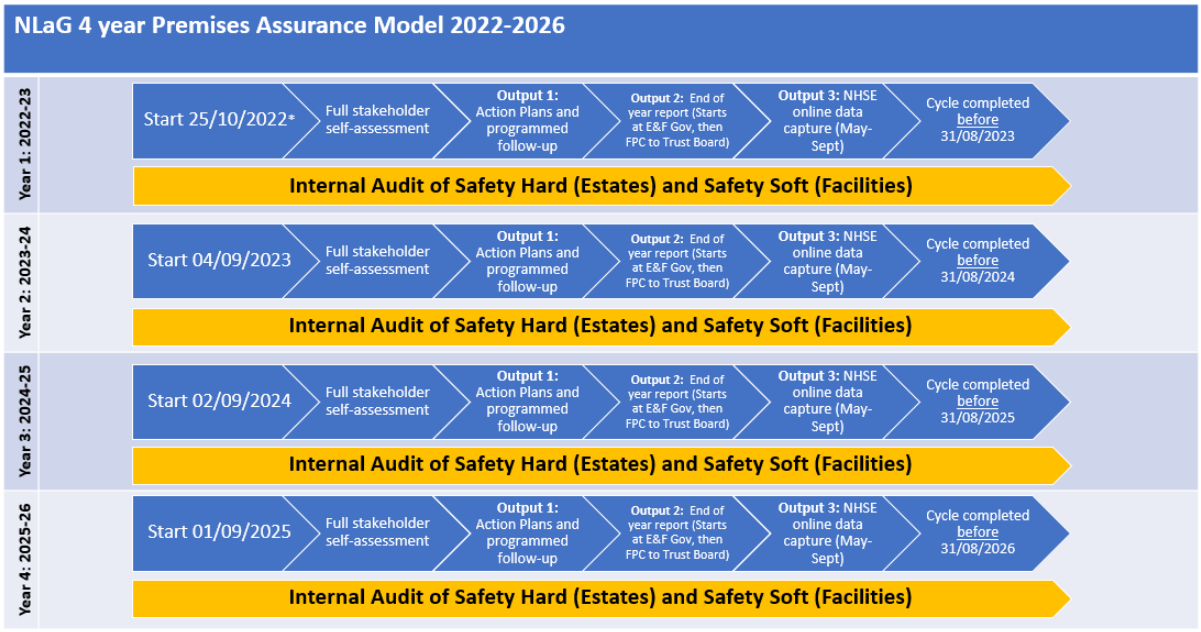
- Not Applicable
- Inadequate *(red)* [<45%]
- Requires Moderate Improvement *(amber)* [45-65%]
- Requires Minimal Improvement *(yellow)* [66-85%]
- Good *(green)* [>85%]
- Outstanding *(blue)* [100%]

Additionally, national guidance such Health Technical Memorandums (HTM) and Trust policy requirements also inform the audit scope for their operational accuracy. Findings of internal audit reports are summarised each month at the E&F Governance meeting group along with PAM completion progress as well as the progress made against improvement actions that are identified from each self-assessment session.

As the PAM is near the end of the 5th year of the current model and upon review, the delivery model is assessed as fit for purpose and delivers a meaningful self-assessment within the confines of the national mandated process.

The future plan for PAM is represented in Table 1, below, represents the next four year period of the PAM delivery model (year's 2022 to 2026).

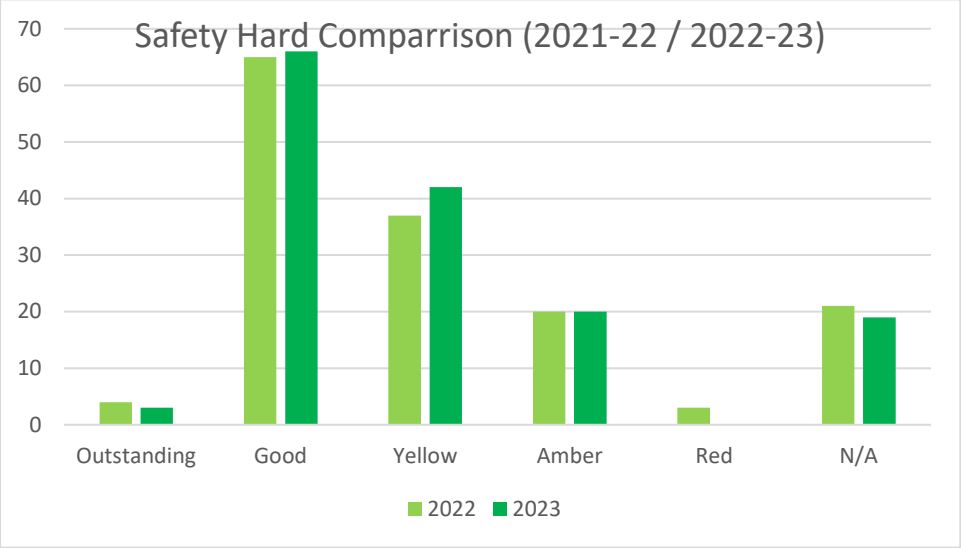
Table 1 *NLaG PAM 4 Year Cycle 2022 – 2026*

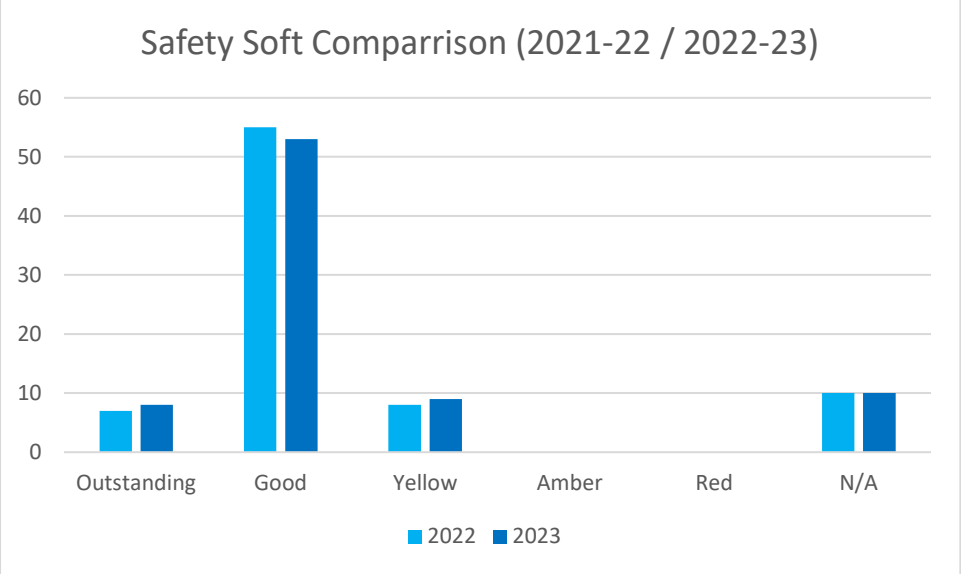


2022/23 Estates and Facilities PAM Summary of Findings

The charts below captures the end of year comparisons that visually represents the judgements for the E&F primary service provision (Hard and Soft FM) domains of Estates and Facilities against each standardised question set. Appendix 1 provides the full data capture for each domain.

Graphical illustration of the displacement of judgements for both Estates (SH1 to SH19) and Facilities (SS1 to SS10).





	Policy	R & R	RA	Maint	T&D	EPRR	Review	*Average*
SH1	2	2	3	4	2	3	2	***3***
SH2	2	2	2	4	2	3	2	***2***
SH4	2	2	3		3	2	2	***2***
SH5	2	2	3		2	2	2	***2***
SH6	4	3	3	3	3	4	2	***3***
SH7	2	2	2	3	2	4	3	***3***
SH8	3	2	4	4	2	3	2	***3***
SH9	3	4	3	4	2	4	2	***3***
SH10	2	3	3	4	3	4	2	***3***
SH11	3	2	3	3	2	3	2	***3***
SH12	2	2	2	2	2	2	2	***2***
SH13	4	2	4	3	2	3	2	***3***
SH14	3	4	3	4	3	4	3	***3***
SH15	3	2	3	4	2	2	2	***3***
SH16	3	1	2	3	2		2	***2***
SH17	2	3	3		4	4	2	***3***
SH18	1	1	2	3	2	3	2	***2***
SH19	2	2	2	2	2	2	2	***2***
Average	***3***	***2***	***3***	***3***	***2***	***3***	***2***	

	Policy	R & R	RA	Maint	T&D	EPRR	Review	*Average*
SS1	3	2	3	3	3	2	2	***3***
SS2	2	2	2	2	2	2	1	***2***
SS3	3	3	2	2	3	2	2	***2***
SS4	2	1	3	2	2	2	1	***2***
SS5	2	2	2	2	1	2	2	***2***
SS6	2	2	2	2	2	2	2	***2***
SS7	1	3	2	1	1	1	2	***2***
SS8	2	2	2	2	2	2	2	***2***
SS9	2	2	2	2	2	2	2	***2***
SS10	2	2	2	2	2	2	2	***2***
Average	***2***	***2***	***2***	***2***	***2***	***2***	***2***	

Key Considerations

- Water; move from inadequate to requires moderate improvement.
- E&F has a mature existing governance reporting structure that runs alongside the Premises Assurance Model. To avoid reporting duplication any costed

improvement action plans that require capital investment follow the Trust reporting financial / capital request systems.

- The new National Standards for Healthcare Cleanliness[2] and National Standards for Healthcare Food and Drink[3] have impacted upon Safety Soft scores, as anticipated, but these are minor and reflect the work being done to assess and implement fully.
- There is a NHSE mandatory requirement to record the Trust's self-assessment judgements on a national online data capture system.

Areas of Good Practice

- Continued strong presence of sector policies with robust document control oversight throughout E&F.
- Dedicated mandatory and statutory training provision with a specific E&F training budget that ensures compliance regarding regulatory Authorised and Competent Persons training / compliance requirements.
- Mature review process and monitoring processes across all sector specialisms supported by dedicate E&F internal auditing programme and risk and governance provision.
- Continued robust management process pertaining to the identification and reviewing of strategic risks.
- Established Facilities structure in all sectors which brings with it a deep understanding of processes and the necessary expertise to effectively implement.
- Established Facilities procedures providing standardised consistency in application of duties.
- Excellent commitment demonstarted by all internal stakeholders towards the Trusts' startegic service provision.
- The following areas had a theme of *Good* in the Safety Hard domain:
    - Roles and Responsibilities
    - Trainign and Development, and
    - Review process
- All themes[4] in the safety domain were assessed as *Good*.

[2] National Standards Cleanliness 2021
[3] National Standards for Healthcare Food and Drink
[4] Policy and Procedure; Roles and Responsibilities; Risk Assessment; Maintenance; Training and Development; EPRR and Review Process.

Key Areas for Improvements

- The following areas had a theme of requiring improvement in the Safety Hard domain:
  - Policy and Procedure
  - Risk Assessment
  - Maintenance, and
  - EPRR
- Maintenance[5] saw a theme of *Requires Improvements*; this anecdotally is cited as being due to a lack of staff, against the backdrop of an aging estate, with an increasing M^2 footprint. The evidence to support the *Requires Improvement* assessments is that there are a number of asset reviews being undertaking in most engineering disciplines. Once asset reviews are concluded, then Planned Preventative Maintenance (PPM) schedules will be reviewed. The outcome of the Asset and PPM reviews are that there will be a measurable metric to support the suggestion that there may be insufficient labour resource in the Estates departments.

Conclusion

Completed in isolation of any verification process, the very nature of self-assessment is a subjective process at best. However, the E&F Compliance and Statutory Compliance team act independently of the Estates and Facilities departments and offer an impartiality that challenges the validity of the assessment judgements as part of the validation and auditing process. There is therefore a level of assurance that standardisation across all Self-Assessment Questions (SAQs) due to standardisation provided by the facilitators; some of whom are either actively, or recently involved with other Trusts' PAM process.

The Facilities department and its 'soft' services continue to benefit from longevity of key roles being in post for a sustained period, bringing with them the accompanying knowledge and experience. There is a clear overall judgement of 'Good' assurance levels across the Facilties provision.

Below are the reports recommendations for improvement with supporting estimated completion timescales:

Recommendations

- Complete the current implementation of a Trustwide Estates asset data-capture to improve asset management and maintenance with progressmonitored through the Estates meeting structure ***(action continued from previous reports)***
- Assign PPMs to all Estates Assets, to ensure compliance with statutory obligations.

[5] Are assets and plant adequately maintained?

- Create comprehensive suite of Standard Operating Procedures (SOPs) for all engineering disciplines. Water SOPs have recently been reviewed, however some areas, such as MGPS's remain in need of attention[6].

Ron Gregory
Head of Safety and Statutory Compliance

Appendix:

Premises Assurance Model SAQ

Appendix D

[6] SOPs feature at safety groups/sub-groups for oversight.

Appendix A

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

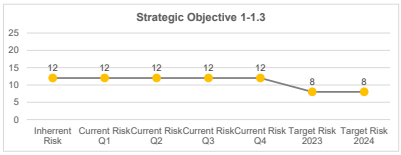
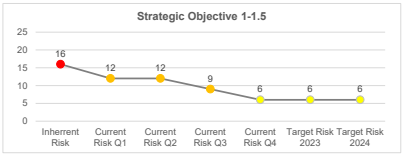
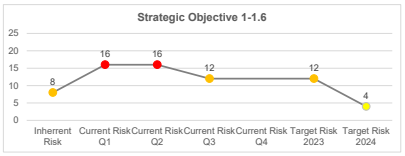
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity 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	5
Likelihood	3	3	3	3	3	3	3	2
Risk Rating Score	15	15	15	15	15	15	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: March 2023, 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
Birthrate plus review	Q2 2024 Q2 2022/23	Amber
Audit of stop and check safety huddle compliance	Q3 2022/23	Green
Business case completed for Transition post	Q3 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 community settings continue	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 Business Planning		
Review policy and embed supportive observation	Q4 2022/23	Amber
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 for the newly proposed LPS in	Q4 2022/23	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green

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 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 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
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

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
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
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
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
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
Validation of all RTT Clock Stops back to 100%	Q4 2022/23	Amber

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 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3145, Ageing and Damaged ENT Theatre Kit, patients on 31/62 and routine pathways being cancelled = 8 (previoously 16, reduced on 27-02-2023)

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	4	4	4	4	4
Likelihood	3	3	3	3	3	2	2	2
Risk Rating	12	12	12	12	12	8	8	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 Apriil 2023, 21 February 2023, 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 Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC, 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 (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
• Draft report from Clinical Senate review 2 (due end July 22)	Q1 2022/23	Blue
• 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	Blue
• CIC / SDC / NED / Governor reviews	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
• Clinical Senate Final Review (scheduled 27 Feb 23)	Q4 2022/23	Blue
• Citizens Panel reviews	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
• To undertake continuous engagement process with public and staff	Q1 2023/24	Green
• Stakeholder Mapping	Q1 2023/24	Green
• Public Consultation	Q2/Q3 2023/24	Green
• NHSEI Gateway review	Q4 2023/24	Green
• ICB Executive Assurance Board / ICBoard Approval	Q4 2023/24	Green
• Final report from Clinical Senate review (due Q1)	Q1 2023/24	Green
• HAS Risk Workshop with ICB Executives (18 April 23)	Q1 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

Appendix A

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	5	5	5	5	5	5	5	5
Likelihood	4	4	4	4	4	4	4	4
Risk Rating	20	20	20	20	20	20	20	20

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: April 2023, January 2023, October 2022, July 2022, 12 April 2022, 11 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
• Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
• Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
• ~~Continue~~ Completed Backlog Maintenance programme fiscal year	Q4 2022/23	Blue
• Complete~~d~~ Core Capital Programme	Q4 2022/23	Blue
• Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24Q4 2022/23	Red
• ~~Clear~~ Completed Ward 25 defects	Q4 2022/23	Blue
• ~~Start~~ Commenced refurbishment of SGH ED (completion end of Q3)	Q3 2023/24 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, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
- Grimsby 21% CIR of the BLM
- Goole 11% CIR of the BLM
- Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance: ~~Coronation block~~ Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
~~No 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~~ 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk				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	3	3	3	3	3
Likelihood	4	3	3	3	2	3	2	2
Risk Rating	16	12	12	9	6	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: April 2023, January 2023, October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Audit, Risk and Governance Committee

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Strategy and Development Committee
- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:
- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:
- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Significant Assurance, 2021

Positive Assurance:
- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Significant Assurance, 2021

Planned Actions

Action	Quarter / Year	Assurance
Completed Conclude IT BC / DR Programme initiation with Gap Analysis report outline required vs. current capabilities approved at Digital Strategy Board in March 2023.. to be provided for Digital Strategy Board in Q4 22/23.(extended from 30 April 2022) DSPT Ref: IA-20724	Q4 2022/23	Blue
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23. Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (Q4 22/23)	Q3 2023/24 Q4 2022/23	Yellow
IPR - further review of current IPR for adding Digital, Finance and Estates KPI. S, Review in April 2023 (this may be deferred) - report to the Board, defer being put into IPR, Divisional IPRs being developed.	Q1 Q3 2023/24	Yellow
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	Q1 2023/24	Green
The Data Warehouse with core activity data sets will be completed and running on the new platform by May 2023 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q2 2023/24 Q1 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q1 2023/24	Green
Completed IT Business Continuity Policy and Procedure	Q1 2023/24	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 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- 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

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16
- No 3095, Data Safety Risk - Delay to patient testing = 9 (previously 16, reduced on 15-02-2023)

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk				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	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
Winter Planning for 2022/23	Ongoing	Green
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
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 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

- No 2562, Constitutional A&E targets = 20

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

Lead Committee: Workforce Committee

Last Reviewed: January 2023, 14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

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
Development and Sign off of Performance Metrics to support roll out of Leadership Strategy and Culture Transformation	Q2 2022/23	Yellow
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 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment

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

Last Reviewed: 9 January 2023, 19 July 2022, 18 May 2022, 31 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2022/23
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSE
- Internal Audit Reports - Internal Control - significant assurance

External:
- Financial Special Measures Meeting - Letter from NHSE related to financial special measures and achievement of action plan
- Approval received at ICS Level for 2022-23 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2022/23

Planned Actions

Action	Quarter / Year	Assurance
Work with system partners, specifically community and local authorities to ensure that our local systems are working in unison to tackle the issues of system flow	2022/23	Green
Agree financial recovery plan to meet 2022/23 year-end target	Q4 2022/23	Green
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

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
No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20

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	5
Likelihood	3	3	3	3	3	3	3	3
Risk Rating	15	12	15	15	15	15	15	15

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 April 2023, 21 February 2023, 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 - HAS Assurance Reviews
- NHSE Financial Speciall Measures Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE attendance at AAU / ED Programme Board
- NHSE Assurance Review Feedback
- CiC Minutes

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Green
Agree forecast spend for current year as part of wider ICS capital planning exercise	Q4 2022/23	Green
Develop strategic capital plan as part of comprehensive service planning exercise - to be completed by end March 2023	Q4 2022/23	Green
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
Present Strategic Capital to Joint Trust Board 4 April 2023)	Q1 2023/24	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	4
Likelihood	3	3	3	3	3	2	2	2
Risk Rating	15	12	12	12	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 April 2023, 21 February 2023, 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 Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)

Assurance (internal & external)

Positive:

- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process

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 (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Action	Quarter / Year	Assurance
CIC / SDC / NED / Governor reviews	Q4 2022/23	Green
Citizens Panel reviews	Q4 2022/23	Green
Clinical Senate reviews (final review held 27 Feb 2023)	Q4 2022/23	Blue
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
HAS Programme:		
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Green
Clinical Senate Final Report due Q1	Q1 2023/24	Green
Stakeholder Mapping	Q1 2023/24	Green
To undertake continuous process of stocktake and assurance reviews	Q1 2023/24	Green
NHSE and Clinical Senate review		
Joint OSC - reviews	Q1 2023/24	Green
NHSE Gateway review	Q1 2023/24	Green
ICS Board approval	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
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
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	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

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
- HAS

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

Appendix B

Risk Register Confirm & Challenge Appendix Full Listing

Northern Lincolnshire and Goole NHS Foundation Trust

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
1620 v.4	08/01/2013	Med Gas: Medical Gas Pipeline System, Mark 4 bedhead terminal outlets - Trustwide There is a risk of losing bed head medical gases due to Mark 4 medical wall terminals outlets (Oxygen, Vacuum Medical Air, Nitrous Oxide) being obsolete with limited spare parts due to damage caused through clinical activity. The loss of medical gas pipeline behind the bedhead terminal outlets at SGH & GDH, could result in loss of oxygen supply and suction ability to an entire ward for an extended period time.	5 x 4 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Risk reviewed, no further update.	31/03/2023

Controls In Place

Ongoing monitoring of alarms.

National supplier support (cylinders) for business continuity.

Replacement in line with ward upgrades.

DCR043 - Procedures for the Management of Medical Gases.

3-yearly clinical staff training.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Any new ward upgrades to be fully compliant with HTM 02-01	James Lewis		16/11/2021	31/03/2024	/ /
Buy new equipment as part of ward upgrades and wider med gas infrastructure	James Lewis	Ward upgrades provide new med gas equipment. DPoW VIE works also providing med gas vacuum pump replacement Date Entered : 03/03/2022 15:11 Entered By : James Lewis	/ /	31/03/2024	/ /

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
1774 v.1	05/06/2014	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.	4 x 4 = 16	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Risk reviewed, no further update.	01/11/2023

Controls In Place

Emergency generator fitted with own fuel supply.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Emergency generator fitted with own fuel supply.	James Lewis	Funding for these works are part of the FY 22/23 Capital bid. Date Entered : 01/02/2022 11:05 Entered By : James Lewis	16/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
1891 v.1	25/09/2015	Med Gas - Access to Medical Gases Storage Facilities - Trustwide Three incidents of theft of medical gas cylinders. Potential for future incidents - the Health and Safety Executive would be involved if the usage of the cylinder or gas causes injury or death, the Trust may be subject to legal action around any failings in the safe and secure storage of cylinders.	4 x 1 = 4	⇔	James Lewis Simon Tighe	09/09/2023	02/03/2023 Keith Leech Risk reviewed. Remains as is.	01/11/2023

Controls In Place
Increased padlocks and deadlocks added to existing boards.
SGH - Installed palisade fence
Additional security rounds.
Upgraded CCTV camera.
All external doors replaced with steel lockable doors on the medical gas plant rooms.

Action Description	Staff Responsible	Progress	Start	Target	Completed
No actions, as current key controls are deemed sufficient at present.	James Lewis		01/02/2022	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2035 v.1	22/08/2016	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.	4 x 4 = 16	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Risk reviewed, no further update.	01/11/2024

Controls In Place

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.

Lifts inspected daily as part of planned preventative maintenance (PPM) regime.

Pink Rose lift is serviced to current standards.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Regular inspections of external areas undertaken by estates staff as part of PPM regime.	James Lewis	Pot hole repairs are picked up and actioned as they arise. Date Entered : 01/02/2022 11:14 Entered By : James Lewis	01/02/2022	31/03/2024	/ /
In order to mitigate this risk significant funding is required. At present this is balanced on risk with competing priorities and limited BLM funding.	James Lewis	The 5 year BLM plan captures planned costs to mitigate elements of this risk. As this is based on operational estates risks, the plan has to remain fluid. Date Entered : 01/02/2022 11:17 Entered By : James Lewis	01/02/2022	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2036 v.2	22/08/2016	Ventilation and Air Conditioning - HVAC - Trustwide There is a risk of failure of the heating and ventilation system due to aged infrastructure resulting in a negative impact on the effective delivery of patient care and pose a risk to the Trusts elective recovery plan in critical areas; theatres, ITU etc…	5 x 3 = 15	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis DPoW; Theatre refurbishment complete. GDH; Theatre chillers - work complete. SGH; Temporary chillers in place. Plans to replace theatre chillers delayed until Financial Year 24/25 due to financial limitations.	31/03/2024

Controls In Place

Planned preventative maintenance (PPM) in place for inspection and maintenance of all ventilation plants.

External specilaist contractor support and inspections - 6 monthly.

Fire detection system

Ducting Survey

Theatre ventilation checks and Monthly particulate tests.

Johnson controls replaced with refurbishments

Theatre 7 & 8 and Theatre A upgraded middle of the Financial Year 23/24.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Re-active maintenance. Delivery of temporary chiller units are available.	James Lewis		16/11/2021	31/03/2024	/ /
Funding has been allocated for FY 22/23 to target some key A/C unit replacement across the trust. This will upgrade some key risk areas.	James Lewis		03/10/2022	31/03/2024	/ /
Ventilation matrix which provides the Air Changes per Hour (ACH) is a live, maintained document whcih tracks the ACH of all Ventilation plant across the trust.	James Lewis	This document is factual and contains a risk based evaluation carried out by IPC. Vent plant are rebalanced on an area priority requirement basis. Date Entered : 01/02/2022 12:12 Entered By : James Lewis	01/02/2022	30/06/2023	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2038 v.2	23/08/2016	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.	5 x 4 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Fire door inspections complete. Remedial work ongoing. Addressing key issues at SGH. SGH work ongoing.	31/03/2023
Controls In Place								
Panels are being replaced. DPoW ward replacement programme includes updated detection loops.								
Drawings being reviewed and the information is to be transferred onto CAD system								
Fire door asset list in complete.								

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2088 v.3	04/11/2016	Building Management Systems (BMS) Controller failure/upgrade There is the risk of failure of elements of the Building Management Systems (BMS). The BMS is the trusts advanced warning system which adjusts and controls the sites ventilation, heating and hot water services, therefore, temperature control of both the hospital environment and water systems could become significantly compromised.	4 x 5 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis SGH; Upgrade of controllers ongoing. GDH; work complete. DPoW; no further update.	31/03/2024

Controls In Place
Continued monitoring of the system for operation (by Estates Staff).
Replacing old controllers (as they fail) with new technology using open protocol or equivalent systems which integrate with systems on the market (future proofing).
Replacement of equipment will be expedited against specific projects or when areas comprising building services are upgraded.
Recently tested the concept of installing Continuum on a windows 10 PC which was successful, following this, 7 replacement PCs (3 DPoW and 4 SGH) have been requested.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Replace the systems for a more robust, reliable common trustwide platform.	James Lewis	EPC funding now not available. BMS replacement now part of FY 22/23 Capital bid Date Entered : 01/02/2022 12:26 Entered By : James Lewis	16/11/2021	31/03/2024	/ /

Risk Register Confirm & Challenge Appendix Full Listing

Northern Lincolnshire and Goole NHS Foundation Trust

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2200 v.2	20/04/2017	Door entry/intercom system - Trustwide If door security systems fail, this could lead to vulnerable patients being able to "wander" around and out of the hospital. It could also lead to an aggressive patient gaining access to other patients and staff leading to possible to harm to individuals.	4 x 1 = 4	⇩	James Lewis Simon Tighe	10/11/2023	28/04/2023 James Lewis Risk reviewed, no further update.	31/03/2024

Controls In Place

Maintenance attends in a fault or failure to attempt to get the system back on line.

Proximity readers are being installed when equipment is being replaced.

ESR now allocating ID cards with proximity readers.

Upgrades happen in line with ward upgrades which include changing from swipe to proximity sensor.

Security Officers can attend incidents in a reactive role.

System failsafe ie doors unlock.

Security are on site 24/7, 365 days per year.

Action Description	Staff Responsible	Progress	Start	Target	Completed
System failsafe ie; doors unlock.	James Lewis		22/02/2022	31/03/2024	/ /
Installation included as part of ward/area upgrades.	Mark Edgar		22/02/2022	30/06/2023	/ /
Site wide standardisation of door access system limied to IT network	James Lewis		22/02/2022	31/03/2024	/ /
Security cover all sites 24/7, 365 days per year.	Keith Fowler		16/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2212 v.1	04/05/2017	Nurse Call System - Trustwide Nurse call system not working will prevent a patient or member of staff raising the need of help from the ward teams, which could lead to deteriation in patient care and/or staff safety. It would also mean that clinical teams would need to "patrol" the ward areas.	4 x 3 = 12	⇔	James Lewis Simon Tighe	03/06/2023	28/03/2023 James Lewis Exploring HTM compliant portable nurse call system.	31/03/2023

Controls In Place

Temporary replacement system at each site can be deployed however there are limitations to their use.

Hold a limited number of replacement handsets.

Long term replacement plan as part of BLM.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Emergency wireless system can be installed at short notice.	James Lewis		22/02/2022	31/03/2024	/ /
Intentional rounding.	James Lewis		22/02/2022	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2216 v.1	08/05/2017	Labour Management System Help Desk - Trustwide The risk is that estates maintenance and help desk could fail with planned and reactive maintenance tasks being missed affecting the patient environment, or support functions.	4 x 3 = 12	⇔	James Lewis Simon Tighe	10/07/2023	28/04/2023 James Lewis Order placed for Zetasafe asset management system. Meeting held 24.04.23 - work ongoing.	31/03/2024

Controls In Place

Service desk help support

Action Description	Staff Responsible	Progress	Start	Target	Completed
New CAFM system being implemented	James Lewis	Full asset review underway linked to implementation of new CAFM system, expected completion mid 2022. Date Entered : 01/02/2022 12:34 Entered By : James Lewis	01/02/2022	31/03/2024	/ /

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2272 v.1	25/09/2017	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.	4 x 4 = 16	⇔	Keith Fowler Simon Tighe	10/06/2023	28/04/2023 Keith Fowler Risk reviewed, no further update.	31/03/2024

Controls In Place

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

Action Description	Staff Responsible	Progress	Start	Target	Completed
Minor works completed by estates team as and when required.	James Lewis		16/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2285 v.4	03/11/2017	Bed Replacement Plan - Trustwide Failure/deterioration/end of life of hospital beds. Risk is to patients and staff users of failing components/parts which could result in injuries such as entrapment, falling, impact or resulting in sharp edges.	4 x 1 = 4	⇩	Bill Parkinson Bill Parkinson	06/06/2023	05/12/2022 Bill Parkinson Bed replacement plan ongoing, with some new beds on order.	/ /

Controls In Place

Ad hoc repairs undertaken when failures identified.
Planned preventative maintenance conducted on all models and type of asset.
A maintenance programme is in place to support and a replacement programme for all assets.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Capital Equipment Programme Group monitor beds spend on a monthly basis.	Bill Parkinson		/ /	30/06/2023	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2464 v.1	14/01/2019	Trust's Estates alarms being effectively covered - Trustwide As a result of switchboard staff not being available to cover a lone worker shift* in the event of a non planned staff absence, there is a risk that the estate's service alarms will not be reacted to which could result in a defect/fire/alarm not being rectified/actioned appropriately leading to loss of clinical services e.g. heating, ventilation etc and financial loss. The main boiler house at DPoW must be legally monitored 365 24/7, if this is not maintained the Trust is in breach of statutory law. *16:30 - 08:30 and all weekends/bank holidays	4 x 3 = 12	⇔	James Lewis Simon Tighe	10/07/2023	28/04/2023 James Lewis Flow chart process Switchboard/Estates formalised and in place.	31/03/2024

Controls In Place

SGH
Most of the switchboard staff are part time therefore many are on the Bank so it is more likely that a shift can be covered.

IT Service Delivery Coordinator (1 person) is partly skilled (but safe) to cover DPOW if needed but not always available outside of their normal working week. This is at the standard cost as member is on bank.

SGH Boiler House Alarm is monitored remotely.

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2538 v.1	15/07/2019	Non compliant with the Medium Combustion Plant Directive (MCPD) - Trustwide From December 2018, the Medium Combustion Plant Directive requires all new boilers rated between 1 and 50 MW to comply with strict new emission limits for NOx, SOx and particulates. The MCPD will also affect existing plant from 2025 or 2030 depending on size. The Trust is required to comply with this legislation / register with the environmental agency authorised if necessary to obtain a permit under "The Environmental Permitting (England and Wales) (Miscellaneous Amendments) Regulations 2018". Failure to comply could result the Trust being fined for non-compliance.	2 x 5 = 10	⇔	James Lewis Simon Tighe	03/06/2023	28/03/2023 James Lewis Risk reviewed, no further update.	/ /

Controls In Place

Estates are currently investigating the requirements to comply with these new regulations and the financial impact to the Trust.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Currently none, capital funding will need to be made available once the costs are fully understood. The implementation date will need to be monitored.	James Lewis		16/11/2021	31/03/2024	/ /

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2623 v.2	23/10/2019	Failure of windows - Trustwide There is the risk of patient harm due to failing aged windows and window restrictors supported by DoH Alert EFA/2013/002. Many of the windows are the original windows installed (in excess of 40 years) and do not meet HBN 00-10 Part D: Windows & associated hardware requirements, which is retrospectively applied.	5 x 4 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Risk reviewed, no further update.	31/03/2024

Controls In Place
Periodic planned maintenance.
Service user notifications.
Replacement of windows as part of ward/area upgrades.
PLACE & 15 Steps Audit

Action Description	Staff Responsible	Progress	Start	Target	Completed
Reliance on items within assurance control and replacement of windows	James Lewis		16/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2655 v.4	12/12/2019	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers Risk is loss of heating and hot water on site. The steam raising boilers are 31 years old and could fail. Boiler failure would result in SGH closing down all clinical services until temporary boilers could be connected to site.	5 x 4 = 20	⇔	James Lewis Simon Tighe	10/06/2023	11/05/2023 Craig Stapleton Major feasibility study ongoing.	30/11/2024

Controls In Place

The management of the energy centre (steam boilers) is outsourced to Equans.

The boilers were due to be replaced as part of the EPC3 scheme at SGH. Unfortunately this funding is no longer an option for this scheme due to the time frame. This has resulted in an increased risk as the boilers are circa 31 years old and are part their serviceable life.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Equans on-call boilerhouse in and out of hour function	James Lewis	18.01.23 - Action reviewed at Directorate Confirm & Challenge Meeting - agreed to amend target date to 31.03.24. Date Entered : 12/05/2023 09:07 Entered By : Lisa Dannatt	22/02/2022	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2683 v.1	04/02/2020	NHS PS Invoice Dispute NLAG are in dispute over Invoices and are therefore withholding payment due to increased costs from NHS PS that do not form part of the current budget, based on out-turn spend 2018-19. Challenges of costs are ongoing at meetings and hoping for resolution prior to 31 March 2020 in readiness for the annual Agreement of Balances exercise between NHS organisations. As a result of the above, there is a potential of a high level financial risk to Trust. Wider finance colleagues are aware of such a risk of the financial implications of increased payments which could result in relocating services which could impact on patient experience and appointments.	4 x 3 = 12	⇔	Bryan Stephenson Craig Hodgson	10/07/2023	27/04/2023 Craig Hodgson Meeting 27.04.23 - NHSPS continue to challenge billing - ongoing.	/ /

Controls In Place

- Monthly financial monitoring, regular meetings with Senior NHS PS /NLAG Teams
- Helpdesk reporting system by NLAG service users
- Monthly Property Meetings
- Regular Management Accountant meetings
- Dashboard / Highlight reporting
- Premises Assurance Module

Action Description	Staff Responsible	Progress	Start	Target	Completed
Monthly Meetings with NHS PS Finance Colleagues Review of Evidence received	Bryan Stephenson	Meetings still ongoing to try to achieve a resolution. Date Entered : 12/05/2023 11:11 Entered By : Lisa Dannatt ---------- Meeting ongoing. Date Entered : 06/09/2022 11:48 Entered By : Lisa Dannatt	16/11/2021	31/08/2023	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2716 v.1	07/05/2020	Water Safety Compliance: Temperature Monitoring - DPoW Inadequate temperature monitoring to the main block and the family services building. There is the possibility of legionella infection of patients without correct controls.	4 x 3 = 12	⇔	James Lewis Simon Tighe	03/06/2023	28/03/2023 James Lewis Work to be done in the new year with support of BMS Estates Officer to install limited temperature monitoring at DPoW.	/ /

Controls In Place

Risk assessments undertaken at two yearly intervals by external competent specialist contractors.

Live defect system showing all current live defects and risk ratings for each defect and mitigating controls in place.

L8Guard electronic flushing return management system. Automatically highlights any areas not submitted flushing returns with escalation processes in place.

City & guilds accredited training for NLG staff undertaking activities on the water systems.

AE management audit and action plan to ensure Approved Code of Practice and HSG 274 guidance is being implemented.

Flushing of little used outlets to prevent stagnant water where legionella bacteria can grow.

Water sampling regime to identify any areas where pneumophila bacteria are growing.

Policy and Standard operating procedures (SOPs) covering maintenance, operation and actions to take if positive detection occurs.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Emergency repairs/upgrades on water infrastructure are carried and funded by revenue as appropriate.	James Lewis		16/11/2021	31/03/2024	/ /
Maintenance to TMV are carried out through the SOPs and PPM regime.	James Lewis		16/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2719 v.3	07/05/2020	Water Safety - Oversized water distribution pipes There is the risk of micro bacterial water infections from under utilised water services due to legacy oversized water distribution pipework which could result in patient(s) contracting infections whilst in hospital.	5 x 4 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Developing plan to conduct pipe re-configuration.	31/03/2023

Controls In Place
Risk assessments undertaken at two yearly intervals by external competent specialist contractors.
Live defect system showing all current live defects and risk ratings for each defect and mitigating controls in place.
L8Guard electronic flushing return management system. Automatically highlights any areas not submitted flushing returns with escalation processes in place.
City & guilds accredited training for NLG staff undertaking activities on the water systems.
AE management audit and action plan to ensure Approved Code of Practice and HSG 274 guidance is being implemented.
Flushing of little used outlets to prevent stagnant water where legionella bacteria can grow.
Water sampling regime to identify any areas where pneumophila bacteria are growing.
Policy and Standard operating procedures (SOPs) covering maintenance, operation and actions to take if positive detection occurs.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Emergency repairs/upgrades on water infrastructure are carried and funded by revenue as appropriate.	James Lewis		16/11/2021	31/03/2024	/ /
Maintenance to TMV are carried out through the SOPs and PPM regime	James Lewis		16/11/2021	31/03/2024	/ /
External targetted contractor support to address key issues	James Lewis		09/01/2023	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2905 v.1	07/04/2021	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	4 x 4 = 16	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Risk reviewed, no further update.	/ /

Controls In Place

Monthly test to start and run Diesel Generator for a period of 90mins

Annual load bank testing (although reduced load test upon generator specialist advice)

Specialist contractor backup

Temporary generator connected

Designs have been developed to replace CSSD1. The delivery is linked to funding availability within the capital plan.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Seeking funding to replace the aging Generator as beyond economic repair and not compatible with the Trusts Net Carbon Zero drive	James Lewis	Funding agreed and design has been completed ready for tendering the works. Works planned and funded for start of FY 2023 Date Entered : 23/12/2022 14:48 Entered By : James Lewis	17/11/2021	31/03/2024	/ /
Temporary generator backup now connected with contractror service	James Lewis		23/02/2022	30/06/2023	/ /

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2906 v.1	07/04/2021	Ageing Diesel Powered Generator Sets - CSSD2 - 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. This will affect clinical services and ability to deal with trauma patients brought to A&E, therefore directly affecting patient safety. - Family Services - Child Development - Day Surgery (Currently ITU) - A&E	4 x 2 = 8	⇔	James Lewis Simon Tighe	03/06/2023	28/03/2023 James Lewis Risk reviewed, no further update.	/ /

Controls In Place

Monthly test to start and run Diesel Generator for a period of 90mins

Annual load bank testing (although reduced load test upon generator specialist advice)

Specialist contractor backup

Action Description	Staff Responsible	Progress	Start	Target	Completed
Seeking funding to replace the aging Generator in 5 - 10 years to align with the Trusts Net Carbon Zero drive.	James Lewis		17/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2907 v.1	07/04/2021	Ageing Diesel Powered Generator Sets - Boiler House Substation-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. This will mean that the SITE will lose heating and hot water, therefore directly affecting patient safety. - Boiler house - West arch - Finance	4 x 2 = 8	⇔	James Lewis Simon Tighe	03/06/2023	28/03/2023 James Lewis Risk reviewed, no further update.	/ /

Controls In Place

Monthly test to start and run Diesel Generator for a period of 90mins

Annual load bank testing (although reduced load test upon generator specialist advice) - NB this will still cause some wear and tear and reduce the life expectancy.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Seeking funding to replace the aging Generator in 5 years to align with the Trusts Net Carbon Zero drive	James Lewis		17/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2951 v.2	04/08/2021	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide There is the risk of failure of aged (40 years plus) Electrical and/or mechanical LV components which could cause power interruptions to key areas. The impact of such failure is for clinical departments to experience reduced capacity or ability to treat and/or carry out diagnostic investigations on patients, leading to possible harm. This risk became a tangible issue on Dec 22 when a power cable failed causing widespread power interruptions.	5 x 4 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 Keith Leech 5 Yearly inspection ongoing.	31/03/2023

Controls In Place

Monitoring switch gear regularly to ensure the situation is not deteriorating.

Thermal monitoring.

Identifying and monitoring fuses that require upgrading.

Ongoing monitoring - replacement of electrical distribution boards as they fail.

5 Yearly inspection scheduled and undertaken.

Suspension of the operation of asbestos containing substation switches to reduce the risk of failure during switching.

Monthly on load test of individual standby generators.

Operation of Safe Systems of Work HTM 06-02

Action Description	Staff Responsible	Progress	Start	Target	Completed
LV Boards require replacement as and when funding is available through BLM, or included in project works. Currently working with supply chain to develop LV panel replacement programme.	James Lewis	18.01.23 - Action reviewed at Directorate Confirm & Challenge meeting agreed to extend target date to 31.03.24. Date Entered : 12/05/2023 09:09 Entered By : Lisa Dannatt	17/11/2021	31/03/2024	/ /
Discussion with Op's team in the event that risk materialises, ensuring the EPRR plan is formulated and communicated	James Lewis	18.01.23 - Action reviewed at Directorate Confirm & Challenge meeting - agreed to extend target date to 30.06.23. Date Entered : 12/05/2023 09:10 Entered By : Lisa Dannatt	17/11/2021	30/06/2023	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2952 v.1	04/08/2021	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.	4 x 4 = 16	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis SGH; full design feasibility study required to ascertain complexity and cost. DPoW; concept complete, full design required.	/ /

Controls In Place

Risk assessments undertaken at three yearly intervals by external competent specialist contractors.

Live defect system showing all current live defects and risk ratings for each defect and mitigating controls in place.

City & guilds accredited training for NLaG staff undertaking activities on the water systems.

AE management audit and action plan to ensure Approved Code of Practice and HSG 274 guidance is being implemented.

Flushing of little used outlets to prevent stagnant water where legionella bacteria can grow.

Policy and Standard operating procedures (SOPs) covering maintenance, operation and actions to take if positive detection occurs.

A feasibility study into the separation is plan in FY 23/24.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Emergency repairs/upgrades on water infrastructure are carried and funded by revenue as appropriate	James Lewis		17/11/2021	31/03/2024	/ /
Maintenance to TMV are carried out through the SOPs and PPM regime	James Lewis		17/11/2021	31/03/2024	/ /
SGH - Designers have been engaged to develop plan to separate the drinking water main from the firefighting system but will require significant investment to complete. DPOW - Small section left to fully separate the services, will be completed when funding is available.	James Lewis		01/09/2022	07/12/2023	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2953 v.2	04/08/2021	Water Safety Compliance: Sensor & Spray taps - Trustwide Due to the installation of sensor and spray taps and the inability to flush for the required time period, there is the risk of legionella which could impact on the health of the building occupants (patients/staff).	4 x 4 = 16	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis SGH; Ongoing removal work. DPoW; work complete. GDH; tbc.	/ /

Controls In Place
Risk assessments undertaken at three yearly intervals by external competent specialist contractors.
Live defect system showing all current live defects and risk ratings for each defect and mitigating controls in place.
City & guilds accredited training for NLG staff undertaking activities on the water systems.
AE management audit and action plan to ensure Approved Code of Practice and HSG 274 guidance is being implemented.
Water sampling regime to identify any areas where pneumophila bacteria are growing.
Policy and Standard operating procedures (SOPs) covering maintenance, operation and actions to take if positive detection occurs.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Ongoing Replacement of mixer taps	James Lewis		23/02/2022	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2954 v.2	04/08/2021	Asbestos; Risk of exposure to asbestos - Trustwide Control of Asbestos Regulations 2012: There is a current Asbestos Management Survey in place across the Trust, however there still remains the risk of exposure to asbestos if personnel don't follow asbestos management protocols resulting in the inadvertent release of asbestos fibres.	5 x 2 = 10	⇩	James Lewis Simon Tighe	10/07/2023	28/04/2023 James Lewis SGH; Red dot plans complete. Plan of dissemination to be established. DPoW/GDH; red dot plans disseminated and displayed.	/ /

Controls In Place

Recently completed Asbestos Management Surveys dated 2022; 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.

A culture of supervision, instruction & training exists for Estates staff and a process for the Control of Contractors including Asbestos awareness, requires a permit to be raised prior to work being conducted. A permit to work system mitigates any contractor from disturbing asbestos containing material.

All Asbestos containing material around the site is clearly identifiable.

On-going plan to remove ACM across the trust as part of BLM and Capital works.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Review all management documentation and resurvey site in line with current guidance to ensure compliance with regulation and minimise the risk. Asbestos management survey started Feb 2021, expected completion end of FY 21/22.	James Lewis	Documentation reviewed and site surveyed. Awaiting issue of red dot plans to ward areas. Date Entered : 24/01/2023 11:01 Entered By : Lisa Dannatt ---------- Documentation reviewed, awaiting completion of asbestos survey works. Date Entered : 05/09/2022 15:48 Entered By : Lisa Dannatt ---------- on-going. Date Entered : 28/04/2022 09:44 Entered By : James Lewis ---------- Progressing well, GDH/SGH almost complete, DPoW majority complete	01/02/2021	30/06/2023	/ /

Date Entered : 24/02/2022 12:24
Entered By : James Lewis

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2955 v.3	04/08/2021	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.	5 x 3 = 15	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis SGH/GDH; no further update. DPoW; Phase 3 complete.	/ /

Controls In Place

Daily monitoring of the oxygen consumption.

Ongoing monitoring of alarms.

National supplier support for business continuity.

Incremental replacement programme, in line with ward upgrades.

Regular monitoring of the VIE and evaporator.
The system is de-iced regularly as per BOC and NHSEI guidance.

Monthly Medical Gas Committee meeting (Covid).

Information provided to ward areas with regard to maximum permissible oxygen flow rate.

Liaison between clinical leadership and estates team to ascertain:
-Daily count of patient flow demand
-the maximum flow rate from your VIE
-the safest physical location to treat multiple patients on high flow O2 or high flow (red dot plan)
-support devices such as oxygen concentrators to be used for low flow, thus reducing aiding reduction load on pipe system

Strategically placed oxygen flow rate meters providing real time flow rate data to estates and operations.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Oxygen usage across the trust is now managed via WebV, this enables clinical and op's teams to view and manage patients requiring oxygen more efficiently.	James Lewis	WebV has recently been updated to reflect the increase at DPoW. The SGH figures remain managed to protect the oxygen flow system. Date Entered : 23/12/2022 15:05 Entered By : James Lewis	01/03/2022	30/06/2023	/ /
Clinicians to evaluate local usage matched to supply information relating to system capacity provided by the Estates team.	James Lewis	This is evaluated through the C-19 working groups and monitored via the WebV portal.	17/11/2021	30/06/2023	/ /

Clinicians evaluating use of appropriate oxygen delivery demand (equipment flow rate)		Date Entered : 03/03/2022 17:41 Entered By : James Lewis				

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2957 v.1	04/08/2021	Water Safety Compliance: BMS - Trustwide There is significant risk of Microbial growth (legionella, Pseudomonas) in cold & hot water system if temperatures are not maintained (hot water above 55 ?C and cold water blow 20 ?C), therefore temperature monitoring devises for water systems are paramount. There is the possibility of legionella infection of patients without correct controls.	4 x 3 = 12	⇔	James Lewis Simon Tighe	03/06/2023	28/03/2023 James Lewis Enhanced oversight due to new monitoring in place.	/ /

Controls In Place
Risk assessments undertaken at three yearly intervals by external competent specialist contractors.
Live defect system showing all current live defects and risk ratings for each defect and mitigating controls in place.
L8Guard electronic flushing return management system. Automatically highlights any areas not submitted flushing returns with escalation processes in place.
City & guilds accredited training for NLaG staff undertaking activities on the water systems.
AE management audit and action plan to ensure Approved Code of Practice and HSG 274 guidance is being implemented.
Flushing of little used outlets to prevent stagnant water where legionella bacteria can grow.
Water sampling regime to identify any areas where pneumophila bacteria are growing.
Policy and Standard operating procedures (SOPs) covering maintenance, operation and actions to take if positive detection occurs.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Emergency repairs/upgrades on water infrastructure are carried and funded by revenue as appropriate.	James Lewis		17/11/2021	31/03/2024	/ /
Maintenance to TMV are carried out through the SOPs and PPM regime	James Lewis		17/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2958 v.1	04/08/2021	Electrical: Failure of High Voltage electrical infrastructure (SGH/DPoW) There is the risk of failure of Electrical and/or mechanical failure of HV components due to insufficient separation within containment, which could lead to loss of HV supply to site. This would result in loss of clinical areas causing the Trust to divert patients to neighbouring hospitals.	5 x 2 = 10	⇔	James Lewis Simon Tighe	10/07/2023	28/04/2023 James Lewis Awaiting connection from DNO.	/ /

Controls In Place
3 monthly substation inspection by the Authorised Person.
Annual visual inspection by specialist company.
Annual & 4-yearly maintenance of the HV equipment.
Generator back up supply with 8 hour fuel run time.
Operation of safe systems of Work HTM 06-03.

Action Description	Staff Responsible	Progress	Start	Target	Completed
Annual visual inspection of HV equipment and emergency attendance contract in place (IUS).	James Lewis		17/11/2021	31/03/2024	/ /
Annual & 4 yearly planned preventative maintenance of HV equipment via specialist supplier (IUS)	James Lewis		17/11/2021	31/03/2024	/ /

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
2959 v.3	04/08/2021	Replacement/Repairs of flat roof - Trustwide There is the risk of failure of flat roofs across the sites. A number of roofs have failed across the site. Roofs of note include the SGH IT roof which houses trustwide servers and a roof over a new £1m MRI unit. A roof failure in either of these areas would result in significant risk to trustwide infrastructure and service delivery impacting elective recovery.	4 x 4 = 16	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Risk reviewed, no further update.	/ /

Controls In Place
Staff report any roof leaks to the facilities department when they occur.
Repairs carried out when required.
Trust wide roof survey carried out
Escalation of funding required by the Programme Director of Strategic Development presented to the TMB requesting circa £8.5m over the next 5 years.

Action Description	Staff Responsible	Progress	Start	Target	Completed
BLM re-prioritised.	James Lewis		17/11/2021	31/03/2024	/ /

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
3015 v.4	01/02/2022	Insufficient estate resources to manage the workload demand Failure to recruit technical capital project team members to support current major capital project delivery programme which is impacting on the estates operational teams ability to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. It is anticipated that this risk will be reduced in 24/25 when capital funding reduces. The impact to the Trust if not actioned; inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance, lack of Engineer resource to complete mandatory work and project works, ineffective management of Pre-Planned Maintenance, ineffective management of water systems due to shortage of water APs (SGH), inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing), ineffective management of the estates leading to reactive maintenance (firefighting), inability to implement proactive management systems (MICAD helpdesk), impact to patient safety, loss of workforce due to on-going work pressure and employee market shortage (supply/demand), reduced staff morale, inability to support wider project delivery, durther degradation and serious incidents within the estates, loss of financial resources due to settlement of claims (majority of claims are under the excess levels so Trust would pay full cost), increase in overall BLM	4 x 5 = 20	⇔	James Lewis Simon Tighe	10/06/2023	28/04/2023 James Lewis Ongoing work to support business case for extra resources.	31/03/2023

		value (6 facet survey) due to limited resourcing levels in FY 21/22 & 22/23						

Controls In Place
Resources prioritized in a reactive manner

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
3108 v.2	11/08/2022	Routine maintenance, testing and calibration of medical equipment and devises across 3 sites Cause: - Access restricted due to high OPEL state - Backlog created by Covid-19 response - Growing equipment base exceeding staffing capacity - End users fail to check "Next Test Due Date" label prior to use, and fail to notify medical engineering when equipment becomes vacant. Impact: Potential to increase breakdown demand, due to faulty/worn components Potential to introduce Electrical Safety faults Med Engineering inability to achieve KPI in relation to preventative maintenance for low, med and high risk medical devices, beyond their control. Financial budget pressure, with avoidable repair costs due to lack of preventative maintenance. Risk: Patients and/or staff may suffer harm under fault condition/s Risk of litigation/financial loss due to non-compliance with Trust Policies.	2 x 3 = 6	⇧	Karen Fisk Simon Tighe	10/07/2023	11/05/2023 Karen Fisk Business case lost in transition from S&CC to E&F. Band 8C .074 wte re-prioritized to another service, within S&CC prior to Medical Engineering moving to E&F. Backlog continuing to increase (doubled in last 2 years). x2 Managers due to leave May 23, recruitment process in place.	11/08/2023

Controls In Place
Medical equipment generally reliable and the majority of PPM inspections are routine without revealing significant levels of component wear and tear.
The majority of failures occur during normal use (rather than during PPM inspection) and are report to Medical Engineering for repair by ward staff or porters.
Medical Engineering staff have been proactive in gaining access to equipment and are engaging with ward staff and Operations staff to support in accessing to equipment
Changes to the way in which equipment is scheduled for servicing has been adopted as a trial. This approach identifies specific wards/departments to be targeted in-month. Teams will focus on clearing all work for the selected area before moving on. It is hoped that this action will assist in locating equipment which has been relocated or abandoned as a consequence of the many ward movements and reconfigurations in response to the Covid pandemic.

Risk Register Confirm & Challenge Appendix Full Listing

Number	Date	Description	SxL=Rate		Staff Responsible	Next Review	Last Review Details	Target
3139 v.2	05/12/2022	Linen Services - Insufficient Site Stock Holding to support additional Operational Demands The externally provided Laundry Management Services has been unable to meet the minimum stock holding levels for sites as an ongoing issue. This demand for additional linen was initially linked to Covid however, ongoing pressures linked to product cost, laundering, transportation and fuel has increased service costs and supply resilience. The industry will become stretched further inlight of anticipated winter pressues linked to ED demand, Flu, Covid and recovery plans	3 x 4 = 12	⇔	Keith Fowler Simon Tighe	10/07/2023	28/04/2023 Keith Fowler Paper to SMT to extend 2yr contract. Paper due at TMB 04.05.23.	31/03/2023

Controls In Place

Contingency Plan is 24 hours of linen on sites

Weekly meetings reporting stock levels

Action Description	Staff Responsible	Progress	Start	Target	Completed
Raised to procurement to discuss with finance teams	Michelle Smith		05/12/2022	30/06/2023	/ /
Collaborative approach with consortium members	Emma Marsden		05/12/2022	30/06/2023	/ /
Procurement to discuss with other local hospitals	Emma Marsden		05/12/2022	30/06/2023	/ /

Appendix C

		MGPS HTM 02	Vent HTM 03	Water HTM 04	Fire HTM 05	LV HTM 06-02	HV HTM 06-03	Lift HTM 08-02	Asbestos (P405 Trained)	Confined Space	Working at Height	Pressure Systems
SGH / GDH	*Est*	*2*	*2*	*2*		*2*	*2*	*1*		*2*		*2*
	Actual	2	2	2		1	1	2	4			
DPOW	*Est*	*2*	*2*	*2*		*2*	*2*	*1*		*2*		*2*
	Actual	1	1	2		2	2	1	2			
Trustwide	*Est*	*4*	*4*	*4*		*4*	*4*	*2*		*4*		*4*
	Actual	3	3	4		3	3	3	6			
Surplus (+)/Deficiency(-)		-1	-1	0	0	-1	-1	1	6	-4	0	-4

17/05/2023 *Date*
04/05/2023 *Last Updated (Date)*
LC *Initials*

✓ *Trained and Appointed*
✓ *Trained, not appointed*
☐ *Not trained (nor appointed)*
3 *Number of AP duties (includes all trained)*

Steve Hargraves	DPOW	☐	☐	☐		✓	✓	☐	☐	☐	☐	☐	2
Mark Copley	DPOW	☐	☐	☐		✓	✓	☐	✓	☐	☐	☐	3
Keith Bell	DPOW	☐	☐	☐		☐	☐	☐	✓	✓	☐	☐	2
Charles Cavernelis	DPOW	☐	✓	✓		☐	☐	✓	☐	☐	☐	✓	4
Reza Khoshdelan	DPOW	✓	☐	✓		☐	☐	☐	☐	✓	☐	✓	4
Paul Greetham	DPOW	✓	✓	☐		☐	☐	✓	☐	☐	☐	✓	4
Chris Crookes	DPOW	☐	✓	✓		☐	☐	☐	☐	✓	☐	☐	3
Derek Perry	DPOW	☐	☐	☐		☐	☐	☐	☐	✓	☐	☐	1
VACANCY	DPOW	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	0
Keith Leech	DPOW	☐	✓	✓		☐	☐	✓	✓	☐	☐	✓	5
Ryan Peck	SGH	✓	✓	✓		☐	☐	☐	✓	✓	☐	✓	6
Gareth Scott	SGH	✓	✓	✓		☐	☐	☐	✓	☐	☐	✓	5
Richard Crookes	SGH	☐	✓	✓		☐	☐	☐	☐	✓	☐	✓	4
Tom Close	SGH	☐	☐	☐		✓	✓	✓	☐	☐	☐	☐	3
Emma Barrett	SGH	☐	✓	☐		☐	☐	☐	☐	☐	☐	☐	1
Vacancy	SGH	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	0
Rob Heeley	SGH	☐	☐	☐		☐	☐	☐	☐	✓	☐	☐	1
Mathew Harrison	SGH	☐	☐	☐		☐	✓	☐	☐	☐	☐	☐	1
Gary Sweeting	SGH	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	0
Steve Roberts	GDH	✓	✓	✓		☐	☐	✓	☐	✓	☐	☐	5
Ben Rhodes	GDH	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	0
Chris Trafford	GDH	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	0
Adam Ladley	GDH	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	0
Rhys Bevan	SGH	☐	☐	☐		☐	✓	☐	☐	☐	☐	☐	1
Paul Leedham	DPOW	✓	✓	☐		☐	☐	☐	☐	☐	☐	☐	2
James Lewis	Trust	☐	✓	✓		☐	☐	☐	✓	☐	☐	☐	3
Simon Tighe	Trust	☐	☐	✓		☐	☐	☐	✓	☐	☐	☐	2
Jug Johal	Trust			✓									
Establishement number of APs		0	0	0	0	0	0	0	0	0	0	0	
Total Numbers of Aps		6	11	10	0	3	5	5	7	8	0	7	

Authorising Engineer (AE) Appointments

Mark Milne HAC Medical Gas T&	Appoint' Expiry	01/07/2022 30/06/2025											mark.milne@hactraining.com
A. Poplett Andrew Poplett Ent	Appoint' Expiry		01/11/2021 31/10/2023										a.poplett@btinternet.com
Peter Gunn Water Hygiene Cent	Appoint' Expiry			14/04/2021 31/03/2026									peter.gunn@waterhygienecentre.com
Darren Kirk Fire Safety Partners	Appoint' Expiry				16/02/2023 15/02/2026								d.kirk@firesafetypartnership.co.uk
Mark Richards HES FM	Appoint' Expiry					20/07/2021 31/12/2024							mark@hesfm.uk
Michael Bottomly VT Consult	Appoint' Expiry							03/12/2019 01/10/2025					michael@vtconsult.co.uk
0 0	Appoint' Expiry								0 0				
Andrew Berridge Moresafe Ltd	Appoint' Expiry									15/03/2022 15/03/2025			andrew.berridge@moresafe.co.uk
Stuart Henry Moresafe Ltd	Appoint' Expiry										15/03/2022 15/03/2025		stuart.henry@mresafe.co.uk
L. Kowalksi Turner PES Ltd	Appoint' Expiry											01/07/2021 30/06/2022	

HTM 02 - Medical Gas pipeline Systems (MGPS)										
Estates Operations Staff Details (Common)			Training		Appointment					
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	Risk		
Steve Hargraves	Estates Officer	DPOW		-		-				
Mark Copley	Estates Officer	DPOW		-		-				
Keith Bell	Senior Estates Officer	DPOW		-		-				
Charles Cavernelis	Estates Officer	DPOW		-		-				
Reza Khoshdelan	Estates Officer	DPOW	14/12/2020	14/12/2023	01/08/2022	01/08/2025				✓
Paul Greetham	Estates Officer	DPOW	10/01/2022	10/01/2025		-				✓
Chris Crookes	Maintenance Team Leader	DPOW		-		-				
Derek Perry	Maintenance Technician	DPOW		-		-				
VACANCY	Maintenance Technician	DPOW		-		-				
Keith Leech	Senior Estates Manager	DPOW		-		-				
Ryan Peck	Senior Estates Officer	SGH	14/12/2020	14/12/2023	14/02/2022	14/02/2025				✓
Gareth Scott	Senior Estates Officer	SGH	10/01/2022	10/01/2025		-				✓
Richard Crookes	Estates Officer	SGH		-		-				
Tom Close	Estates Officer	SGH		-		-				
Emma Barrett	Estates Officer (BMS)	SGH		-		-				
Vacancy	Estates Officer	SGH		-		-				
Rob Heeley	Maintenance Team Leader	SGH		-		-				
Mathew Harrison	Maintenance Technician	SGH		-		-				
Gary Sweeting	Maintenance Technician	SGH		-		-				
Steve Roberts	Maintenance Team Leader	GDH	10/01/2022	10/01/2025	02/04/2022	01/04/2025				✓
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-				
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-				
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-				
Rhys Bevan	Senior Estates Manager	SGH		-		-				
				-		-				
Paul Leedham	Bank P/T	DPOW	21/12/2022	21/12/2025	28/02/2023	28/02/2026				✓
James Lewis	AD of Engineering and Estates	Trust	13/01/2023	13/01/2026		-				
Simon Tighe	DD of E&F	Trust		-		-				
Jug Johal	Director of Estates and Facilities	Trust								
									Establishement number of APs	
									Total Numbers of Aps	6

Authorising Engineer			
Name:	Mark Milne	Appointment:	01/07/2022
Company:	HAC Medical Gas T&S Ltd	Expiry:	30/06/2025

Carl Dennis	Projects	DPOW	13/01/2023	13/01/2026	

HTM 03 Specialist Ventilation								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW		-		-		
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW	30/03/2022	30/03/2025		-		✓
Reza Khoshdelan	Estates Officer	DPOW		-		-		
Paul Greetham	Estates Officer	DPOW	27/01/2023	27/01/2026	28/03/2023	27/03/2026		✓
Chris Crookes	Maintenance Team Leader	DPOW	27/01/2023	27/01/2026	28/03/2023	27/03/2026		✓
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW	12/11/2021	12/11/2024		-		✓
Ryan Peck	Senior Estates Officer	SGH	12/11/2021	12/11/2024	24/12/2022	24/12/2025		✓
Gareth Scott	Senior Estates Officer	SGH	08/09/2021	08/09/2024	01/07/2021	01/07/2024		✓
Richard Crookes	Estates Officer	SGH	24/09/2021	24/09/2024	01/07/2021	01/07/2024		✓
Tom Close	Estates Officer	SGH		-		-		
Emma Barrett	Estates Officer (BMS)	SGH	26/08/2022	26/08/2025	24/12/2022	24/12/2025		✓
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH	26/08/2022	26/08/2025	24/12/2022	24/12/2025		✓
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW	24/12/2022	24/12/2025	24/09/2022	24/09/2025		✓
James Lewis	AD of Engineering and Estates	Trust	25/11/2022	25/11/2025	24/04/2023	23/04/2026		✓
Simon Tighe	DD of E&F	Trust		-		-		
Jug Johal	Director of E&F	Trust		-		-		
							Establishement number of APs	
							Total Numbers of Aps	11

Authorising Engineer			
Name:	A. Poplett	Appointment:	01/11/2021
Company:	Andrew Poplett Enterprises Ltd	Expiry:	31/10/2023

Craig Stapleton	Energy Manager	Trust	24/02/2023	24/02/2026	

HTM 04 Water Systems								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW		-		-		
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW	08/02/2022	08/02/2025	14/06/2022	09/05/2025		✓
Reza Khoshdelan	Estates Officer	DPOW	12/08/2021	12/08/2024	14/06/2022	12/05/2025		✓
Paul Greetham	Estates Officer	DPOW		-		-		
Chris Crookes	Maintenance Team Leader	DPOW	17/12/2021	17/12/2024	27/02/2023	15/08/2023		✓
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW	25/02/2022	25/02/2025	14/03/2023	27/02/2026		✓
Ryan Peck	Senior Estates Officer	SGH	22/10/2022	22/10/2025	14/06/2022	09/05/2025		✓
Gareth Scott	Senior Estates Officer	SGH	12/08/2021	12/08/2024		-		✓
Richard Crookes	Estates Officer	SGH	30/09/2022	30/09/2025	14/06/2022	19/04/2025		✓
Tom Close	Estates Officer	SGH		-		-		
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH	28/01/2022	28/01/2025	12/05/2022	15/08/2023		✓
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust	21/10/2022	21/10/2025	07/11/2022	07/11/2025		✓
Simon Tighe	DD of E&F	Trust	11/03/2022	11/03/2025	13/06/2022	13/06/2025		✓
Jug Johal	Director of Estates and Facilities	Trust		-	13/01/2021	13/01/2024		✓
							Establishement number of APs	
							Total Numbers of Aps	10

Authorising Engineer			
Name:	Peter Gunn	Appointment:	14/04/2021
Company:	Water Hygiene Centre	Expiry:	31/03/2026

Kevin Cawley	Estates Maintenance	DPOW	22/10/2021	22/10/2024	27/02/2023	15/08/2023		✓
Ellie Rodger	Projects	SGH	30/09/2022	30/09/2025	06/03/2023	27/02/2026		✓

HTM 05 Fire Safety								
Bespoke Staff Details			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
				-		-		
				-		-		
				-		-		
				-		-		
				-		-		
				-		-		
				-		-		
				-		-		
				-		-		
				-		-		
							Establishement number of APs	
							Total Numbers of Aps	0

Authorising Engineer			
Name:	Darren Kirk	Appointment:	16/02/2023
Company:	Fire Safety Partnership	Expiry:	15/02/2026

HTM 06-02 Electrical (Low Voltage)								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW	17/08/2022	17/08/2025	01/02/2023	31/10/2026		✓
Mark Copley	Estates Officer	DPOW	15/11/2021	15/11/2024		-		✓
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW		-		-		
Reza Khoshdelan	Estates Officer	DPOW		-		-		
Paul Greetham	Estates Officer	DPOW		-		-		
Chris Crookes	Maintenance Team Leader	DPOW		-		-		
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW		-		-		
Ryan Peck	Senior Estates Officer	SGH		-		-		
Gareth Scott	Senior Estates Officer	SGH		-		-		
Richard Crookes	Estates Officer	SGH		-		-		
Tom Close	Estates Officer	SGH	24/09/2021	24/09/2024	17/01/2023	31/12/2024		✓
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH		-		-		
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust		-		-		
Simon Tighe	DD of E&F	Trust		-		-		
Jug Johal	Director of Estates and Facilities	Trust						
							Establishement number of APs	
							Total Numbers of Aps	3

Authorising Engineer			
Name:	Mark Richards	Appointment:	20/07/2021
Company:	HES FM	Expiry:	31/12/2024

Tom Doo	Projects	DPOW	11/02/2022	11/02/2025	

HTM 06-02 Electrical (High Voltage)								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW	17/09/2021	17/09/2024	30/11/2021	30/09/2024		✓
Mark Copley	Estates Officer	DPOW	16/12/2022	16/12/2025		-		✓
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW		-		-		
Reza Khoshdelan	Estates Officer	DPOW		-		-		
Paul Greetham	Estates Officer	DPOW		-		-		
Chris Crookes	Maintenance Team Leader	DPOW		-		-		
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW		-		-		
Ryan Peck	Senior Estates Officer	SGH		-		-		
Gareth Scott	Senior Estates Officer	SGH		-		-		
Richard Crookes	Estates Officer	SGH		-		-		
Tom Close	Estates Officer	SGH	08/10/2021	04/10/2024	15/01/2023	30/09/2024		✓
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH	11/02/2022	11/02/2025		-		✓
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH		-		-		
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH	16/12/2022	16/12/2025		-		✓
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust		-		-		
Simon Tighe	DD of E&F	Trust		-		-		
							Establishement number of APs	
							Total Numbers of Aps	5

Authorising Engineer			
Name:	Mark Richards	Appointment:	20/07/2021
Company:	HES FM	Expiry:	20/07/2024

HTM 08-02 Lifts								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW		-		-		
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW	15/12/2021	15/12/2024		-		✓
Reza Khoshdelan	Estates Officer	DPOW		-		-		
Paul Greetham	Estates Officer	DPOW	04/02/2022	04/02/2025	30/08/2022	30/08/2025		✓
Chris Crookes	Maintenance Team Leader	DPOW		-		-		
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW	04/02/2022	04/02/2025		-		✓
Ryan Peck	Senior Estates Officer	SGH		-		-		
Gareth Scott	Senior Estates Officer	SGH		-		-		
Richard Crookes	Estates Officer	SGH		-		-		
Tom Close	Estates Officer	SGH	07/10/2022	07/10/2025	30/08/2022	30/08/2025		✓
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH	07/10/2022	07/10/2025	30/08/2022	30/04/2025		✓
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust		-		-		
Simon Tighe	DD of E&F	Trust		-		-		
							Establishement number of APs	
							Total Numbers of Aps	5

Authorising Engineer			
Name:	Michael Bottomly	Appointment:	03/12/2019
Company:	VT Consult	Expiry:	01/10/2025

P405 Asbestos Management								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW	31/03/2019	31/03/2024		-		✓
Keith Bell	Senior Estates Officer	DPOW	18/09/2018	18/09/2023		-		✓
Charles Cavernelis	Estates Officer	DPOW		-		-		
Reza Khoshdelan	Estates Officer	DPOW		-		-		
Paul Greetham	Estates Officer	DPOW		-		-		
Chris Crookes	Maintenance Team Leader	DPOW		-		-		
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW	30/06/2021	30/06/2026		-		✓
Ryan Peck	Senior Estates Officer	SGH	31/05/2021	31/05/2026		-		✓
Gareth Scott	Senior Estates Officer	SGH	30/11/2019	30/11/2024		-		✓
Richard Crookes	Estates Officer	SGH		-		-		
Tom Close	Estates Officer	SGH		-		-		
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH		-		-		
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust	30/06/2021	30/06/2026		-		✓
Simon Tighe	DD of E&F	Trust	18/09/2018	18/09/2023		-		✓
							Establishement number of APs	
							Total Numbers of Aps	7

Authorising Engineer			
Name:		Appointment:	
Company:		Expiry:	

Ellie Rodger	Projects	SGH	30/06/2021	30/06/2026	

Confined Space Management								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW		-		-		
Keith Bell	Senior Estates Officer	DPOW	09/03/2023	09/03/2026		-		✓
Charles Cavernelis	Estates Officer	DPOW		-		-		
Reza Khoshdelan	Estates Officer	DPOW	24/03/2021	24/03/2024		-		✓
Paul Greetham	Estates Officer	DPOW		-		-		
Chris Crookes	Maintenance Team Leader	DPOW	17/12/2020	17/12/2023		-		✓
Derek Perry	Maintenance Technician	DPOW	09/03/2023	09/03/2026		-		✓
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW		-		-		
Ryan Peck	Senior Estates Officer	SGH	17/03/2022	17/03/2025		-		✓
Gareth Scott	Senior Estates Officer	SGH		-		-		
Richard Crookes	Estates Officer	SGH	20/05/2021	20/05/2024		-		✓
Tom Close	Estates Officer	SGH		-		-		
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH	25/11/2021	25/11/2024		-		✓
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH	09/03/2023	09/03/2026		-		✓
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust		-		-		
Simon Tighe	DD of E&F	Trust		-		-		
							Establishement number of APs	
							Total Numbers of Aps	8

Authorising Engineer			
Name:	Andrew Berridge	Appointment:	15/03/2022
Company:	Moresafe Ltd	Expiry:	15/03/2025

Working at Height Management								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW		-		-		
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW		-		-		
Reza Khoshdelan	Estates Officer	DPOW		-		-		
Paul Greetham	Estates Officer	DPOW		-		-		
Chris Crookes	Maintenance Team Leader	DPOW		-		-		
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW		-		-		
Ryan Peck	Senior Estates Officer	SGH		-		-		
Gareth Scott	Senior Estates Officer	SGH		-		-		
Richard Crookes	Estates Officer	SGH		-		-		
Tom Close	Estates Officer	SGH		-		-		
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH		-		-		
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust		-		-		
Simon Tighe	DD of E&F	Trust		-		-		
						Establishement number of APs		
						Total Numbers of Aps	0	

Authorising Engineer			
Name:	Stuart Henry	Appointment:	15/03/2022
Company:	Moresafe Ltd	Expiry:	15/03/2025

Pressure and Mechanical Systems								
Estates Operations Staff Details (Common)			Training		Appointment			
Name	Role	Site	Date of Training	Date of Expiry	Date of Appointment	Date of Expiry	Certificate Number	
Steve Hargraves	Estates Officer	DPOW		-		-		
Mark Copley	Estates Officer	DPOW		-		-		
Keith Bell	Senior Estates Officer	DPOW		-		-		
Charles Cavernelis	Estates Officer	DPOW	08/07/2021	08/07/2024		-		✓
Reza Khoshdelan	Estates Officer	DPOW	03/12/2020	03/12/2023		-		✓
Paul Greetham	Estates Officer	DPOW	11/11/2022	11/11/2025		-		✓
Chris Crookes	Maintenance Team Leader	DPOW		-		-		
Derek Perry	Maintenance Technician	DPOW		-		-		
VACANCY	Maintenance Technician	DPOW		-		-		
Keith Leech	Senior Estates Manager	DPOW	12/03/2020	12/03/2023		-		✓
Ryan Peck	Senior Estates Officer	SGH	10/09/2020	10/09/2023		-		✓
Gareth Scott	Senior Estates Officer	SGH	11/11/2022	11/11/2025		-		✓
Richard Crookes	Estates Officer	SGH	10/09/2020	10/09/2023		-		✓
Tom Close	Estates Officer	SGH		-		-		
Emma Barrett	Estates Officer (BMS)	SGH		-		-		
Vacancy	Estates Officer	SGH		-		-		
Rob Heeley	Maintenance Team Leader	SGH		-		-		
Mathew Harrison	Maintenance Technician	SGH		-		-		
Gary Sweeting	Maintenance Technician	SGH		-		-		
Steve Roberts	Maintenance Team Leader	GDH		-		-		
Ben Rhodes	Multi-skilled Craftsperson	GDH		-		-		
Chris Trafford	Multi-skilled Craftsperson	GDH		-		-		
Adam Ladley	Multi-skilled Craftsperson	GDH		-		-		
Rhys Bevan	Senior Estates Manager	SGH		-		-		
				-		-		
Paul Leedham	Bank P/T	DPOW		-		-		
James Lewis	AD of Engineering and Estates	Trust		-		-		
Simon Tighe	DD of E&F	Trust		-		-		
							Establishement number of APs	
							Total Numbers of Aps	7

Authorising Engineer			
Name:	L. Kowalksi	Appointment:	01/07/2021
Company:	Turner PES Ltd	Expiry:	30/06/2022

Appendix D

Instructions: NHS Premises Assurance Model 2019: Please also read the separate NHS PAM Guidance Document

<table>
<tr><td rowspan="8">Purpose and structure of this file</td><td colspan="3">This file contains Self-Assessment Questions that help evaluate the way your organisation/site manages its estate and facilities in 5 Domains. Although the Safety Domain is notionally split between hard and soft Facility Management (FM) services some questions within the 'Combined and Hard FM' supply to both sections. These questions should be assessed across both hard and soft FM e.g. the SAQ relating to Health and Safety is within the 'Safety: Combined and Hard FM' but clearly applies to soft FM also. A number of other relevant sheets are also provided</td></tr>
<tr><td>1. Governance:</td><td>►►Go</td><td rowspan="6">◄Use the link in the yellow box to navigate to the relevant sheet
Rate the individual prompt questions by using the drop down menu on the sheets with the yellow tabs</td></tr>
<tr><td>2A. Safety: Combined & Hard FM</td><td>►►Go</td></tr>
<tr><td>2B. Safety: Soft FM</td><td>►►Go</td></tr>
<tr><td>3. Patient Experience</td><td>►►Go</td></tr>
<tr><td>4. Efficiency</td><td>►►Go</td></tr>
<tr><td>5. Effectiveness</td><td>►►Go</td></tr>
<tr><td>SAQ, Regs & Guidance Mapping</td><td>►►Go</td><td>This sheets shows the relationship with the SAQs, CQC guidance and relevant Regulations</td></tr>
<tr><td>How to complete it</td><td colspan="3">The way to use this file is to fill in the 5 worksheets with yellow tabs, which include the domain self-assessment questions (SAQs).

<table>
<tr><td>Year 1</td><td>Year 2</td><td>The assessment can be for one or two years if comparisons are required.</td></tr>
<tr><td>2021-22</td><td>2022-23</td><td>◄Use the drop down in the yellow boxes to alter the years where relevant</td></tr>
</table>
Each SAQ contains several prompt questions. By answering the prompt questions, a result is automatically calculated for the SAQs and the domains. Please note it is not possible to give a rating to the SAQ directly, it has to be rated indirectly using the prompt questions or, alternatively, classified as not applicable.

There are six possible responses for a prompt question:
- Not applicable: this prompt question does not apply to your organisation/site.
- Outstanding: compliant with no action plus evidence of high quality services and innovation.
- Good: compliant no action required.
- Requires minimal improvement: the impact on people who use services, visitors or staff is low.
- Requires moderate improvement: the impact on people who use services, visitors or staff is medium.
- Inadequate: action is required quickly - the impact on people who use services, visitors or staff is high.</td></tr>
<tr><td>Results</td><td colspan="3">The "Summary' sheets show graphically the results of the NHS PAM self-assessment.
- The 'summary' one shows the ratings at the domain level. It includes the average rating and the distribution of SAQ ratings for the 5 domains (i.e. the % of SAQs that obtain a rating of "Outstanding", the % of SAQs that obtain a rating of "Good", etc.)
- The other 5 red 'Results' sheet detail the average rating and the distribution of the prompt questions ratings for each SAQ within the domain. This allows the user to see which SAQs are driving the results of the domains.</td></tr>
</table>

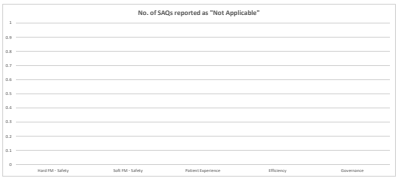
Annual Changes	**Annual changes may be required in line with updates to guidance and legislation, you can find an overview of the latest changes listed below.** **Changes for 2022:** •Slight Amend to evidence and updated links •Patient Experience – P6 (Cell 46B) wording amended for PLACE •Efficiency –F3 (cell 30b) Net Zero Carbon added 'Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?' •Efficiency – F5 (cell 41B) – added 'and net zero carbon targets' •Effectiveness – E4 (cell 33B) – added '1: Green Plan / Sustainability Strategy •Has your Green Plan been approved by Board and submitted to the ICS / ICB' •Effectiveness: - E4 (cell B36) – added 'overview of these procedures is included within the Green Plan' •Effectiveness – E4 (cell 38b)

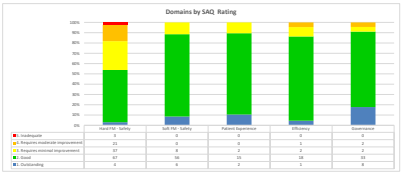
NHS Premises Assurance Model (NHS PAM)

Trust:	2021-22
Site Name:	2021-22
Year:	2021-22

SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans					Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH1	Estates and Facilities Operational Management	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal im	2. Good	3. Requires minimal im	2. Good	2. Good	Not applicable					0	0	
SH2	Design, Layout and Use of Premises	Hard FM - Safety	Applicable	2. Good	3. Requires minimal im	2. Good	3. Requires moderate	2. Good	3. Requires minimal im	2. Good	Not applicable					0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Document Management System in Place	2. Approval of documents	3. Review of documents	4: Availability of documents	5: Legibility of Documents	6: Document Control	7. Obsolescence	8. Costed Action Plans					Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH3	Estates and Facilities Document Management	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	3. Requires minimal im	2. Good	3. Requires minimal im	3. Requires minimal im	Not applicable					0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans					Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH4	Health & Safety at Work	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires moderate	2. Good	4. Requires moderate	2. Good	Not applicable	Not applicable					0	0	
SH5	Asbestos	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires moderate	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SH6	Medical Gas Systems	Hard FM - Safety	Applicable	3. Requires moderate	3. Requires minimal im	2. Good	2. Good	2. Good	3. Requires minimal im	2. Good	Not applicable					0	0	
SH7	Natural Gas and specialist sized systems	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal im	Not applicable					0	0	
SH8	Water Safety Systems	Hard FM - Safety	Applicable	3. Requires minimal im	4. Inadequate	4. Requires moderate	4. Inadequate	2. Good	3. Requires minimal im	2. Good	Not applicable					0	0	
SH9	Electrical Systems	Hard FM - Safety	Applicable	3. Requires minimal im	3. Requires moderate	2. Good	3. Requires moderate	3. Requires minimal im	3. Requires minimal im	2. Good	Not applicable					0	0	
SH10	Mechanical Systems and Equipment	Hard FM - Safety	Applicable	2. Good	3. Requires minimal im	2. Good	4. Requires moderate	3. Requires minimal im	3. Requires minimal im	2. Good	Not applicable					0	0	
SH11	Ventilation, Air Conditioning and Refrigeration Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal im	3. Requires moderate	3. Requires moderate	2. Good	3. Requires minimal im	4. Inadequate	Not applicable					0	0	
SH12	Fire, Security and Communal Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal im	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SH13	Pressure Systems	Hard FM - Safety	Applicable	3. Requires moderate	3. Requires minimal im	3. Requires moderate	3. Requires minimal im	2. Good	3. Requires minimal im	2. Good	Not applicable					0	0	
SH14	Fire Safety	Hard FM - Safety	Applicable	3. Requires minimal im	3. Requires minimal im	3. Requires minimal im	3. Requires moderate	3. Requires minimal im	3. Requires minimal im	2. Good	Not applicable					0	0	
SH15	Medical Devices and Equipment	Hard FM - Safety	Applicable	2. Good	3. Requires minimal im	3. Requires minimal im	3. Requires moderate	2. Good	3. Requires minimal im	2. Good	Not applicable					0	0	
SH16	Resilience, Emergency and Business Continuity Planning	Hard FM - Safety	Applicable	3. Requires minimal im	2. Good	2. Good	3. Requires minimal im	3. Requires minimal im	3. Requires minimal im	2. Good	Not applicable					0	0	
SH17	Safety Alerts	Hard FM - Safety	Applicable	3. Requires minimal im	2. Good	3. Requires minimal im	3. Requires moderate	3. Requires moderate	3. Requires moderate	3. Requires minimal im	3. Requires minimal im					0	0	
SH18	Externally supplied estate	Hard FM - Safety	Applicable	1. Outstanding	1. Outstanding	2. Good	3. Requires moderate	2. Good	3. Requires minimal im	1. Outstanding	Not applicable					0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Contractor Compliance	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans					Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH19	Contractor Management for Soft and Hard FM services	Hard FM - Safety	Applicable	3. Requires minimal im	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans					Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS1	Catering services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SS2	Decontamination process	Soft FM - Safety	Applicable	2. Good	3. Requires minimal im	2. Good	2. Good	2. Good	2. Good	1. Outstanding	Not applicable					0	0	
SS3	Waste and Recycling Management	Soft FM - Safety	Applicable	2. Good	3. Requires minimal im	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SS4	Cleanliness and Infection Control	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SS5	Laundry and Linen Services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SS6	Security Management	Soft FM - Safety	Applicable	2. Good	3. Requires minimal im	2. Good	3. Requires minimal im	3. Requires minimal im	3. Requires minimal im	2. Good	Not applicable					0	0	
SS7	Transport Services	Soft FM - Safety	Applicable	1. Outstanding	1. Outstanding	2. Good	2. Good	1. Outstanding	1. Outstanding	1. Outstanding	2. Good					0	0	
SS8	Pest control	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal im	2. Good	Not applicable					0	0	
SS9	Portering services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SS10	Telephone and switchboard services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable					0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Views and Experiences	2. Engagement	3. Staff Engagement	4. Prioritisation	5. Value	6: Costed Action Plans							Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P1	Engagement and involvement	Patient Experience	Applicable	2. Good	3. Requires minimal im	2. Good	3. Requires minimal im	2. Good	Not applicable							0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. PLACE Assessment	2. Other Assessments	3: Costed Action Plans										Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P2	Condition, appearance, maintenance and upkeep and dignity perception	Patient Experience	Applicable	2. Good	2. Good	Not applicable										0	0	
P3	Cleanliness	Patient Experience	Applicable	2. Good	2. Good	2. Good										0	0	
P4	Access and Car Parking	Patient Experience	Applicable	Not applicable	1. Outstanding	Not applicable										0	0	
P5	Grounds and Gardens	Patient Experience	Applicable	Not applicable	2. Good	Not applicable										0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Regulation	3. Choice	4. Equality issues	5. Information	6. PLACE Assessment	7. Other Assessments	8. Legal Standards	9: Costed Action Plans				Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P6	Catering services	Patient Experience	Applicable	2. Good	2. Good	1. Outstanding	2. Good	2. Good	2. Good	2. Good	Not applicable	Not applicable				0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Analysing Performance	2: Benchmarking	3: Costed Action Plans										Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F1	Performance management	Efficiency	Applicable	2. Good	2. Good	Not applicable										0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Business Planning	2: Estate Optimisation	3: Commercial Opportunities	4: Partnership working	5: New Technology	6: PFI and LIFT contracts	7: Other contracts	8. Property	9: Cost improvement plans	10: Costed Action Plans			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F2	Improving efficiency - running	Efficiency	Applicable	2. Good	2. Good	2. Good	4. Requires moderate	Not applicable	2. Good	2. Good	2. Good	2. Good	Not applicable			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Capital Procurement	2: Capital Procurement Efficiencies	3. Flexibility	4. Identification and disposal of surplus land	5: Costed Action Plans								Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F3	Improving efficiency - capital	Efficiency	Applicable	1. Outstanding	1. Requires minimal im	2. Good	Not applicable									0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy & Procedures	2: Review Process	3: Costed Action Plans										Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F4	Financial controls	Efficiency	Applicable	2. Good	2. Good	Not applicable										0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Quality and Sustainability	2. Financial Pressure	3. Continuous improvement	4. Quality improvements	5. Recognition	6. Use of Information	7: Costed Action Plans						Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F5	Continuous improvement	Efficiency	Applicable	2. Good	2. Good	2. Good	3. Requires minimal im	2. Good	2. Good	Not applicable						0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Vision and Values	2. Strategy	3. Development	4. Vision and Values Understood	5. Strategy Understood	6. Progress	7: Costed Action Plans						Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E1	Vision and strategy	Effectiveness	Applicable	1. Outstanding	1. Outstanding	1. Outstanding	2. Good	2. Good	2. Good	Not applicable						0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Local Planning	2. Neighbourhood Planning	3. Planning Control	4. Special Interests	5. Enforcement	6: Costed Action Plans							Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E2	Town planning	Effectiveness	Applicable	2. Good	2. Good	2. Good	1. Outstanding	1. Outstanding	Not applicable							0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Disposal of land and property	2. Granting of Leases	3: Acquisition of land and property	4: Costed Action Plans									Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E3	Land and Property management	Effectiveness	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good					0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Sustainable Development Management Plan (SDMP)	2: Energy	3: Waste	4: Air Pollution	5: Water	6: Climate Change Adaptation	7: Procurement	8: Costed Action Plans					Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E4	Sustainability	Effectiveness	Applicable	2. Good	4. Requires moderate	2. Good	3. Requires minimal im	2. Good	4. Requires moderate	3. Requires minimal im	Not applicable					0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Framework	2. Roles	3. Partners	4. Framework	5: Assurance	6. Monitoring	7. Audit	8. Mitigation	9. Alignment	10: Costed Action Plans			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G1	Governance process	Governance	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Effectiveness	3. Challenges	4. Visibility	5. Relationships	6. Respect	7. Behaviours	8. Culture	9. Honesty	10. Safety & Wellbeing	11. Healthier workplace	12. Collaboration	13: Costed Action Plans	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G2	Leadership and culture	Governance	Applicable	2. Good	1. Outstanding	1. Outstanding	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Collaborative	Not applicable	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Professional advice	2. In-house advisors	3. External advisors	4: Costed Action Plans									Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G3	Professional advice	Governance	Applicable	2. Good	2. Good	2. Good	Not applicable									0	0	

Domain	SAQs -Not applicable	Sub-SAQs -Not applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total No.
Hard FM - Safety	0	20	4	67	37	21	3	152
Soft FM - Safety	0	30	0	51	8	0	0	89
Patient Experience	0	6	2	15	2	0	0	27
Efficiency	0	11	1	13	2	1	0	28
Governance	0	6	6	33	2	2	0	91
Total	0	93	23	189	51	24	3	338





NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH1	**SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 2. CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Health Building Note 00-08: The efficient management of healthcare estates and facilities 5. Health Building Note 00-08: Land and Property Appraisal - Available on the NHS Estates Collaboration Hub 6 A Risk-Based Methodology for establishing and Managing Backlog (NHS Estates 2004) 7. Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services 8. BS ISO 55000, 55001 & 55002: 2014 Asset Management 9 Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/guidance-policies-and-principles-of-healthcare-engineering https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148143/Backlog_costing.pdf https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/guidance-and-support/ https://www.iso.org/standard/55088.Health Technical Memorandum https://www.iso.org/iso-9001-quality-management.Health Technical Memorandum	
SH1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH1	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH1	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH2	**SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?**	Applicable	Applicable	SH2: With regard to the Design, Layout and Use of Premises in relation to functional suitability can the organisation evidence the following? Critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs	1. Health and Social Care Act 2008 Regulations 14 2. CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 3. Land and property appraisal (2007 DH) 4. Equality Act 2010 5. 2010 to 2015 government policy: compassionate care in the NS 6. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability https://www.gov.uk/government/publications/nhs-car-parking-management-Health Technical Memorandom-07-03 7. Health Building Notes 00-01 General design guidance for healthcare buildings 8. Health Building Notes 00-08 Strategic framework for the efficient management of healthcare estates and facilities 9. Health Building Notes 00-02 Designing sanitary spaces 10. Building Regulations Parts M and K 11. Dementia design checklist 12. Health Building Notes 08-02 Dementia friendly health and social care environments 13. NHSI Dementia assessment and improvement framework 14. Privacy and dignity report by the CNO into mixed sex accommodation in hospitals 15. NHS Protect crime risk assessment standard - cross reference to security SAQ SS6 16. Health Building Notes 00-09 Infection control in the built environment	
SH2	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Estate strategy setting out current baseline, plans to address deficiencies including organisations risk management process/systems 4. Dementia strategy/policy 5. Privacy and dignity strategy/policy 6. Equality Act accessibility assessment 7. Local Authority approved travel plan 8. Security policy 9. Standard specification+E21	1. Health and Social Care Act 2008 Regulations 14: and CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 2. CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 3. Land and property appraisal (2007 DH) 4. Equality Act 2010 5. 2010 to 2015 government policy: compassionate care in the NHS 6. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 7. Health Building Note 00-01 General design guidance for healthcare buildings 8. Health Building Note 00-08 Strategic framework for the efficient management of healthcare estates and facilities 9.. Health Building Note 00-02 Designing sanitary spaces	

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. If technical expertise in-house - job descriptions, PDP's, TNA, training plans 5. If technical expertise outsourced - specification, qualifications and references. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandum's and other standards.	10. Building Regulations Parts M and K 11. Dementia design checklist 12. Health Building Note 08-02 Dementia friendly health and social care environments 13. NHSI Dementia assessment and improvement framework 14. Privacy and dignity report by the CNO into mixed sex accommodation in hospitals 15. NHS Protect crime risk assessment standard - cross reference to security SAQ SS6 16. Health Building Note 00-09 Infection control in the built environment https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/other-guidance/ https://www.legislation.gov.uk/ukpga/2010/15/contents https://www.gov.uk/government/publications/2010-to-2015-government-policy-compassionate-care-in-the-nhs/2010-to-2015-government-policy-compassionate-care-in-the-nhs https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/316247/HBN_00-01-2.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/370592/HBN_08_Part_A.pdf https://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces https://www.gov.uk/government/publications/consolidation-and-simplification-of-parts-m-k-and-n-of-the-building-regulations https://www.dementiaaction.org.uk/assets/0000/4336/dementia_friendly_environments_checklist.pdf https://www.gov.uk/government/publications/dementia-friendly-health-and-social-care-environments-hbn-08-02 https://improvement.nhs.uk/resources/dementia-assessment-and-improvement-framework/ NEW-Delivering_same_sex_accommodation_sep2019.pdf (england.nhs.uk) https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment	
SH2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Six facet survey		
SH2	**4: Maintenance** Are relevant assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in		
SH2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. If technical expertise outsourced - appointment of qualified consultant or investment in training for staff in functional suitability issues (critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs) 4. If technical expertise in-house - PDP's, TNA, training plans, certificates of attendance/accreditation Purpose is to be able to identify levels of compliance to inform strategy/priority/investment		
SH2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans in place if ward/unit is closed due to unacceptable levels of compliance - breech of 15 (1) (c, d and f) 6. Test reports/action plans 7. Escalation to relevant committees 8. Peer review outputs		
SH2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Six facet survey; 4. Access audits; 5. Technical reports to cover critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs 6. Audit plan 7. Audit reports 8. Peer review output		
SH2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH3	**SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the coordination and control of the flow (storage, retrieval, processing, printing, copying, routing, distribution and disposal) of electronic and paper documents for Estates & Facilities documents in a secure and efficient manner.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents 2. CQC Guidance for providers on meeting the regulations https://www.cqc.org.uk/files/guidance-providers-meeting-regulations 17(2)(d) maintain securely such other records as are necessary to be kept in relation to—	

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Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH3	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Asset Register; 4. Estates Terrier; 5. Risk Assessments; 6. Test Certificates and records; 7. Insurance test certificates; 8. Building Information Modelling (BIM);	(i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity; Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance. Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This applies to all staff, not just newly appointed staff. Providers must observe data protection legislation about the retention of confidential personal information. Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents. Records must be kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so. Information in all formats must be managed in line with current legislation and guidance. 2. Health Technical Memorandum 00: Policies and principles of healthcare engineering https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/Health Technical Memorandom_00.pdf 3. BS EN 15221 Facilities Management https://shop.bsigroup.com/ProductDetail?pid=000000000030206404 3. BS ISO 55000, 55001 & 55002: 2014 Asset Management https://www.iso.org/standard/55088.Health Technical Memorandum 5. Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent.	
SH3	**2: Approval of documents** Are documents approved for adequacy prior to issue?	2. Good	2. Good	1. Test Certificates and records; 2. Insurance test certificates;		
SH3	**3: Review of documents** Are documents reviewed and updated as necessary with changes identified?	2. Good	2. Good	1. Regular of policies and procedures to ensure implementation;		
SH3	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of document availability both in terms of policies/procedures as well as spot checks on availability;	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. BS EN 15221 Facilities Management 5. BS ISO 55000, 55001 & 55002: 2014 Asset Management 6. Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://shop.bsigroup.com/ProductDetail?pid=000000000030206404 https://www.iso.org/standard/55088.html "https://www.iso.org/iso-9001-quality-management.html https://efqm.org/efqm-model/	
SH3	**5. Legibility of Documents** Are all relevant documents legible and readily identifiable?	1. Outstanding	2. Good	1. Review of document availability both in terms of policies/procedures as well as spot checks on legibility;		
SH3	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of policies and procedures to ensure implementation;		
SH3	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	3. Requires minimal improvement	3. Requires minimal improvement	1. Formal procedures in place to identify and replace obsolete documents; 2. Records of document replacement; 3. Review of documents replacement records to ensure completeness and accuracy;		
SH3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH4	**SH4: With regard to Health & Safety at Work can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to overall H&S management. Most of the Safety SAQs will contain aspects of compliance with H&S legislation also e.g. risk assessments and COSHH assessments.	1. The Health and Safety at Work etc. Act 1974: The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. HSE. Management of health and safety at work. Management of Health and Safety at Work Regulations 1999: Approved Code of Practice & guidance. L21 2nd edition. 2000. 3. IoD / HSC. Leading health and safety at work: leadership actions for directors and board members. IoD & HSE publication, 2007 4. HSE. Consulting workers on health and safety. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended): Approved Codes of Practice and guidance. L186. 2008. 5. HSE, A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, HSE Books, 3rd Edition, 2008. 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations	
SH4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Evidence that H&S regulations are: - Understood by all teams involved - Applied by all teams involved - Systematically checked for compliance - Reported for exceptions 4. H&S Committee involvement - committee structure chart and terms of reference 5. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities	15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
SH4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:1. Adequate welfare facilities 4. COSHH assessments 5. Health and Safety audits / inspections (completed internal and examples of any external agency reports and associated action plans) 6. Plant and equipment are safe including maintenance, service and test reports 7. Safe arrangements for the use, handling, storage and transport of articles, materials and substances, 8. Safe access and egress.	7. CQC Provider Handbooks W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 1. The Health and Safety at Work etc. Act 1974: The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. HSE. Management of health and safety at work. Management of Health and Safety at Work Regulations 1999: Approved Code of Practice & guidance. L21 2nd edition. 2000. 3. IoD / HSC. Leading health and safety at work: leadership actions for directors and board members. IoD & HSE publication, 2007 4. HSE. Consulting workers on health and safety. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended): Approved Codes of Practice and guidance. L186. 2008. 5. HSE, A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, HSE Books, 3rd Edition, 2008. 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 7. CQC Guidance for providers on meeting the regulations 8. CQC Provider Handbooks	

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Examples of completed risk assessments – including COSHH, DSE, stress etc.	8. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.hse.gov.uk/pubns/hsc13.pdf https://www.hse.gov.uk/pUbns/indg417.pdf https://www.hse.gov.uk/pubns/books/l146.htm https://www.hse.gov.uk/pubns/indg453.htm https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH4	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports		
SH4	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. H&S information for staff 6. Copies of permits to work issued and documented procedures and training records for staff responsible for issue of permit to work 7. Copies of insurance and written schemes of inspection certificates 8. Evidence of compliance with all relevant published HBNs, CFPPs and Health technical Memorandum TMs 9. Meeting minutes 6. Documentation and procedures for Safe systems of work		
SH4	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports and subsequence investigations including root cause analysis investigations		
SH4	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH5	**SH5: With regard to Asbestos can the organisation evidence the following?**	Applicable	Applicable		1. Control of Asbestos Regulations 2016 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. 3. REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2006). 4. HSE equipment and method series (em1 etc.) 5. HSE asbestos essentials task sheets (A1 etc.) 1. Control of Asbestos Regulations 2016 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 3. CQC Guidance for providers on meeting the regulations 4. REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2006). 5. HSE equipment and method series (em1 etc.) 6. HSE asbestos essentials task sheets (A1 etc.) https://www.legislation.gov.uk/uksi/2012/632/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.hse.gov.uk/reach/ https://www.hse.gov.uk/pubns/guidance/emseries.htm https://www.hse.gov.uk/pubns/guidance/emseries.htm	
SH5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Permits to work 4. Procedures to undertake work 5. Asbestos management plan 6. Asbestos register		
SH5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Procedures to ensure staff and contractors have appropriate competencies, licences, professional indemnities and liability cover, also a record that these have been checked. 5. Permits to work 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. A documented record of the location and condition of the asbestos containing materials - or materials which are presumed to contain asbestos. 5. Evidence of risk assessments relating to the potential exposure to fibres from the materials identified. 6. A plan that sets out in detail how the risks from these materials will be managed and how this has been actioned.		
SH5	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH5	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence that reasonable steps have been taken to find out if there are materials containing asbestos in non-domestic premises, and if so, its amount, where it is and its condition. 6. Evidence that there is a period review of the plan and the arrangements in place to ensure that the plan remains relevant and up-to-date.		
SH5	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence that information on the location and condition of the materials is provided to anyone who is liable to work on or disturb them 4. Active asbestos register 5. Significant findings from Authorising Engineer reports and action plans.		
SH5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH6	**SH6: With regard to Medical Gas Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum: 02-01: Medical gas pipeline systems 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 4. CQC Provider Handbooks S3.10. Do arrangements for managing medicines, medical gases and contrast media keep people safe? (This includes obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.) 1. Health Technical Memorandum: 02-01: Medical gas pipeline systems 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks https://www.gov.uk/government/publications/medical-gas-pipeline-systems-part-a-design-installation-validation-and-verification https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum Health technical memorandum TM02-01 Part B. 3. The organisation has used Appendix H to the Health Technical Memorandum 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system. 4. Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU).		
SH6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. The organisation has reviewed the skills and competencies of identified roles within the Health Technical Memorandum and has assurance of resilience for these functions; 3. Key relevant Objectives for the period:1. Permit to work 4. Approved persons 5. Authorised Persons 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards		

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Organisation has a risk assessment as per section 6.6 of the Health Technical Memorandum 02-01 3. Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the Health Technical Memorandum 02-01 (please indicated in the organisational evidence column the date of your last review)	https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum Health Technical Memorandom02-01 Part B.		
SH6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has reviewed the skills and competencies of identified roles within the Health Technical Memorandum and has assurance of resilience for these functions; including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	4. Requires moderate improvement	1. The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases; 2. Emergency response and business continuity plans developed and reviewed. The organisation has a clear escalation plan and processes for management of surge in oxygen demand; 3. Regular testing of Emergency response, business continuity plans and escalation plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports and action plans. 4. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities		
SH6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH7	**SH7: With regard to Natural Gas and specialist piped systems can the organisation evidence the following?**	Applicable	Applicable	See SAQ SH6 for Medical gas systems. This SAQ covers other gas installations and piped systems with specialist requirements such as high purity, compressed air negative pressure systems.	1. Gas Appliances (Safety) Regulations 1995 2. Gas Safety (Installations) & Use) Regulations 1998 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	
SH7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Approved persons, including employing a suitably qualified person where appropriate, i.e. "Gas Safe Registered" 5. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards. 6. Permit to work	1. Gas Appliances (Safety) Regulations 1995 2. Gas Safety (Installations) & Use) Regulations 1998 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1995/1629/contents/made https://www.legislation.gov.uk/uksi/1998/2451/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents	

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;	https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	4. Requires moderate improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Quality Control Evidence		
SH7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH8	**SH8: With regard to Water Safety Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 00: Policies and principles of healthcare engineering 3. Water Supply (Water Fittings) Regulations 1999 4. Defra's guidance to the Water Supply (Water Fittings) Regulations 5. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: the control of legionella, hygiene, "safe" hot water, cold water and drinking water systems (Scheduled to be replaced in April 2016 by Health Technical Memorandum 04-01: Safe water in healthcare premises) 4. Notification of Cooling towers and Evaporative Condensers Regulations 1992 4. Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa 5. Health Technical Memorandum 07-01: Water Management and Water Efficiency 6. Health Technical Memorandum 07-04: Water management and water efficiency – best practice advice for the healthcare sector 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 1. Health Technical Memorandum 00: Policies and principles of healthcare engineering 2. Water Supply (Water Fittings) Regulations 1999 3. Defra's guidance to the Water Supply (Water Fittings) Regulations 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: the control of legionella, hygiene, safe hot water, cold water and drinking water systems (Scheduled to be replaced in April 2016 by Health Technical Memorandum 04-01: Safe water in healthcare premises) 5. Notification of Cooling towers and Evaporative Condensers Regulations 1992 6. Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa 7. Health Technical Memorandum 07-01: Water Management and Water Efficiency	
SH8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities; 4. Water Safety Plans in place, including legionella written scheme 5. Action Plans, including their implementation 6. Control Measures and testing micro- organisms including Legionella and Pseudomonas 7. Organisations with boreholes must comply with the Private Water Supplies Regulations 2009		
SH8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	5. Inadequate	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Water Safety Group with relevant advice and attendees		
SH8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH8	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	5. Inadequate	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical	8. Health Technical Memorandum 07-04: Water management and water efficiency – best practice advice for the healthcare sector 9. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10. CQC Guidance for providers on meeting the regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.hse.gov.uk/pubns/books/l8.htm https://www.legislation.gov.uk/uksi/1992/2225/contents/made https://www.gov.uk/government/publications/hot-and-cold-water-supply-storage-and-distribution-systems-for-healthcare-premises https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Reports to Infection Control Committee or other groups within the Governance Structure 4. Significant findings from Authorising Engineer reports and action plans.		
SH8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH9	**SH9: With regard to Electrical Systems can the organisation evidence the following?:**	Applicable	Applicable	This SAQ covers all aspects of electrical safety such as high and low voltage, switchgear, BMS, fire detection, communication, security, Lightening protection, PAT testing etc.	15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 1. Electricity at Work Regulations 1989 (EAWR) 2. Electrical Equipment (safety) Regulations 1994 3. Electromagnetic Compatibility regulations 1992 4. Fuel and Electrical (Heating) (Control) (Amendment) Order 1980 5. Health Technical Memorandum 06-01: Electrical Services/Safety 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health Technical Memorandum 06-01: Electrical Services/Safety; 8. Health Technical Memorandum 06-02: Electrical Safety Guidance for Low Voltage Systems in healthcare premises 9. Health Technical Memorandum 06-03 Electrical safety guidance for high voltage systems in healthcare premises 10. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 11. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1989/635/contents/made https://www.legislation.gov.uk/uksi/1994/3260/contents/made https://www.legislation.gov.uk/uksi/1992/2372/contents/made https://www.legislation.gov.uk/uksi/1980/1013/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/608037/Health_tech_memo_0601.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.gov.uk/government/publications/guidance-on-electrical-services-supply-and-distribution-within-healthcare-premises https://www.gov.uk/government/publications/electrical-safety-guidance-for-low-voltage-systems-in-healthcare-premises https://www.gov.uk/government/publications/electrical-safety-guidance-for-high-voltage-systems-in-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of the policies and procedures through the ESG, or add separate bullet point for the ESG;		
SH9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards and Authorised Persons appointed as recommended by Authorising Engineer.		
SH9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. The Risk register should be developed and monitored by the ESG as per Health Technical Memorandum 06-01; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Up to date asset register incorporated into CAFM system; 4. Quality control/Inspection records 5. Copies of test certificates/EC Declarations of Conformity 6. Records of inspections/thorough examinations 7. Written schemes of examination 8. Copies of insurance certificates/formal documentation from notified bodies		

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	4. Requires moderate improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH10	**SH10: With regard to Mechanical Systems and Equipment e.g. Lifting Equipment can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers mechanical systems not included elsewhere e.g. space heating. Equipment with a medical use is assessed under SH15 Medical devices and Equipment.	1. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 2. Provision and Use of Work Equipment Regulations 1998 (PUWER) 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	
SH10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;	1. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 2. Provision and Use of Work Equipment Regulations 1998 (PUWER) 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 5. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/work-equipment-machinery/loler.htm https://www.hse.gov.uk/pubns/books/puwer.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH10	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Copies of test certificates/EC Declarations of Conformity 5. Records of inspections/thorough examinations 6. Copies of insurance certificates/formal documentation from notified bodies 7. Written schemes of examination		
SH10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH10	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH11	**SH11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises 2https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations	
SH11	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration	
SH11	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH11	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;	1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations https://www.gov.uk/government/publications/guidance-on-specialised-ventilation-for-healthcare-premises-parts-a-and-b https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH11	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Health Technical Memorandum 03-01 part B recommends: a. All ventilation plant should meet a minimum requirement in terms of the control of Legionella and safe access for inspection and maintenance. b. All ventilation plant should be inspected annually. c. The performance of all critical ventilation systems (such as those servicing operating suites) should be verified annually		
SH11	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH11	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	5. Inadequate	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH11	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		

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Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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SH11	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH12	**SH12: With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following?**	Applicable	Applicable	Medical hoists and lifts are covered under SH15 Medical Devices and Equipment.	1. Lifts Regulations 1997 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering - https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf 3. 3. Health Technical Memorandum 08-02: Design and maintenance of lifts in the health sector - Lifts 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 1. Lifts Regulations 1997 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health Technical Memorandum 08-02: Design and maintenance of lifts in the health sector - Lifts 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1997/831/contents/made https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.gov.uk/government/publications/guidance-concerning-the-planning-installation-and-operation-of-lifts-in-healthcare-buildings https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH12	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH12	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH12	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH12	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH12	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH12	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH12	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH12	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH13	**SH13: With regard to Pressure Systems can the organisation evidence the following?**	Applicable	Applicable	Users can assess the specific requirements around Pressure Systems in this SAQ or within relevant SAQ with pressure systems e.g. medical gases. The approach used should be explained in the notes column.	1. Simple Pressure Vessels (Safety) Regulations 1991 2. Pressure Systems Safety Regulations 2000 (PSSR) 3. Pressure Equipment Regulations 1999 4. HSE Guidance Note PM5 1989 Automatically Controlled steam and hot water boilers 5. ACoP L122 Safety of Pressure Systems 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering - https://www.england.nhs.uk/wp	

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH13	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 1. Simple Pressure Vessels (Safety) Regulations 1991 2. Pressure Systems Safety Regulations 2000 (PSSR) 3. Pressure Equipment Regulations 1999 4. HSE Guidance Note PM5 1989 Automatically Controlled steam and hot water boilers 5. ACoP L122 Safety of Pressure Systems 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1991/2749/contents/made https://www.legislation.gov.uk/uksi/2000/128/contents/made https://www.legislation.gov.uk/uksi/1999/2001/contents/made https://www.hse.gov.uk/research/hsl_pdf/2005/ci05-11.pdf https://www.hse.gov.uk/pubns/books/l122.htm#:~:text=The%20Pressure%20Systems%20Safety%20Regulations,one%20of%20its%20component%20parts. https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH13	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH13	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH13	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH13	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH13	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH13	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH13	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH14	**SH14: With regard to Fire Safety can the organisation evidence the following?**	Applicable	Applicable	This SAQ assesses Fire Safety in its entirety including detection and alarm systems, sprinkler/water mist systems, fire damper operation etc. There may be some overlap with other SAQs, e.g. SH9 and SH11 that can be cross referred to avoid duplication	1. Regulatory Reform (Fire Safety) Order 2005 2. Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 3. The Fire and Rescue Services Act 2004 4. Health and Safety (Training for Employment) Regulations 1990 5. Health and Safety at Work Act 1974 6. Management of Health and Safety at Work Regulations 1999 7. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 8. Safety Representatives and Safety Committees Regulations 1977 9. Building Regulations 2010 10. The Housing Act 2004 11. Health Technical Memorandum 05-01: Managing Healthcare Fire Safety 12. Health Technical Memorandum 05-02 Guidance in Support of Functional Provisions for Healthcare Premises 13. Health Technical Memorandum 05-03 Operational Provisions 14. HM Government – fire safety risk assessment: 'Means of Escape for Disabled People' 15. HM Government – fire safety risk assessment: 'Healthcare premises' 16. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and	
SH14	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site aligned to guidance; 2. Regular assessment of policies and procedures; 3. Local operating procedures in place including such items as contractors working on fire compartments		
SH14	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people, in compliance with relevant legislation and published guidance, with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH14	**3. Governance** Are there regular meetings of the fire safety committee, is there an external annual report by the authorising engineer (fire) is there an annual internal report to the Board	Not applicable	3. Requires minimal improvement	1. Minutes of committee meetings 2. Annual AE report 3.Annual internal report	• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 1. Regulatory Reform (Fire Safety) Order 2005 2. Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 3. The Fire and Rescue Services Act 2004 4. Health and Safety (Training for Employment) Regulations 1990 5. Health and Safety at Work Act 1974 6. Management of Health and Safety at Work Regulations 1999 7. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 8. Safety Representatives and Safety Committees Regulations 1977 9. Building Regulations 2010 10. The Housing Act 2004 11. Health Technical Memorandum 05-01: Managing Healthcare Fire Safety 12. Health Technical Memorandum 05-02 Guidance in Support of Functional Provisions for Healthcare Premises 13. Health Technical Memorandum 05-03 Fire safety - Operational Provisions 14. HM Government – fire safety risk assessment: 'Means of Escape for Disabled People' 15. HM Government – fire safety risk assessment: 'Healthcare premises' 16. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/2005/1541/contents/made https://www.legislation.gov.uk/uksi/2003/2457/contents/made https://www.legislation.gov.uk/ukpga/2004/21/pdfs/ukpga_20040021_en.pdf https://www.legislation.gov.uk/uksi/1990/1380/contents/made https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1995/3163/contents/made https://www.legislation.gov.uk/uksi/1977/500/contents/made https://www.legislation.gov.uk/uksi/2010/2214/contents/made https://www.legislation.gov.uk/ukpga/2004/34/contents https://www.gov.uk/government/publications/managing-healthcare-fire-safety https://www.gov.uk/government/publications/guidance-in-support-of-functional-provisions-for-healthcare-premises https://www.gov.uk/government/publications/suite-of-guidance-on-fire-safety-throughout-healthcare-premises-parts-a-to-m#:~:text=Operational%20Provisions%20Part%20A%20(HTM,Part%20C%20%E2%80%93%20Textiles%20and%20furnishings&text=Part%20H%20%E2%80%93%20Reducing%20false%20alarms%20in%20hospital%20premises https://www.gov.uk/government/publications/fire-safety-risk-assessment-means-of-escape-for-disabled-people https://www.gov.uk/government/publications/fire-safety-risk-assessment-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH14	**4. Enforcement** Has there been any enforcement of the fire safety order, either under articles 29, 30 and 31 of the fire safety order (alterations, enforcement or prohibition notice) or informal (notification of deficiencies) where no enforcement notices have been received, this should be scored as good.	Not applicable	2. Good	1. Copies of FSO notices 2. Copies of notification of deficiencies		
SH14	**5: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers where appropriate; 4. Fire Risk Assessments 5. Fire Safety Plans and Reviews 6. Compartmentalization drawings showing fire compartments and fire dampers.		
SH14	**6 Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Risk based evidence backed planned preventative maintenance system in place e.g. fire alarm systems, fire doors, fire compartmentation, fire dampers, fire extinguishers; 3. Risk based methodology, quality control/Inspection records		
SH14	**7 Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records, incorporating specific evacuation training for staff with patient contact and evidence of this training.		
SH14	**8: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans for fire alarm mitigation in cases of system failure 6. Reduction of unwanted fire signals (both false alarms and spurious calls on the fire and rescue authority)		
SH14	**9: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures? (Note 1)	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports; 4. Fire service audits; 5. Evacuation tests; 6. Fire risk assessment review frequency aligned to legislative requirements and risk.		
SH14	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH15	**SH15: With regard to Medical Devices and Equipment can the organisation evidence the following?**	Applicable	Applicable	Decontamination is covered under SAQ SS1	1. Provision and Use of Work Equipment Regulations 1998 2. ACoP 22 Safe Use of work Equipment. Health Technical Memorandum 00: Policies and principles of healthcare engineering 3. Medicines and Healthcare Products Regulatory Agency (MHRA) Guidance 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used, • Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010. • There must be sufficient equipment to provide the service. 15(1)(d) properly used, 15(1)(e) properly maintained, and • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds)	
SH15	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH15	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH15	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;	There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided. • Providers must make sure that staff and others who operate the equipment are trained to use it appropriately. 15(1)(f) appropriately located for the purpose for which they are being used. Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical equipment, and moving and handling equipment. 15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. • Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this 1. Provision and Use of Work Equipment Regulations 1998 2. ACoP 22 Safe Use of work Equipment. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Medicines and Healthcare Products Regulatory Agency (MHRA) Guidance 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/pubns/books/puwer.htm https://www.hse.gov.uk/pubns/books/l22.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH15	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH15	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH15	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH15	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH15	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH16	**SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?**	Applicable	Applicable	This SAQ looks at the overall approach to resilience, emergency and business continuity planning.	1. Civil Contingencies Act 2004 2. NHS Standard Contract; 3. Health Building note 00-07: Resilience Planning for the Healthcare Estates 2014 Edition 4. NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and Associated Guidance 5. ISO 22301:2014 'Business Continuity Management Systems' 6. ISO 22313:2012 'Business Continuity management Systems Guidance'. 5. CQC Provider Handbooks S5.2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed? 1. Civil Contingencies Act 2004 2. NHS Standard Contract; 3. Health Building note 00-07:Resilience planning for NHS facilities 30 April 2014: Guidance 4. NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and Associated Guidance 5. ISO 22301:2014 'Business Continuity Management Systems' 6. ISO 22313:2012 'Business Continuity management Systems Guidance'. 7. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/2004/36/contents https://www.england.nhs.uk/nhs-standard-contract/ https://www.gov.uk/government/publications/resilience-planning-for-nhs-facilities https://www.england.nhs.uk/wp-content/uploads/2017/12/eprr-guidance-chart-v3.pdf https://shop.bsigroup.com/ProductDetail/?pid=000000000030292502 https://www.iso.org/standard/75107.html https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH16	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301; 2. The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board;		
SH16	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	1. Outstanding	1. The organisation's Estates and Facilities team is appropriately represented at the organisation's committee(s) which oversee Business Continuity and/or Emergency Preparedness; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH16	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH16	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH16	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH16	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s); 2. Outputs of reviews and their inclusion in Action Plans;		
SH16	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH17	**SH17: With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to: 1. Reporting safety related incidents and accidents, 2. Ensuring corrective action is taken where notified in E&F safety alert system and similar.	1. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2. Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 3. Department of Health Never Events Policy Framework 4. RIDDOR 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 17(2)a Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.	
SH17	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH17	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Embedding bulletins into practice	1. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2. Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 3. Department of Health Never Events Policy Framework 4. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf https://www.cqc.org.uk/files/care-quality-commission-registration-regulations-2009 https://improvement.nhs.uk/resources/never-events-policy-and-framework/ https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH17	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH17	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH17	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	4. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH17	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports 4. Investigations		
SH17	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
SH18	**SH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?**	Applicable	Applicable	This SAQ mainly refers to ensuring rented (or similar) premises and related services are safe and suitable. Outsourced services will generally be considered under the relevant SAQ and Contractor management SH16. See the NHS PAM guidance for details on the PAM assessment for multiple small sites.	1. Health and Safety at Work Act 1974 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration 3. CQC Provider Handbooks W2.3. How are working arrangements with partners and third party providers managed? 1. Health and Safety at Work Act 1974 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 3. CQC Guidance for providers on meeting the regulation 4. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH18	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH18	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	1. Outstanding	1. Outstanding	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH18	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4.. A fire safety risk assessment has been undertaken and that a practice fire evacuation of the building has been undertaken		
SH18	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SH18	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH18	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		
SH18	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	1. Outstanding	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Safe systems in place for electrical safety to include Portable Appliance Testing (PAT) testing 4. Control of Substances Hazardous to Health (COSHH) assessment has been undertaken and documented 5. Adequate security of the premises, e.g., panic alarms in the consulting rooms 6. A safe and effective system for storage of all waste 7. All staff are aware of their roles and responsibilities in the event of an emergency		
SH18	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
SH19	**SH19: With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers using E&F contractors for a full range of services from maintenance and servicing to major construction, **both Hard and Soft FM**. It is about ensuring: competent contractors are appointed, adequately informed, instructed and trained, managed and supervised, co-ordinated and co-operate.	1. Health and Safety at Work etc. Act 1974 2. Construction (Design and Management) Regulations 3. HSE INDG368 4. Management of Health and Safety at Work Regulations 5. Legislation relevant to the service provided, as detailed in relevant SAQs. 6. Building Regulations 7. Planning Legislation including listed building consents 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used, • Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Any change of use of premises and/or equipment should be informed by a risk assessment and providers must make appropriate alterations to premises and equipment where reasonably practical. Where this is not possible, providers should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. Alterations must be in line with current legislation and guidance. 9. CQC Provider Handbooks W2.3. How are working arrangements with partners and third party providers managed? 1. Health and Safety at Work etc. Act 1974 2. Construction (Design and Management) Regulations 3. HSE INDG368 4. Management of Health and Safety at Work Regulations 5. Legislation relevant to the service provided, as detailed in relevant SAQs. 6. Building Regulations 7. Planning Legislation including listed building consents 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 9. CQC Guidance for providers on meeting the regulations 10. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.hse.gov.uk/construction/cdm/2015/index.htm https://www.hse.gov.uk/pubns/indg368.htm https://www.legislation.gov.uk/uksi/1999/3242/contents/made Planning (Listed Buildings and Conservation Areas) Act 1990 (legislation.gov.uk) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH19	**1: Policy** Does the organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SH19	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood who are responsible for the management of contractors?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH19	**3: Risk Assessment** Are contractors risk assessments and if applicable, method statements (RAMS) requested from the contractor(s) prior to works commencing and reviewed for their appropriateness?	2. Good	2. Good	1. Agreed allocation of risk is monitored; 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH19	**4: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Documented evidence of audits and reviews to support compliance. 5. Auditing and inspecting the Contractors' work, ensuring that they comply with the contractual requirements on quality, Health and Safety, environmental and legislative requirements. 6. Managing communication between the Contracting Body and the Sub-Contractors;		
SH19	**5. Contractor Competence** With regards to the competence of the contractors - has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?	2. Good	2. Good	1. Adequate insurance. 2. Performance monitoring against agreed Key Performance Indicators. 3. Evidence of professional qualifications and experience;		
SH19	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Supplier Business Continuity and Disaster Recovery Plan.		
SH19	**7: Review Process** Is there a robust regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors;		

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◄◄ Back to instructions		

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH19	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS1	**SS1: With regard to Catering Services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the safety aspects of catering and food with SAQ PE4 looking at patient feedback on food. Note: This applies to all food sources on-site including commercial and charitable outlets.	1. Food Hygiene (England) Regulations 2006. 2. Control of Substances Hazardous to Health 2002 3.Food Safety Act 1990.(Amended Regulations 2004) 4. HSG (96) 20 -Management of Food Hygiene & Food Services in the National Health Service. 5. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 6. Regulation EC 852/2004 on the hygiene of foodstuffs. 7. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2007 8. Compliance with Healthcare Commission Core Standard 14 (Food) 9. Health Act 2006 Code of Practice for Prevention and Control of Health Care Associated Infections (Department of Health 2006) revised January 2008 10. Food Safety(England) Regulations 2005 11. Food Safety (Temperature Control) Regulations 1995 12. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 1. Food Hygiene (England) Regulations 2006. 2. Control of Substances Hazardous to Health 2002 3.Food Safety Act 1990.(Amended Regulations 2004) 4. HSG (96) 20 -Management of Food Hygiene & Food Services in the National Health Service. 5. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 6. Regulation EC 852/2004 on the hygiene of foodstuffs. 7. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2007 8. Compliance with Healthcare Commission Core Standard 14 (Food) 9. Health Act 2006 Code of Practice for Prevention and Control of Health Care Associated Infections (Department of Health 2006) revised January 2008 10. Food Safety(England) Regulations 2005 11. Food Safety (Temperature Control) Regulations 1995 12. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 13.CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/2006/14/contents/made https://www.hse.gov.uk/nanotechnology/coshh.htm https://www.legislation.gov.uk/uksi/2004/2990/contents/made https://www.legislation.gov.uk/eur/2004/852/contents http://www.hospitalcaterers.org/publications/ "https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-14-meeting-nutritional-hydration-needs https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586490/HFSP_Report.pdf" https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance https://www.legislation.gov.uk/uksi/2005/2059/contents/made https://www.legislation.gov.uk/uksi/1995/2200/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy, Food Safety Management System and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has the organisation documented all processes and procedures in an approved HACCP document?	2. Good	3. Requires minimal improvement	1. Food Standards Agency ratings and Nonmental Health Officer reports. 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers; 5. Nutritional screening programme identifying patients at risk from malnutrition and dehydration. 6. Allergens screening		
SS1	**4: Maintenance** Are assets, equipment and plant adequately maintained, regularly and monitored to ensure equipment relating to temperature control is functioning correctly?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements including level 2 hygiene for all food handlers and HACCP at the appropriate level for supervisors and Managers?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS1	**7: Review Process** Is there a robust regular review process to assure compliance and effectiveness of relevant standards, policies and procedures which includes sampling and testing where required?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS2	**SS2: With regard to Decontamination Processes can the organisation evidence the following?**	Applicable	Applicable	Management, operation and maintenance of decontamination equipment and processes covering the decontamination of surgical equipment, linen, dental equipment and flexible endoscopes. As set out in the HTM 01 Suite 01-06		

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SS2	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Quality manual and supporting processes.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation F18and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration HTM01-01A, B, C, D, E; HTM01-04A, B, C, D; HTM01-05; HTM01-06A, B, C, D, E; ISO 9001 and ISO13485 Estate/MHRA alerts Medical Devices Directive. Revision to the Medical Devices Directive. CQC Guidance about compliance. GS1 coding. NHS Operating Framework 2012/13. Medical Devices Regulations (MDR) 2002. BS EN ISO 13485. Executive Letter EL(98)5. Decontamination Services Agreement. In-vitro Diagnostic Devices Directive. Kirby, E., Dickinson, J., Vassey, M., Dennis, M., Cornwall, M., Mcleod N. et al. (2012). Bioassay stunnex L. IHEEM AE(D) register. Institute of Decontamination Sciences (Discs). Institute of Healthcare Engineering and Estate Management (IHEEM). ESAC-Pr report. MHRA's 'Managing medical devices: guidance for healthcare and social services organisations' MHRA 'Medical devices: conformity assessment and the CE mark'. BSG Guidance for flexible endoscopy JAG Guidance for endoscopy BS EN ISO 15883 (washers – surgical and endo) BS EN ISO 285 (sterilizers) BS EN ISO 14662 (drying cabinets endo) 1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained 2. CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained, and 3. Health Technical Memorandum01-01A, B, C, D, E 4. Health Technical Memorandum01-04A 5. Health Technical Memorandum01-05 6. Health Technical Memorandum01-06A, B, C, D, E; 7. ISO 9001 8. ISO13485 9. Estate/MHRA alerts 10. Medical Devices Directive. 11. Revision to the Medical Devices Directive. 12. CQC Guidance about compliance. - Guidance about compliance Essential standards of quality and safety 13. GS1 coding. 14. NHS Operating Framework 15. Medical Devices Regulations (MDR) 2002. 16. BS EN ISO 13485. 17. Executive Letter EL(98)5. 18. Decontamination Services Agreement. 19. In-vitro Diagnostic Devices Directive. 20. Kirby, E., Dickinson, J., Vassey, M., Dennis, M., Cornwall, M., Mcleod N. et al. (2012). Bioassay stunnex L. 21. IHEEM AE(D) register. 22. Institute of Decontamination Sciences (IDSc). 23. Institute of Healthcare Engineering and Estate Management (IHEEM). 24. ESAC-Pr report. 25. MHRA's 'Managing medical devices: guidance for healthcare and social services organisations' 26. MHRA 'Medical devices: conformity assessment and the CE mark'. 27. BSG Guidance for flexible endoscopy 28. JAG Guidance for endoscopy 29. BS EN ISO 15883 (washers – surgical and endo) 30. BS EN ISO 285 (sterilizers) 31. BS EN ISO 14662 (drying cabinets endo) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations NHS England » Health technical memoranda	
SS2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Trust management structure for decontamination 5. Appointment letter for AE, job descriptions e.g. decontamination lead, SSD manager, Endoscopy Unit decontamination team 6. Appointment letter for AP(D) 7. Evidence of employing appropriately qualified experienced people in key roles as identified in the HTMs and other standards.		
SS2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS2	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Validation reports for washer disinfectors and drying cabinets. 5. Permits to work for service engineers. Service contracts. PPM dockets and maintenance instructions 6. Permit to work system		
SS2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training needs analysis, staff training matrix for SSD/Endoscopy and Estates Teams. Specialist training with external providers. Scope cleaning training 4. Competency documents for endoscopy technicians 5. Competency documents for contractors required to work on decontamination equipment 6. Agency staff - if used include matrix of assessment of competency etc?		
SS2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business Continuity plans for SSD and Endoscopy Unit. 6. Test reports for efficacy of plans. 7. Training records for staff following testing		

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SS2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	1. Outstanding	1. Outstanding	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Internal and external audit reports 4. Use of ISO 9001 and ISO13485 can be incorporated into evidence 5. AE audit of Trust policy and processes 6. IHEEM JAG audit report and certificate 7. Significant findings from Authorising Engineer reports and action plans.	NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda ISO - ISO 9000 family — Quality management https://shop.bsigroup.com/ProductDetail?pid=00000000030353196&creative=435401337506&keyword=&matchtype=b&network=g&device=c&gclid=Cj0KCQjwhb36BRCfARIsAKcXh6GMNUjeSJRKxBsGuwxpkqp_2sQxy7VOg8DODJbCx0VtftiaOupLFzQaAoDMEALw_wcB https://www.cas.mhra.gov.uk/Home.aspx https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf https://www.gs1.org/standards/barcodes https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13 https://www.legislation.gov.uk/uksi/2002/618/contents/made https://shop.bsigroup.com/products/medical-devices-quality-management-systems-requirements-for-regulatory-purposes/tracked-changes https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376918/Guidance_on_the_In_Vitro_Diagnostic_Medical_Devices_Directive.pdf http://eprints.gla.ac.uk/75539/1/75539.pdf https://www.iheem.org.uk/IHEEM-Authorising-Engineer-Decontamination-Register https://www.idsc-uk.co.uk/ https://www.iheem.org.uk/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271414/Frequently_asked_questions.pdf https://www.gov.uk/government/publications/managing-medical-devices https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.bsg.org.uk/clinical-resource/guidance-on-decontamination-of-equipment-for-gastrointestinal-endoscopy-2017-edition/	
SS2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS3	**SS3: With regard to Waste and Recycling Management can the organisation evidence the following?**	Applicable	Applicable	The scope of this SAQ may gross over into Effectiveness Question E4 (SDMP)		
SS3	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS3	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS3	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;	1. Waste Electrical and Electronic Equipment Regulations 2006 2. Pollution Prevention and Control (England and Wales) Regulations 2000 3. Environment Act 1995 4. Environmental Protection Act 1990 5. Health Technical Memorandum 07-01; Safe Management of Healthcare Waste 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean, • Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance. 7. CQC Provider Handbooks S3.9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.) 1. Waste Electrical and Electronic Equipment Regulations 2006 2. Pollution Prevention and Control (England and Wales) Regulations 2000 3. Environment Act 1995 4. Environmental Protection Act 1990 5. Health Technical Memorandum 07-01; Safe Management of Healthcare Waste 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 7. CQC Guidance for providers on meeting the regulations 8. CQC Provider Handbooks https://www.legislation.gov.uk/uksi/2006/3289/contents/made https://www.legislation.gov.uk/uksi/2000/1973/contents/made https://www.legislation.gov.uk/ukpga/1995/25/contents https://www.legislation.gov.uk/ukpga/1990/43/contents https://www.gov.uk/government/publications/guidance-on-the-safe-management-of-healthcare-waste https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SS3	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS3	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS3	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		

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SS3	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS4	**SS4: With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence the following ?**	Applicable	Applicable	This SAQ covers the safety aspects of cleaning and infection control. SAQ PE3 looks at patient feedback relating to cleanliness.	1. Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. 2. Infection Control (HBN 00-09) 2013 3. Department of Health (2011) PAS 5748:2011 Specification for the planning, application and measurement of cleanliness in hospitals 4. Association of Healthcare Cleaning Professionals (AHCP) (2009) Colour Coding Hospital Cleaning Materials and Equipment: Safer Practice Notice 15 5. National Patient Safety Agency (2007) The National Specification for Cleanliness in the NHS: A Framework for Setting and Measuring Performance Outcomes. 6. Department of Health (2006) Saving Lives: A delivery programme to reduce healthcare associated infection including MRSA. 7. Department of Health (2004) Towards cleaner hospitals and lower rates of infection. 8. Department of Health (2004) A Matron's Charter: An Action Plan for Cleaner Hospitals. 9. NHS Estates (1997). Health Building Note 4 In-Patient Accommodation: Options for Choice (HBN) 4. 10. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean, • Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance and should be visibly clean and free from odours that are offensive or unpleasant. • Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. o Make sure that staff with responsibility for cleaning have appropriate training. 15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. • Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. • Where applicable, premises must be cleaned or decontaminated in line with current legislation and guidance, and equipment must be cleaned, decontaminated and/or sterilised in line with current legislation and guidance and manufacturers' instructions. Equipment must be cleaned or decontaminated after each use and between use by different people who use the service. • Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this. 11. CQC Provider Handbooks S3.5. How are standards of cleanliness and hygiene maintained? S3.6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection? 1. Health and Social Care Act 2008: Code of Practice for health 2. adult social care on the prevention and control of infections and related guidance. 3. (Health Building Note 00-09) Infection control in the built environment 4. Department of Health (2011) PAS 5748:2011 Specification for the planning, application and measurement of cleanliness in hospitals 5. Association of Healthcare Cleaning Professionals (AHCP) (2009) Colour Coding Hospital Cleaning Materials and Equipment: Safer Practice Notice 15 6. National Patient Safety Agency (2007) The National Specification for Cleanliness in the NHS: A Framework for Setting and Measuring Performance Outcomes. 7. Department of Health (2006) Saving Lives: A delivery programme to reduce healthcare associated infection including MRSA. 8. Department of Health (2004) Towards cleaner hospitals and lower rates of infection. 9. Department of Health (2004) A Matron's Charter: An Action Plan for Cleaner Hospitals. 10. Health Building Note 04-01) Adult in-patient facilities: planning and design 11. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 12. CQC Guidance for providers on meeting the regulations 13. CQC Provider Handbooks	
SS4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	1. Outstanding	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS4	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS4	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS4	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS4	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	1. Outstanding	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		

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SS4	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment https://www.nric.org.uk/node/53525 https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-clea-ng-manual-2009-06-v1.pdf http://faad.co.uk/Includes/NPSA%20cleaning%20specification.pdf https://www.nric.org.uk/node/53978 https://www.westhertshospitals.nhs.uk/about/board_meetings/2008/aug/infection_control/trust_board_infection_control_july_matrons_charter_action_plan_app2.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_dat	
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS5	**SS5: With regard to Laundry and Linen Services can the organisation evidence the following?**	Applicable	Applicable	There may be some cross over with this SAQ and SS4.	1. Choice Framework for Local Policies and Procedures (CFPP) 01-04: Decontamination of Linen for Health & Social Care 2. Department of Health Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers 2010 3. Centre for Disease Control (2000) Laundry: Washing Infected Material, Atlanta, USA 4. Department of Health (1995) Hospital Laundry Arrangements for Used and Infected Linen. 5. Health Service Guidelines (95)18, London 6. Department of Health (2006) Immunisation against infectious diseases 7. Immunisation against infectious disease: 'The Green Book' 8. Department of Health (2007) Essential Steps to safe, clean care. London: DH 9. HSE (1999) Management of Health and Safety at Work Regulations. London: Stationery Office 10. HSE (2002) Control of Substances Hazardous to Health Regulations. London: Stationery Office 11. McCulloch, J 2000. Infection Control: Science, Management and Practice, London. 12. NHS Executive (1995) HSG 95 (18) Hospital Laundry Arrangements for Used and Infected Linen. London: Health Publications Unit 13. NPSA (2010) The National Specifications for Cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises. NPSA London 14. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean, • Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance. • Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant. • Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. 15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. • Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. 15. CQC Provider Handbooks S3.5. How are standards of cleanliness and hygiene maintained? 1. Choice Framework for Local Policies and Procedures (CFPP) 01-04: Decontamination of Linen for Health & Social Care 2. Department of Health Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers 2010 3. Centre for Disease Control (2000) Laundry: Washing Infected Material, Atlanta, USA 4. Department of Health (1995) Hospital Laundry Arrangements for Used and Infected Linen. 5. Health Service Guidelines (95)18, London 6. Department of Health (2006) Immunisation against infectious diseases 7. Immunisation against infectious disease: 'The Green Book' 8. Department of Health (2007) Essential Steps to safe, clean care. London: DH 9. HSE (1999) Management of Health and Safety at Work Regulations. London: Stationery Office 10. HSE (2002) Control of Substances Hazardous to Health Regulations. London: Stationery Office 11. McCulloch, J 2000. Infection Control: Science, Management and Practice, London. 12. NHS Executive (1995) HSG 95 (18) Hospital Laundry Arrangements for Used and Infected Linen. London: Health Publications Unit 13. NPSA (2010) The National Specifications for Cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises. NPSA London 14. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 15. CQC Guidance for providers on meeting the regulations 16. CQC Provider Handbooks https://www.directhealthcaregroup.com/app/uploads/CFPP_01-04_Social_care_Final.pdf https://www.england.nhs.uk/about/equality/equality-hub/uniforms-and-workwear/ https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book http://antibiotic-action.com/wp-content/uploads/2011/07/DH-Clean-safe-care-v2007.pdf https://www.hse.gov.uk/pubns/hsc13.pdf	
SS5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS5	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	1. Outstanding	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS5	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		
SS5	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS5	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS6	**SS6: With regard to Security Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates only to the Physical Security infrastructure and labour related to the security of NHS facilities and not fraud or cybersecurity.		
SS6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Identified and allocated resources are stipulated in the policy 4. The organisation has in place a security management strategy as a standalone document or as part of a policy statement. 5. Evidence of a Security Policy, Violence and Aggression Policy, 6. Procedure for the dissemination of key and vital information e.g. security alerts. The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.	1. Home Office ten principles of crime reduction 2. NHS Standard Contract 2017-2019 General Conditions 3. NHS Standard contract 2017-2019 service conditions; • SC24 NHS Counter-Fraud and Security Management 4. NICE Guidance; • NG10 Violence and aggression: short-term management in mental health, health and community settings • NG11 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges 5. Regulations and Investigatory Powers Act 2000 6. Police and Criminal Evidence Act 1984 7. Criminal Procedure and Investigation Act 2006 8. Counter Terrorism Act 9. National Counter Terrorism Security Office guidance 10. National Police Chiefs Council 11. Human rights act 12. Criminal investigations act 13. Guidance from the Surveillance Commissioners Office 14. General Data Protection Regulations 2018 15. Criminal Justice and Immigration Act 2008 16. Criminal Law Act 1967 17. Following the principle of NHS Protect Guidance Security Standards for providers 2017 18. Health and Safety at work act 19741. 19. NHS Protect crime risk assessment standard 20. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— • Security arrangements must make sure that people are safe while receiving care, including: o Protecting personal safety, which includes restrictive protection required in relation to the Mental Capacity Act 2005 and Mental Health Act 1983. This includes the use of window restrictors or locks on doors, which are used in a way that protects people using the service when lawful and necessary, but which does not restrict the liberty of other people using the service. o Protecting personal property and/or money. o Providing appropriate access to and exit from protected or controlled areas. o Not inadvertently restricting people's movements. o Providing appropriate information about access and entry when people who use the service are unable to come and go freely and when people using a service move from the premises as part of their care and treatment. o Using the appropriate level of security needed in relation to the services being delivered. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Guidance for providers on meeting the regulations March 2015 • If any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. Any surveillance should be operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website. 21. CQC Provider Handbooks S3.4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures? S4.5. How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges? E1.7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice? E6.6. Do staff understand the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty? E6.7. Is the use of restraint of people who lack mental capacity clearly monitored for its necessity and proportionality in line with legislation and is action taken to minimise its use? Removed 1-7 & 10 (Andy advise) 8. Counter-Terrorism and Border Security Act 2019 9. National Counter Terrorism Security Office guidance 11.Human Rights Act 1998 12. Criminal Procedure and Investigations Act 1996 13. Guidance from the Surveillance Commissioners Office 14. General Data Protection Regulations 2018	
SS6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Board nominated executive with the responsibility for overseeing security management 5. Nominated Qualified and Accredited Security Management Specialist to oversee and undertake the delivery of the full range of security management work - external/internal. 6. Evidence of internal (including capital development) and external liaison and involvement in local and national groups and with agency partners also to be included in job descriptions.		
SS6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risks identified include those related to; -Violent and aggressive individuals - Premises suitability - Lone working arrangements. - Evidence of Security assessment programme		
SS6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Evidence of security involvement in new builds. 5. Evidence of a managed and maintained security access control system		
SS6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Evidence of the promotion of security awareness via multiple mediums 4. Evidence of tiered security training commensurate with duties based on a training needs analysis which is monitored, evaluated and reviewed as needed. 5. Demonstration of staff training in relation to incident reporting		

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SS6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence of plans as required by the security standards; - Planning for Lockdowns; - Planning for child abductions;	15. Criminal Justice and Immigration Act 2008 16. Criminal Law Act 1967 17. Following the principle of NHS Protect - Standards for providers 2017-18 Fraud, bribery and corruption 18. Health and Safety at work act 19741. 19. NHS Protect crime risk assessment standard 20. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 21. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1996/25/contents https://www.legislation.gov.uk/ukpga/2019/3/contents/enacted https://www.gov.uk/government/latest?departments%5B%5D=national-counter-terrorism-security-office https://www.npcc.police.uk/ https://www.legislation.gov.uk/ukpga/1998/42/contents https://www.legislation.gov.uk/ukpga/1996/25/contents https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786444/Guide_to_the_Regulation_of_Surveillance.pdf https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted https://www.legislation.gov.uk/ukpga/2008/4/contents https://www.legislation.gov.uk/ukpga/1967/58/contents https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SS6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Demonstration that risks identified through assessment are sufficiently funded to enable mitigation and response 4. Annual report to board in relation to security management 5. Evidence of work plan and ongoing review and update of plan 6. Evidence that incidents where harm or injury occur or had the potential to occur are sufficiently followed up and investigated including where appropriate support being provided to victims.		
SS6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS7	**SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?**	Applicable	Applicable	SAQ covers fleet management and transport of goods and services on and between sites. It excludes patient transport apart from the management of taxi services. Related patient experience is covered in SAQ P5. Access arrangements may also be covered under SH2.		
SS7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	1. Outstanding	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	1. Outstanding	1. Outstanding	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health Technical Memorandum 07-03: Transport Management and Car Parking 2. Building Research Establishment BRE - BREEAM Travel Plan documentation. 3. NHS car parking guidance 2021 for NHS trusts and NHS foundation trusts	
SS7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	1. Outstanding	1. Outstanding	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:	1. Health Technical Memorandum 07-03: Transport Management and Car Parking 2. Building Research Establishment BRE - BREEAM Travel Plan documentation. https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03 https://kb.breeam.com/knowledgebase/transport-assessments-and-transport-statements/	

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SS7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	1. Outstanding	1. Outstanding	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS8	**SS8: With regard to Pest Control can the organisation evidence the following?**	Applicable	Applicable			
SS8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;. 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SS8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS8	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974 4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Improving non-emergency patient transport services - Report of the non-emergency patient transport review August 2021 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.1.The Environmental Protection Act 1990 1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974 4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40	

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SS8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Records of pest infestation, COSHH data sheets for pesticides, records of bait placement etc. 4. Documented evidence of audits and reviews to support compliance.	https://www.legislation.gov.uk/ukpga/1974/40 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukpga/1972/66 https://www.legislation.gov.uk/uksi/1988/1657/contents/made https://www.legislation.gov.uk/uksi/1986/1510/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS9	**SS9: with regard Portering Services can the organisation evidence the following?**	Applicable	Applicable	In line with local organisational portfolio for this area.		
SS9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Patient transfer policy. 4. Infection control procedures and training.		
SS9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risk assessments for injury from needles and exposure to harmful substances and bodily fluids		
SS9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1988 3. CQC Provider Handbooks E4.3. Do staff work together to assess and plan ongoing care and treatment in a timely way when people are due to move between teams or services, including referral, discharge and transition? E5.1. Is all the information needed to deliver effective care and treatment available to relevant staff in a timely and accessible way? (This includes test and imaging results, care and risk assessments, care plans and case notes.) E5.2. When people move between teams and services, including at referral, discharge, transfer and transition, is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols?	
SS9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Manual handling training	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1988 3. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1988/1222/contents/made https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SS9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence of patient involvement and feedback. 4. Patient Feedback considered and actioned		
SS9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS10	**SS10:with regard Telephony and Switchboard can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates only to those Telephony and Switchboard services that are run by the Estates and Facilities team e.g. Internet and related services are excluded.		
SS10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS10	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1989 3. CQC Provider Handbooks C1.7. Do staff respect confidentiality at all times?	
SS10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Process for monitoring operators handling of calls for quality purposes	1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974 4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations	
SS10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business continuity procedures in place in case of fire or other emergency to maintain service including standby operating facilities located on individual sites 6. Loss of service plans including bleeps and mobile phones. 7. Robust Majax call out procedures tested over all sites monthly with table top exercises.	https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukpga/1972/66 https://www.legislation.gov.uk/uksi/1988/1657/contents/made https://www.legislation.gov.uk/uksi/1986/1510/contents/made https://www.legislation.gov.uk/ukdsi/2014/97801111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS10	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. KPIs on performance including call pick up times		
SS10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	Applicable	Applicable	P1 replicates the CQC Provider handbooks KLOE R4 and assesses your processes for patient involvement, compliments and complaints	1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 16: Receiving and acting on complaints (FS) 17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; 17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). 4. CQC Provider Handbooks R1.1. Is information about the needs of the local population used to inform how services are planned and delivered? R1.2. How are commissioners, other providers and relevant stakeholders involved in planning services? R1.3. Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? R1.4. Where people's needs are not being met, is this identified and used to inform how services are planned and developed? 5. NHS England Transforming Participation in Health and Care – September 2013 6. The Kings Fund Research Paper; Patient Engagement and Involvement 7. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010 1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. NHS England Transforming Participation in Health and Care – September 2013 7. The Kings Fund Research Paper; Patient Engagement and Involvement 8. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010 https://www.legislation.gov.uk/ukpga/1998/29/contents https://www.legislation.gov.uk/ukpga/2000/36/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/2013/09/trans-part/ https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement	
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Review of the Patient Led Assessment of the Care Environment (PLACE) results and implementation of the outcomes;		
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	3. Requires minimal improvement	2. Good	1. Engagement process and methodology 2. Friends and Family Test 3. Patient Advice and Liaison Service (PALS)		
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Engagement feedback influencing services developments and improvements		
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	3. Requires minimal improvement	2. Good	1. Governance and process for dealing with feedback		
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	2. Good	2. Good	1. Adherence to confidentiality policy 2. Feedback to stakeholders and patients		
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on condition, appearance, maintenance and P&D. Safety aspects are dealt with in the safety domain.	1. Department of Health Mixed-Sex accommodation guidance 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association 'Patients not numbers, People not statistics' 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks C1.5. How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care? 1. Department of Health Mixed-Sex accommodation guidance 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association guidance and advice 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks https://improvement.nhs.uk/resources/delivering-same-sex-accommodation/ https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://www.ombudsman.org.uk/publications/care-and-compassion https://www.cqc.org.uk/publications/surveys/surveys https://www.nhsconfed.org/resources/2012/06/delivering-dignity-securing-dignity-in-care-for-older-people-in-hospitals-and-care#:~:text=hospitals%20and%20care-,Delivering%20Dignity%3A%20Securing%20dignity%20in%20care%20for,people%20in%20hospitals%20and%20care&text=Delivering%20Dignity%20is%20the%20final,underlying%20causes%20of%20poor%20care. https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf https://www.patients-association.org.uk/Pages/FAQs/Category/policy https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services 7evelopments and improvements 8. Adherence to confidentiality policy 9. Feedback to stakeholders and patients 10. Complaints Procedure 11. Diversity considerations		
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements		
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	Revenue consequences of achieving compliance	£0	£0			
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on cleanliness. Safety aspects of cleanliness are covered in the safety domain.		
P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	2. Good	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 9. Diversity considerations		
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements	1. Health and Social Care Information Centre: Patient Led Assessments of the Care Environment (PLACE) https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/	
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	2. Good	3. Requires minimal improvement	1. Reviews of policy stating where schedules are available compared with actual checking of availability.		
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements		
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	Not applicable	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations	1. Department of Health: NHS patient, visitor and staff car parking principles 2021 2. Car parking charges best practise for implementations, Department of Health (2006) 3. Health Technical Memorandum 07-03 (2006): Transport management and car parking, Department of Health 1. Department of Health: NHS patient, visitor and staff car parking principles 29 October	

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	1. Outstanding	1. Outstanding	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements	2015 2. Car parking charges best practise for implementations, Department of Health (2006) 3. Health Technical Memorandum 07-03 (2006): NHS car parking management https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/481556/HTM0703NovemberUpdated.pdf https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03	
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F1	**F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 2	1. CQC Guidance For Providers KLOE W2.5. Is there a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information?	
F1	**1: Analysing Performance** A process in place to analyse estates and facilities services and costs and if these continue to meet clinical and organisational needs?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection 5. Patient Lead Assessments of the Care Environment (PLACE) 6. In patient Survey 7. NHS Premises Assurance Model Metrics Dashboard 8. ISO 55000/01/02 Asset Management 2004	
F1	**2: Benchmarking** A process in place to regularly benchmark estates and facilities costs?	2. Good	2. Good	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position 2. Benchmarking including the use of metrics and KPIs from suitable sources including: - Estates Return Information Collection (ERIC) - Contract/Service Level agreement KPIs - Estate Strategy KPIs - Energy and sustainability targets - Cost Improvement Plan targets - NHS Model Hospital	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection 5. Patient Lead Assessments of the Care Environment (PLACE) 6. In patient Survey "7. NHS Premises Assurance Model Metrics Dashboard - RICS Real Estate "8. ISO 55000/01/02 Asset Management 2004 ISO 55000:2014 Asset management — Overview, principles and terminology" Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://nhssurveys.org/surveys/survey/02-adults-inpatients/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.iso.org/standard/55088.html	
F1	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F2	**F2: With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 3		
F2	**1: Business Planning** An effective and efficient estate and facilities business planning process in place?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Business plans.		
F2	**2: Estate Optimisation** An effective and efficient process in place to ensure estate optimisation and space utilisation?	2. Good	2. Good	1. Space utilisation studies and monitoring of usage. 2. Response to NHS Long Term Plan of reduction to 30% non clinical space.		
F2	**3: Commercial Opportunities** An effective and efficient process in place to identify and maximise benefits from commercial opportunities from land and property that support the main business of the NHS ?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts. 2. Land and property sale receipts. 3. Commercial Strategy or agreements such as letting of space for retail use.	1. CQC Guidance For Providers KLOE W2.5. Is there a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information?	
F2	**4: Partnership working** An effective and efficient process in place to investigate and implement improvements through partnership working?	2. Good	2. Good	1. Partnership Working, i.e. One Public Estate	2. Health Building Note 00-08 Part B - commercial opportunities 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Premises Assurance Model Metrics 6. ISO 55000/01/02 Asset Management 2004	
F2	**5: New Technology** An effective and efficient process in place to maximise the benefits from new technologies?	4. Requires moderate improvement	3. Requires minimal improvement	1. New Technology and Innovation - examples of product design or system implementation 2. IT strategy.		
F2	**6: PFI and LIFT contracts** An effective and efficient process in place to achieve value for money from existing PFI and LIFT contracts?	Not applicable	Not applicable	1. Date and outcome of PFI/PPP reviews and next steps.	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 - The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Premises Assurance Model Metrics 6. ISO 55000/01/02 Asset Management 2004	
F2	**7: Other contracts** An effective and efficient process in place to achieve value for money from existing other contracts?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts.	Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/model-hospital/ https://www.iso.org/standard/55088.html	
F2	**8. Property** An effective and efficient process in place to record and managing property interest and leases held	2. Good	2. Good	1. Asset/Estate Terrier		
F2	**9. Cost Improvement plans** A robust methodology for identifying the delivery and implications of cost improvement plans	2. Good	4. Requires moderate improvement	1. Regular and accurate submission of CIPs 2. Monitoring of progress of delivery		

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F2	**10: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F3	**F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 4.0	1. Health Building Note 00-08, Part B - disposal 2. NHS Model Hospital 3. Estates Return Information Collection (ERIC) 4. Building Cost information Service 5. Government Construction Strategy 6. Procure22 guidance 7. Naylor Review: 8. Lord Carter Review: 9. NHS Long Term Plan: 1. Health Building Note 00-08, The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 2. NHS Model Hospital 3. Estates Return Information Collection (ERIC) 4. Building Cost information Service 5. Government Construction Strategy 6. Procure22 guidance 7. Naylor Review: 8. Lord Carter Review: 9. NHS Long Term Plan: https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://improvement.nhs.uk/resources/model-hospital/ https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://www.rics.org/uk/products/data-products/bcis-construction/ https://www.gov.uk/government/publications/government-construction-strategy https://procure22.nhs.uk/ https://www.gov.uk/government/publications/naylor-review-government-response#:~:text=The%20Naylor%20review%20was%20a,response%20capitalises%20on%20those%20opportunities. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals https://www.longtermplan.nhs.uk/	
F3	**1. Capital Procurement** Capital procurement and refurbishment projects progressed in line with local standing orders and financial instructions and relevant HM Treasury and DH guidance.	1. Outstanding	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F3	**2. Capital Procurement Efficiencies** Capital procurement and refurbishment projects that actively seek efficiency such as through cost benchmarking, Building Information Modelling and repeatable designs?	3. Requires minimal improvement	3. Requires minimal improvement	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position		
F3	**3. Flexibility** Capital procurement and refurbishment projects that actively seek flexible designs to accommodate changes in services?	2. Good	2. Good	1. Consideration of innovative design and building options e.g. "New for Old".		
F3	**4. Identification and disposal of surplus land** An effective and efficient process for the identification and disposal of surplus land?	2. Good	2. Good	1. Benchmarking including the use of metrics and KPIs from suitable sources 2. Surplus land identified in Annual Surplus Land Return, STP/ICS Estate Strategy, and EPIMS and shared through One Public Estate.		
F3	**Net Zero Carbon** Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?		3. Requires minimal improvement	1. Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance)		
F3	**5: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F4	**F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?**	Applicable	Applicable		1. Health Building Note 00-08 2. NHS Standing Financial Instructions and Standing Orders 3. Audit Commission Report 2004 - Achieving first-class financial management in the NHS 4. Public Procurement Regulations 2015 5. Corruption and Bribery Act 2010 6. Leading the fight against NHS Fraud, organisational strategy 2017-2020 7. HFMA Finance training modules 1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. NHS Standing Financial Instructions -These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by us. 3. Audit Commission Report 2004 - Achieving first-class financial management in the	
F4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F4	**2: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Internal Audits 2. Financial controls and scheme of delegation 3. Business Case procedure and Capital regime		

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	NHS 4. The Public Contracts Regulations 2015 5. The Bribery Act 2010 - Guidance (publishing.service.gov.uk) 6. Leading the fight against NHS Fraud, organisational strategy 2017-2020 -Standards for NHS Providers 2020-21 Fraud, bribery and corruption January 2020 7. HFMA Finance training modules https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.england.nhs.uk/publication/standing-financial-instructions/ http://www.wales.nhs.uk/documents/FinanceinNHS_Report.pdf https://www.legislation.gov.uk/uksi/2015/102/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832011/bribery-act-2010-guidance.pdf https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2020_v1.3.pdf https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance	
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F5	**F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?**	Applicable	Applicable	SAQ taken from CQC KLOE W5. Prompt 6 can be cross referred to SAQ F1 and Patient Experience SAQs		
F5	**1. Quality and Sustainability** When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability and net zero carbon targets assessed, understood and monitored, before, during and after the development?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Action from surveys and feedback. 4. Backlog Risk Assessment, impact assessment and mitigation and action plan.	1. CQC Guidance For Providers KLOE S5.3. How is the impact on safety assessed and monitored when carrying out changes to the service or the staff? W2.5. Is there a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information? 2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Model Hospital 6. Department of Health Built Environment Key Performance Indicators (KPIs) 7. ISO 55000/01/02 Asset Management 2004 1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Model Hospital 6. Department of Health Built Environment Key Performance Indicators (KPIs) 7. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/model-hospital/ https://www.gov.uk/government/statistics/key-performance-indicators https://www.iso.org/standard/55088.html	
F5	**2. Financial Pressure** Are there examples of where financial pressures have negatively affected estates and facilities services?	2. Good	3. Requires minimal improvement	1. Estates Incidents impacting on clinical care- ERIC returns, & feedback to EFM Division to NHS England and NHS Improvement.		
F5	**3. Continuous Improvement** Do leaders and staff strive for continuous learning, improvement and innovation?	2. Good	2. Good	1. Risk Assessments and Registers 2. Derogations documented with clinical impact assessment and clinical sign-off. 3. Training and Development plans and records.		
F5	**4. Quality Improvements** Are staff focused on continually improving the quality of estates and facilities services?	3. Requires minimal improvement	2. Good	1. Regular assessments of quality outputs e.g. PLACE scores; 2. Inclusion of quality assessments in Costed Action Plans.		
F5	**5. Recognition** Are improvements to quality and innovation recognised and rewarded?	2. Good	2. Good	1. Staff suggestion scheme. 2. Staff awards and recognition.		
F5	**6. Use of Information** Is information used proactively to improve estates and facilities services?	2. Good	2. Good	1. Use of design evaluation tools.		
F5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W1 and covers the estates and other related strategies as described in HBN 00-08 Part B section 2. Prompt 3 can be linked to SAQ PE1. Operational management is covered in SAQ S01	1. Developing an Estate Strategy document 2. Health Building Note 00-08 3. Health building Note 00-08: Land and Property Appraisal 4. Strategic Health Asset Planning & Evaluation (SHAPE) tool 5. RICS UK Commercial Real Estate Agency Standards. 6. RICS Guidance Notes- Real Estate disposal and acquisition. 7. Assets in Action 8. Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services 9. Monitor: Strategy development: a toolkit for NHS providers 10. Monitor: Developing strategy What every trust board member should know 11. Estates Net Zero Carbon Delivery Plan 1. Developing an Estate Strategy document 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Health building Note 00-08The efficient management of healthcare estates and facilities (part A): Land and Property Appraisal 4. Strategic Health Asset Planning & Evaluation (SHAPE) tool 5. RICS UK Commercial Real Estate Agency Standards. 6. RICS Guidance Notes- Real Estate disposal and acquisition. 7. Assets in Action 8. Healthcare providers: asset register and disposal of asset 9. Strategy development: a toolkit for NHS providers 10. Developing strategy What every trust board member should know 11. Energy guidance section (how to produce an SDMP) to the current guidance for green plans: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf https://www.gov.uk/government/publications/developing-an-estate-strategy https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-	
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	1. Outstanding	2. Good	1. Estates Strategy and related documents;		
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	1. Outstanding	2. Good	1. Documentary evidence relevant to the prompt questions e.g. document articulating the vision such as mission statement		
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	1. Outstanding	1. Outstanding	1. Regular discussions/meetings/exchanges with interested parties; 2. Integration of these discussions into Strategies and Visions/Values;		
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	2. Good	2. Good	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;		
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	2. Good	2. Good	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;		
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	2. Good	2. Good	2. Staff, Patient and stakeholder engagement and feedback 2. Analysis of relevant complaints;		
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 3.0.	1. Energy guidance section (how to produce an SDMP) to the current guidance for green plans: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf 2. Health building Note 00-08: Land and Property Appraisal 3. HTM 05 Firecode 4. Estates Net Zero Carbon Delivery Plan 1. Health Building Note 00-08: The efficient management of healthcare estates and facilities 2. Health building Note 00-08:The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. Health Technical Memorandum 05 Firecode 4. Estates Net Zero Carbon Delivery Plan 5.Health Technical Memorandum 07-02 https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/managing-healthcare-fire-safety	
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	2. Good	2. Good	1. Involvement in town planning issues		
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	2. Good	2. Good	3. Involvement in town planning issues		
E2	**4. Special Interests** **A**n effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	1. Outstanding	1. Outstanding	1. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 2. Preventing third parties gaining inappropriate rights over land and property 3. Management of easement agreements 4. Management of tenancy and other contractual arrangements 5. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented		
E2	**5. Enforcement** **A**n effective and efficient process to deal with any enforcement procedures served on the organisation?	1. Outstanding	1. Outstanding	1. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green		
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 4.0 to 8.0		

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Demonstration of re-investment of income. 8. Maintenance of an up-to-date and accurate property asset register 9. All statutory obligations to be identified and met 10. Preventing third parties gaining inappropriate rights over land and property 11. Management of easement agreements 12. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green 13. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented 14. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. Health Building Note 00-08: The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. RICS UK Commercial Real Estate Agency Standards. 4. RICS Guidance Notes- Real Estate disposal and acquisition. 5. Assets in Action 6. Real estate management - 3rd edition, October 2016" 7. Healthcare providers: asset register and disposal of asset 8. Estates Net Zero Carbon Delivery Plan https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/real-estate-management-3rd-edition-rics.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets	
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	2. Good	2. Good	1. Management of leases, tenancy and other contractual arrangements		
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Maintenance of an up-to-date and accurate property asset register 8. All statutory obligations to be identified and met 9. Preventing third parties retaining inappropriate rights over land and property 10. Management of easement agreements 11. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 12. Consideration of mandatory energy efficiency ratings.	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	Applicable	Applicable			
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	2. Good	1. Outstanding	1. The Green Plan / Sustainability Strategies published on the Trust's website and has been updated within the last 3 years 2. The organisation tracks its progress using the Sustainable Development Assessment Tool (SDAT) 3. The Green Plan / Sustainability Strategy names an executive lead for sustainability 4. The Green Plan / Sustainability Strategy states progress against carbon emission reduction targets in line with the Climate Change Act 5. Alignment with STP/ICS estates strategy; 6. Green Plan is published on the Trust's website & has been updated within the last 3 years 7. Green plan states progress against carbon emission reduction targets in line with national NHS net zero targets.	1. CIBSE TM44 : Inspection of Air Conditioning Systems 2. EU Emissions Trading System 3. Combined Heat and Power Quality Assurance Programme 4. Making energy work in healthcare (Health Technical Memorandum 07-02) 5. ISO 50001 Energy Management 6. Estates Net Zero Carbon Delivery Plan https://www.cibse.org/AirConditioning_1 https://ec.europa.eu/clima/policies/ets_en https://www.gov.uk/guidance/chpqa-guidance-notes https://www.gov.uk/government/publications/making-energy-work-in-healthcare-htm-07-02 https://www.iso.org/iso-50001-energy-management.html	

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	4. Requires moderate improvement	4. Requires moderate improvement	1. The organisation has evidence of TM44 Air Conditioning System Assessments 2. Organisations which qualify for the EU Emissions Trading Scheme (EUETS) have an EUETS assessor and can demonstrate relevant annual reporting systems 3. Organisations with Combined (Cooling) Heat and Power Plant (CHP/CCHP) have a CHP Quality Assurance (CHPQA) Certificate for Climate Change Levy (CCL) exemption for each unit installed 4. The organisation has a current energy efficiency policy 6. Evidence that utility bills are checked and validated before payment 7. The organisation has rolled out smart metering across the estate, or has a programme to roll out within the next 3 years 9. Monthly meter readings are taken and recorded, and automated readings validated physically 10. The organisation employs a dedicated (spends > 50% of their time working on energy management activities) energy manager / responsible person for energy 11. Organisation is compliant to HTM 07-02; Making Energy work in Healthcare 12. Organisation has achieved ISO 50001	1. CIBSE TM44 : Inspection of Air Conditioning Systems 2. EU Emissions Trading System 3. Combined Heat and Power Quality Assurance Programme 4. Making energy work in healthcare (HTM 07-02) 5. ISO 50001 Energy Management 6. Estates Net Zero Carbon Delivery Plan 1.How to produce a Green Plan 2. Sustainable Development Assessment Tool 3. Climate Change Act 2008 https://improvement.nhs.uk/resources/how-produce-sustainable-development-management-plan-sdmp/ https://www.sduhealth.org.uk/sdat/default.aspx https://www.legislation.gov.uk/ukpga/2008/27/contents	
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	2. Good	3. Requires minimal improvement	1. The organisation has a current waste management and minimisation policy 2. The organisation's Dangerous Goods Safety Advisor (DGSA) has reported within the last 12 months 3. The organisation can evidence completion of Pre-acceptance Audits? 4. The Trust can demonstrate processes to fulfil their Duty of Care for waste 5. The organisation holds regular contract review meetings 6. The organisation can evidence record receipt and review of monthly progress reports 7. The organisation holds regular operational meetings 8. The organisation conducts monthly independent audits of the service 9. The organisation maintains statutory waste records (disposal notes, destruction certificates) and compliance audits 10. The organisation can evidence training records 11. The organisation employs a dedicated (spends > 50% of their time working on waste management activities) waste manager / responsible person for waste 12. The organisation is compliant with HTM 07-01; Safe Management of Healthcare Waste		
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	2. Good	3. Requires minimal improvement	1. The organisation has completed the Clean Air Hospitals Framework Tool 2. The organisation has a Clean Air policy 3. The organisation has an action plan for tackling air pollution from its buildings 4. The organisation keeps an FGAS register 5. The organisation has a plan for migrating to Ultra Low Emission Vehicles	1. https://www.globalactionplan.org.uk/clean-air-hospital-framework/ 2. https://www.gov.uk/government/collections/fluorinated-gas-f-gas-guidance-for-users-producers-and-traders 1. Clean Air Hospital Framework 2. Fluorinated gas (F gas): guidance for users, producers and traders https://www.globalactionplan.org.uk/clean-air-hospital-framework/ https://www.gov.uk/government/collections/fluorinated-gas-f-gas-guidance-for-users-producers-and-traders	
E4	**5: Water** Are water services efficiently and effectively delivered?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has a water efficiency policy 2. The organisation has automated meter reading (AMR) for its water supply 3. Monthly meter readings are taken and recorded, and automated readings validated physically	Estates Net Zero Carbon Delivery Plan	
E4	**6: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	4. Requires moderate improvement	3. Requires minimal improvement	1. The organisation has a climate change adaptation risk assessment on the Trust risk register 2. The organisation reports on estate related events, such as extreme weather events including flooding, heatwave and cold winter events	Estates Net Zero Carbon Delivery Plan	
E4	**7: Procurement** Is all relevant procurement consistent with Government policy?	3. Requires minimal improvement	4. Requires moderate improvement	1. The organisation has a sustainable procurement policy 2. The organisation measures and reports on emissions from its procurement activities. 3. All procurement include a mandatory 10% weighting for social value and net zero carbon.		
E4	**8: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
E4	Capital cost to achieve compliance	£0	£0			
E4	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2021-22	2022-23	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W2.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 2. NHS Constitution and Handbook to the NHS Constitution 3. NHS Long Term Plan 4. Quality Governance in the NHS 5. National Quality Board A guide for provider boards 6. Monitor Code of Governance for Foundation Trusts 7. NHS TDA Delivering High Quality Care 8. NHS Good Corporate Citizen 9. Monitor: Risk Assessment Framework for NHS Foundation Trusts 10. HSE five steps to risk assessment - INDG163 (rev 3) 06/11 11. Monitor: Developing strategy What every trust board member should know 12. Modern Slavery Act 2015 13. Public Services (Social Value) Act 2012 1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 2. NHS Constitution and Handbook to the NHS Constitution 3. NHS Long Term Plan 4. Quality Governance in the NHS 5. Gov.uk - Quality governance in the NHS - A guide for provider boards 6. Monitor Code of Governance for Foundation Trusts 7. NHS TDA Delivering High Quality Care 8. NHS Good Corporate Citizen 9. Monitor: Risk Assessment Framework for NHS Foundation Trusts 10. HSE five steps to risk assessment - INDG163 (rev 4) 06/11 11. Developing strategy What every trust board member should know 12. Modern Slavery Act 2015 13. Public Services (Social Value) Act 2012 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.longtermplan.nhs.uk/ https://www.gov.uk/government/publications/quality-governance-in-the-nhs-a-guide-for-provider-boards https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance Foreword: https://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdf https://healthbusinessuk.net/features/good-corporate-citizenship-nhs https://www.gov.uk/government/publications/risk-assessment-framework-raf https://www.hse.gov.uk/pubns/INDG163.pdf https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted https://www.legislation.gov.uk/ukpga/2012/3/enacted	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	2. Good	2. Good	1. Governance Structure 2. Annual Plan/Programme Board 3. Structure chart 4. Committee terms of reference and minutes		
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	2. Good	2. Good	1. Local sustainability and transformation partnership plans		
G1	**4. Framework** The governance framework and management systems are regularly reviewed and improved?	2. Good	2. Good	1.Estate Strategy 2 Standing Orders		
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	2. Good	2. Good	1. Evidence of walkarounds 2. Signed-of processes and procedures documentation, including risk register. 3. Signed-off roles and responsibilities documentation.		
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	2. Good	2. Good	1. Audit reports, peer and external reviews.		
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	2. Good	2. Good	1. Surveillance Programme 2. Audit Programme		
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	2. Good	2. Good	1. Job descriptions and training records for risk management. 2. Corporate, current risk register in place, with an identifiable owner. 3. Signed-off risk management strategy by the Board		
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	2. Good	2. Good	4. Evidence risks are passed into corporate risk register and actions taken, do not simply disappear without action		
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
G2	**G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W3.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations Regulation 20: Duty of candour (FS) 20(1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. 20(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must– (a) notify the relevant person that the incident has occurred in accordance with paragraph (3) and 20(3) The notification to be given under paragraph (2)(a) must– (a) be given in person by one or more representatives of the registered person, (b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification, (c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate, (d) include an apology, and (e) be recorded in a written record which is kept securely by the registered person. 20(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing— (a) the information provided under paragraph (3)(b), (b) details of any enquiries to be undertaken in accordance with paragraph (3)(c), (c) the results of any further enquiries into the incident, and (d) an apology. 20(5) But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person –	
G2	**1. Effectiveness** Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies		
G2	**2. Challenges** Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.	1. Outstanding	2. Good	1. Local and national staff surveys and feedback		
G2	**3. Visibility** Leaders are visible and approachable.	1. Outstanding	2. Good	1. Organograms and structure charts		
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	2. Good	2. Good	1. Local and national staff surveys and feedback		
G2	**5. Respect** Staff feel respected and valued.	2. Good	2. Good	1. Local and national staff surveys and feedback		
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	2. Good	2. Good	1. Performance reviews 2. Local and national staff surveys and feedback		

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G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	2. Good	2. Good	1. Local and national staff surveys and feedback	(a) paragraphs (2) to (4) are not to apply, and (b) a written record is to be kept of attempts to contact or to speak to the relevant person. 20(6) The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).2. Code of 2. NHS Long Term Plan 3. Conduct for NHS Managers 4. NHS Constitution and Handbook to the NHS Constitution 5. NHS complaints procedure in England SN / SP / 5401 24.01.14 6. ISO 10002 : 2004 customer satisfaction 7. NHS whistleblowing procedures in England SN06490 13.12.13 8. Public Interest Disclosure Act 1998 1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 3. CQC Regulation 20: Duty of candour (FS) 4. NHS Long Term Plan 5. Conduct for NHS Managers 6. NHS Constitution and Handbook to the NHS Constitution 7. NHS complaints procedure in England SN / SP / 5401 24.01.14 "8. ISO 10002:2004 Quality management — Customer satisfaction — Guidelines for complaints handling in organizations" 9. NHS whistleblowing procedures in England SN06490 13.12.13 10. Public Interest Disclosure Act 1998 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour https://www.longtermplan.nhs.uk/ https://www.nhsemployers.org/~/media/Employers/Documents/Recruit/Code_of_conduct_for_NHS_managers_2002.pdf https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-	
G2	**8. Honesty** The culture encourages candour, openness and honesty.	2. Good	2. Good	1. Local and national staff surveys and feedback		
G2	**9. Safety & Wellbeing** There is a strong emphasis on promoting the safety, health and wellbeing of staff.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies		
G2	**10. Healthier workplace** Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G2	**11. Collaboration** Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.	1. Outstanding	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G2	**12: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	Applicable	Applicable			
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors		
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors		
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS PAM Safety Prompt Question Guidance Sheets	◄◄ Back to instructions
Introduction	
This sheet supplements the 'generic' prompt questions contained within NHS PAM safety domain. It provides key references from the following documents that users should consider when undertaking their assessment of the relevant prompts: 1. Health and Safety Executive publication HSG 65 'Managing for health and safety' 2. The Care Quality Commission Provider Handbooks Appendix A 'Key Lines of Enquiry' 3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Associated CQC guidance	
Extracts from HSG 65 primarily relate to H&S regulations so may not be strictly relevant in all instance. However the advice may still be useful. HSG 65 'Managing for health and safety' is available from: http://www.hse.gov.uk/pubns/priced/hsg65.pdf. Similarly some references from the regulations and CQC guidance, particularly around training and development, may relate primarily to clinical and clinical support staff but again they still may be useful.	
1: Policy & Procedures **Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?**	
1.1 HSG 65 page 21:	
Policies should be designed to meet legal requirements, prevent health and safety problems, and enable you to respond quickly where difficulties arise or new risks are introduced.	
1.2 Regulations and CQC Guidance	
15(1)d • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	
15(1)d&e • All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	
1.3 Regulations and CQC Guidance	**CQC KLOE**
15(1)d • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
2: Roles and Responsibilities **Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?**	
2.1 HSG 65	
HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including: ■ ensuring there is adequate and appropriate supervision in place; ■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;	
HSG 65 page 17: The competence of individuals is vital, whether they are employers, managers, supervisors, employees or contractors, especially those with safety-critical roles (such as plant maintenance engineers). It ensures they recognise the risks in their activities and can apply the right measures to control and manage those risks.	
2.2 Regulations and CQC Guidance	
15(1)d&e • Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	
2.4 Regulations and CQC Guidance	**CQC KLOE**

18(1) Guidance: Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).	E3.1. Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis?
3: Risk Assessment **Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?**	
3.1 HSG	
HSG 65 Page 27) **What the law says on assessing risks** The law states that a risk assessment must be 'suitable and sufficient', i.e. it should show that: ■ a proper check was made; ■ you asked who might be affected; ■ you dealt with all the obvious significant risks, taking into account the number of people who could be involved; ■ the precautions are reasonable, and the remaining risk is low; ■ you involved your workers or their representatives in the process. The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work. Insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks. Your risk assessment should only include what you could reasonably be expected to know – you are not expected to anticipate unforeseeable risks.	
HSG 65 page 14) Leaders, at all levels, need to understand the range of health and safety risks in their part of the organisation and to give proportionate attention to each of them. This applies to the level of detail and effort put into assessing the risks, implementing controls, supervising and monitoring.	
HSG 65 page 13) The risk profile of an organisation informs all aspects of the approach to leading and managing its health and safety risks.	
HSG 65 page 13) Every organisation will have its own risk profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible and immediate safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent.	
3.2 Regulations and CQC Guidance	
15(1)c: • Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	
17(2)(b) Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
3.3 Regulations and CQC Guidance	**CQC KLOE**
15(1)d&e • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?
4: Maintenance **Are assets, equipment and plant adequately maintained?**	
4.1 Regulations and CQC Guidance	

15(1)d
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

5.1 HSG 65

HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

3.2 Regulations and CQC Guidance

18(2) Persons employed by the service provider in the provision of a regulated activity must
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.

Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised.

Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.

Other mandatory training, as defined by the provider for their role.

Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

Other mandatory training, as defined by the provider for their role.

Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.

Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.

18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.

Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.

4.3 Regulations and CQC Guidance	**CQC KLOE**
Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.	E3.2. How are the learning needs of staff identified? E3.3. Do staff have appropriate training to meet their learning needs? E3.4. Are staff encouraged and given opportunities to develop?
Staff should be supported to make sure they are can participate in: Statutory training.	S3.2. Do staff receive effective mandatory training in the safety systems, processes and practices?
Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.	E3.5. What are the arrangements for supporting and managing staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) E3.6. How is poor or variable staff performance identified and managed? How are staff supported to improve?

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

6.1 CQC KLOE

S5.2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed?

S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?

7: Review Process **Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?**	
7.1 Regulations and CQC Guidance	
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
7.2 Regulations and CQC Guidance	**CQC KLOE**
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
8: Costed Action Plans **If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?**	
References to risk assessment and management are details under prompt 3 above	

NHS Premises Assurance Model 2016

◄◄ Back to instructions	
This sheet shows the relationship and link between the NHS PAM SAQs and: 1. Relevant parts of the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' 2. Associated CQC guidance to providers on meeting the Regulations 3. CQC provider Handbooks Annex A: Key Lines of Enquiry	
Regulations (bold text) **CQC Guidance** (non-bold text), **CQC KLOE** (bold italics)	**PAM Ref.**
Regulation 14: Meeting nutritional and hydration needs (FS)	
CQC KLOE: E1.4. How are people's nutrition and hydration needs assessed and met?	
14(1) The nutritional and hydration needs of service users must be met.	
Providers must include people's nutrition and hydration needs when they make an initial assessment of their care, treatment and support needs and in the ongoing review of these. The assessment and review should include risks related to people's nutritional and hydration needs. Providers should have a food and drink strategy that addresses the nutritional needs of people using the service.	SS1
14(2) Paragraph 1 applies where— **(a) care or treatment involves—** **the provision of accommodation by the service provider, or** **an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or** **(b) the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.**	SS1
Providers must meet people's nutrition or hydration needs wherever an overnight stay is provided as part of the regulated activity or where nutrition or hydration are provided as part of the arrangements made for the person using the service.	
14(3) But paragraph (1) does not apply to the extent that the meeting of such nutritional or hydration needs would— **(a) result in a breach of regulation 11, or** **(b) not be in the service user's best interests**	NA
14(4)(a) receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,	
Nutrition and hydration assessments must be carried out by people with the required skills and knowledge. The assessments should follow nationally recognised guidance and identify, as a minimum: requirements to sustain life, support the agreed care and treatment, and support ongoing good health dietary intolerances, allergies, medication contraindications how to support people's good health including the level of support needed, timing of meals, and the provision of appropriate and sufficient quantities of food and drink.	SS1 should demonstrate following the Nutrition & hydration assessment but assessment is not part of PAM
Nutrition and hydration needs should be regularly reviewed during the course of care and treatment and any changes in people's needs should be responded to in good time. A variety of nutritious, appetising food should be available to meet people's needs and be served at an appropriate temperature. When the person lacks capacity, they must have prompts, encouragement and help to eat as appropriate.	SS1
Where a person is assessed as needing a specific diet, this must be provided in line with that assessment. Nutritional and hydration intake should be monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Action must be taken without delay to address any concerns. Staff must follow the most up-to-date nutrition and hydration assessment for each person and take appropriate action if people are not eating and drinking in line with their assessed needs. Staff should know how to determine whether specialist nutritional advice is required and how to access and follow it.	NA

Water must be available and accessible to people at all times. Other drinks should be made available periodically throughout the day and night and people should be encouraged and supported to drink. Arrangements should be made for people to receive their meals at a different time if they are absent or asleep when their meals are served. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.	SS1
14(4)(b) receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,	NA
14(4)(c) the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and	
People should be able to make choices about their diet. People's religious and cultural needs must be identified in their nutrition and hydration assessment, and these needs must be met. If there are any clinical contraindications or risks posed because of any of these requirements, these should be discussed with the person, to allow them to make informed choices about their requirements. When a person has specific dietary requirements relating to moral or ethical beliefs, such as vegetarianism, these requirements must be fully considered and met. Every effort should be made to meet people's preferences, including preference about what time meals are served, where they are served and the quantity.	SS1
14(4)(d) if necessary, support for a service user to eat or drink	NA
Regulation 15: Premises and equipment (FS)	
15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean,	
CQC KLOE S3.5. How are standards of cleanliness and hygiene maintained?	
• Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance.	
• Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant.	
• Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. o Make sure that staff with responsibility for cleaning have appropriate training.	Safety SAQ SS4
• Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance.	
CQC KLOE S3.9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	Safety SAQ SS3
15(1) All premises and equipment used by the service provider must be— 15(1)(b) secure,	Safety SAQ SS6
• Security arrangements must make sure that people are safe while receiving care, including:	
CQC KLOES3.4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	Safety SAQ SS6
o Protecting personal safety, which includes restrictive protection required in relation to the Mental Capacity Act 2005 and Mental Health Act 1983. This includes the use of window restrictors or locks on doors, which are used in a way that protects people using the service when lawful and necessary, but which does not restrict the liberty of other people using the service.	Safety SAQ SS6
CQC KLOE E1.7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	

o Protecting personal property and/or money.	Safety SAQ SS6
o Providing appropriate access to and exit from protected or controlled areas.	
o Not inadvertently restricting people's movements.	
o Providing appropriate information about access and entry when people who use the service are unable to come and go freely and when people using a service move from the premises as part of their care and treatment.	
o Using the appropriate level of security needed in relation to the services being delivered. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Guidance for providers on meeting the regulations March 2015 57	
• If any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. Any surveillance should be operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website.	
15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used,	Safety SAQ SH2
Premises must be fit for purpose in line with statutory requirements and should take account of national best practice.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe?	
• Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time. There must be sufficient equipment to provide the service.	Safety SAQ SH2 & SH15
• Adequate support facilities and amenities must be provided where relevant to the service being provided. This includes sufficient toilets and bathrooms for the number of people using the service, adequate storage space, adequate seating and waiting space.	Safety SAQ SH2
• People's needs must be taken into account when premises are designed, built, maintained, renovated or adapted. Their views should also be taken into account when possible.	Patient Experience SAQ P1
• People should be able to easily enter and exit premises and find their way around easily and independently. If they can't, providers must make reasonable adjustments in accordance with the Equality Act 2010 and other current legislation and guidance.	Safety SAQ SH2 & Patient Experience SAQ P6
• Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences. This includes making sure that privacy, dignity and confidentiality are not compromised.	Safety SAQ SH2
• Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.	Safety SAQ SH15
15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and	Safety prompt questions 1,4 & 7 for each technical area e.g. electrical safety
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe? S3.8. Does the maintenance and use of equipment keep people safe?	
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	Safety SAQ SH2 & SH15

• Any change of use of premises and/or equipment should be informed by a risk assessment and providers must make appropriate alterations to premises and equipment where reasonably practical. Where this is not possible, providers should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. Alterations must be in line with current legislation and guidance.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required.	SH4 & safety SAQ prompt 3
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures.	Safety SAQ SH1 & Safety SAQ prompt 4
• Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	Safety SAQ SH1 & Safety SAQ prompt 4
S3.8. Does the maintenance and use of equipment keep people safe?	
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	Safety SAQ SH15 & Safety SAQ prompt 2&5
15(1) All premises and equipment used by the service provider must be— 15(1)(f) appropriately located for the purpose for which they are being used.	
• When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.	Patient Experience SAQ P1
• Facilities should be appropriately located to suit the accommodation that is being used. This includes short distances between linked facilities, sufficient car parking that is clearly marked and reasonably close, and good access to public transport.	Safety SAQ SH2
Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical equipment, and moving and handling equipment.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.	
• Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Safety SAQ SS4
S3.6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection?	
• Where applicable, premises must be cleaned or decontaminated in line with current legislation and guidance, and equipment must be cleaned, decontaminated and/or sterilised in line with current legislation and guidance and manufacturers' instructions. Equipment must be cleaned or decontaminated after each use and between use by different people who use the service.	Safety SAQ SS4

• Ancillary services belonging to the provider, such as kitchens and laundry rooms, which are used for or by people who use the service, must be used and maintained in line with current legislation and guidance. People using the service and staff using the equipment should be trained to use it or supervised/risk assessed as necessary.	Safety SAQ SS1, SS4 & SH10
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this.	Safety SAQ SS2 & SS4
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Regulation 16: Receiving and acting on complaints (FS)	Patient Exp SAQ P1
R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?	
16(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.	P1
People must be able to make a complaint to any member of staff, either verbally or in writing. All staff must know how to respond when they receive a complaint. Unless they are anonymous, all complaints should be acknowledged whether they are written or verbal. Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf. Appropriate action must be taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. Information must be available to a complainant about how to take action if they are not satisfied with how the provider manages and/or responds to their complaint. Information should include the internal procedures that the provider must follow and should explain when complaints should/will be escalated to other appropriate bodies. Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, the provider should cooperate with any independent review or process.	P1
16(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.	P1
Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service. Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested. When complainants do not wish to identify themselves, the provider must still follow its complaints process as far as possible. Providers must have effective systems to make sure that all complaints are investigated without delay. This includes: Undertaking a review to establish the level of investigation and immediate action required, including referral to appropriate authorities for investigation. This may include professional regulators or local authority safeguarding teams. Making sure appropriate investigations are carried out to identify what might have caused the complaint and the actions required to prevent similar complaints. When the complainant has identified themselves, investigating and responding to them and where relevant their family and carers without delay.	P1

Providers should monitor complaints over time, looking for trends and areas of risk that may be addressed. Staff and others who are involved in the assessment and investigation of complaints must have the right level of knowledge and skill. They should understand the provider's complaints process and be knowledgeable about current related guidance. Consent and confidentiality must not be compromised during the complaints process unless there are professional or statutory obligations that make this necessary, such as safeguarding. Complainants, and those about whom complaints are made, must be kept informed of the status of their complaint and its investigation, and be advised of any changes made as a result. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reasons for this should be recorded. Providers must act in accordance with Regulation 20: Duty of Candour in respect of complaints about care and treatment that have resulted in a notifiable safety incident.	P1
16(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of— **(a) complaints made under such complaints system,** **(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and** **(c) any other relevant information in relation to such complaints as the Commission may request.**	P1
CQC can ask providers for information about a complaint; if this is not provided within 28 days of our request, it may be seen as preventing CQC from taking appropriate action in relation to a complaint or putting people who use the service at risk of harm, or of receiving care and treatment that has, or is, causing harm. The 28-day period starts the day after the request is received.	P1
Regulation 17: Good governance (FS)	
W2.6. Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance ***S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?*** ***W2. Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?***	The NHS PAM is designed to be used as a system that meets this requirement
17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.	
Providers must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service.	
The system must include scrutiny and overall responsibility at board level or equivalent.	Governance domain
17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—	
17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);	
S3.3. Is implementation of safety systems, processes and practices monitored and improved when required?	

1. Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. The audits should be baselined against Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and should, where possible, include the experiences people who use the service. The systems and processes should be continually reviewed to make sure they remain fit for purpose. Fit for purpose means that: systems and processes enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. providers have access to all necessary information.	The NHS PAM is designed to be used as a system that meets this requirement
17(2)(a) 2. Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken.	G1.7
W2.7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? ***W5.6. How is information used proactively to improve care?***	
17(2)(a) 3. Providers should have effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review.	NA
17(2)(a) 4. Providers should actively seek the views of a wide range of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, about their experience of, and the quality of care and treatment delivered by the service. Providers must be able to show how they have: analysed and responded to the information gathered, including taking action to address issues where they are raised, and used the information to make improvements and demonstrate that they have been made	Patient Experience SAQ P1
W4. How are people who use the service, the public and staff engaged and involved?	
Providers must seek professional/expert advice as needed and without delay to help them to identify and make improvements.	Governance SAQ G3
17(2)a Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected.	PE domain and action plan prompt under each SAQ
Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.	Safety SAQ SH17
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	Safety SAQ prompt Question 1
E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	
17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	

S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? ***S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?*** ***S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?***	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	Safety SAQ prompt question 3 & G1.9 & G1.10
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	
17(2)(b) Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;	NA
17(2)(d) maintain securely such other records as are necessary to be kept in relation to— **(i) persons employed in the carrying on of the regulated activity, and** **(ii) the management of the regulated activity;**	
Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance.	
Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This applies to all staff, not just newly appointed staff. Providers must observe data protection legislation about the retention of confidential personal information.	
Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents.	Safety SAQ SH3
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Records must be kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so.	
Information in all formats must be managed in line with current legislation and guidance.	
Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 1998.	
17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;	

17(2)(e) Providers should actively encourage feedback about the quality of care and overall involvement with them. The feedback may be informal or formal, written or verbal. It may be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.	Patient Experience SAQ P1
17(2)(e) All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider.	
17(2)(e) Improvements should be made without delay once they are identified, and the provider should have systems in place to communicate how feedback has led to improvements.	
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	
17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).	Safety SAQ prompt question 7, SAQ G1.8 & G1.4
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
17(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—-	NA
Regulation 18: Staffing (FS)	see also 'prompt guidance sheet'
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	Safety SAQ prompt question 2: See 'prompt guidance sheet'
S4.1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available?	
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,	Safety SAQ prompt question 5: See 'prompt guidance sheet'
S5.2. Do staff receive effective mandatory training in the safety systems, processes and practices?	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to	
Regulation 19: Fit and proper persons employed (FS)	NA
Regulation 20: Duty of candour (FS)	**G2.9**

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6 June 2023
Director Lead	Ivan McConnell, Director of Strategic Development/HAS Interim Director of Strategic Development, HUTH
Contact Officer/Author	Ivan McConnell, Director of Strategic Development/HAS Interim Director of Strategic Development, HUTH
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 3: To Live Within Our Means** **Strategic Objective 4: To work more collaboratively** **The Board is asked to note:** • The leadership role that the Trust is taking in delivering these objectives not only internally but at Place, Sub System and System Level, particularly in relation to: o Trust ▪ Humber Clinical Collaboration Programme o Sub System / Place ▪ Humber Acute Service Programme • Clinical Pathway Redesign • Strategic Workforce Planning ▪ Community Diagnostic Centres ▪ Strategic Capital Investment ▪ Place Boards o System ▪ Collaboration of Acute Providers ▪ Planned Care Strategy Development **The Board is asked to note** the significant progress that has been made on these programmes, the external assurance they have undertaken and the leadership roles that have led to at a system and national level for some of our team. **It is important that the Board recognise** that the successful delivery of these programmes is not without risk. This falls into a number of categories: • Political/ representative group challenge • Capital/revenue affordability • Deliverability within required timescales The table within the report provide a summary of the status, achievements and key risks associated with each strategic objective.
Background Information and/or Supporting Document(s) (if applicable)	
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)	Capital funding	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Updated Board Report: Strategic Development - May 2023

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

- **Strategic Objective 1: To Give Great Care**

  1:3 To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

- **Strategic Objective 3: To Live Within Our Means**

  3.2: To secure adequate capital investment for the needs of the Trust and its patients.

- **Strategic Objective 4: To Work More Collaboratively**

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

The Board is asked to note:

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

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

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

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

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

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
1.3, 3.2 and 4.1	**Humber Acute Services:**	The Humber Acute Services is reaching a critical stage in its development. Over the past 20 months the programme has engaged with over 12,000 people and developed a range of options for the delivery of Urgent and Emergency Care, Maternity, Paediatrics and Neonatal Care. The Programme has been through multiple external assurance reviews and is now in the final stages of concluding a Pre-Consultation Business Case to support a Statutory Consultation from Summer 2023.	• Clinical Senate Review of Options: Highest Level of Assurance – "Reasonable" on all three Questions Asked • Independent Consultation Institute Review undertaken of Engagement to date – No major areas of weakness identified • Place Boards briefed on options and planned next steps • JHOSC plans being agreed with Scrutiny Officers • Ongoing Monthly NHSE Assurance Reviews • PCBC Drafted • Consultation Document and Narrative in early draft • Final options being prepared for presentation to ICB for approval to go to consultation • HAS team been recognised for exemplar work and currently delivering training to NHSE Transformation/Workforce teams nationally on: • Reconfiguration • Workforce Planning • Engagement	• ICB assurance on process to date and agreement to go to consultation • NHSE Gateway Review: Finance focus – capital affordability and revenue savings • JHOSC approval of consultation documents and plan • Potential challenge of process to date • Potential challenge/opposition to consultation options • Potential challenge to decision post consultation: IRP/SoS/JR	• **Failure to gain ICB/NHSE approval to consult** ***Impact:*** *Delay to implementation leaving unsustainable services on the Southbank and potential increased revenue costs* ***Mitigation:*** *ICB/NHSE briefings – capital affordable on preferred option internally / Consider move to split programme and deliver incrementally as a Plan B* • **Political / representative group challenge to decision** ***Impact:*** *Potential delays due to referral to SoS/IRP or JR* ***Mitigation:*** *Pre engagement work programme, OSC approval to date,*

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
			• Inequalities		*Independent Assurance provided on approach, evidence packs prepared and continued engagement*

1.3, 3.2 and 4.1	**Humber Clinical Collaboration Programme**	The Humber Clinical Collaboration Programme has been born out of the Interim Clinical Plan which has been through three iterations of development over the past 18 months.
		
		The Programme is currently undergoing a stocktake review to identify the potential options on the way forward as the Group Structure emerges
		
		The Stocktake is aligned to a Programme of activity on Consultant Engagement being undertaken by the
			• Programme Stocktake scope and approach agreed
			• Joint Board presentation on findings to date:
			  • Timeline
			  • Outputs
			  • Status
			• Activity aligned to Consultant engagement events
			• Updated Heatmap being prepared on 10 specialties – current status
			• Feedback being collated
			• Options to progress being considered – to be presented to CiC and Boards (end June 23)
				• Heatmap may show both progress or deterioration in performance within specialties
				• Programme structure needs to align to Group Operating Model
				• Programme needs appropriate support: Leadership/PMO/Enabling workstreams
				• Programme enablers – digital/OD in particular will be essential to “make it happen”
				• Programme needs to focus on “Making it Stick” – implementation resource
				• Risk of potential performance deterioration during any period of future change
				• Leadership structures cannot duplicate – need to reduce cost
					• ***Potential delay to the stocktake or inconclusive results***
					
					Mitigation:
					Detailed preparation and planning to support the timescales and resource for the stocktake review

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		Chief Medical Officer(s)		• Focus may need to be more incremental and micro over short periods of time	
1.3 and 4.1	**Community Diagnostic Centre**	The CDC Programme is part of a National Policy Initiative to deliver an increased volume if diagnostics in a community setting NLaG has led the delivery of two business cases with a total value of c£29.4m on the South Bank The SoS has formally approved the Scunthorpe Hub case at a value of £19.4m The Grimsby Spoke case has been submitted at a cost of £10m and is awaiting NHSE National CDC Team approval	• SoS approval of the Scunthorpe Hub case - £19.4m o Planning Application Submitted o Procurement Strategy Designed o Plan to Procure in Place • Grimsby Spoke case - £10m – focussed on ophthalmology/audiology and a mix of diagnostic/pathology tests submitted o NHSE Regional Team review undertaken o Awaiting NHSE National Team approval • Integrated Governance Structure implemented covering both North and North East Lincolnshire o Programme Implementation and Oversight Board established o Workstreams established and resourced	• SoS requires something to be delivered on each site – 1 December 2023 • SoS requires full service opening by end of March 2024 • Resourcing: o CDC workforce plan developed – rotational posts planned – recruitment risk for some roles – will need National support (Insourcing contract) • Workforce to deal with demand arising – Primary/Community/Acute/Mental Health – workstream established • Funding – revenue funding on going for service – risk of failure of tariff to cover costs • Funding – on going capital costs not covered	• **SGH delays to planning or build due to lack of build/equipment capacity in timescales** ***Impact:*** *Reduced capacity available to meet backlog / loss of political goodwill and central challenge from NHSE* ***Mitigation:*** *Planning pre-engagement/ Phased procurement / potential to use National Contracts for equipment* • **Inability to meet demand** ***Impact:*** *Increased waiting lists / increased complaints* ***Mitigation:*** *Implementation*

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
			o Reporting agreed to ICB Diagnostics Board/CAP Board and Place Boards • Programme team established for procurement • Programme team established for build	• Potential delays to build – supplier and kit availability • Potential cost increases – inflation / scope creep/cost overruns • Resourcing – programme design/implementation	*Programme Team established at sub system level to review capacity/demand gaps and actions required* • **Inability to find workforce** ***Impact:*** *Inability to open/run service in accordance with agreed plan – impact on waiting lists and potential increased complaints* ***Mitigation:*** *Strategic workforce plan developed, rotational posts will be in place, use of national contract to insource and international recruitment*

3.2	**Strategic Capital Investment**	The Trust has a 6Facet Capital gap of c£117m – of which £107m relates to Backlog Maintenance
		
		The Trust Board agreed to submit a Strategic Capital
			• NHP application submitted
			• Workstreams established in parallel to develop:
			  • Strategic capital plans for HAS
			  • Strategic Outline Case: NLaG and HUTH
			• Strategic capital options discussed at CiC, SDC and Joint Boards –
				• Strategic Capital Programme needs to reflect multiple programme priorities and risks:
				  • HAS implementation
				  • BLM and CIR risks
				• Capital affordability and prioritisation
					• **Do not get access to funding to cover BLM/CIR risk in short term**
					Impact:
					continued risk of capital failure, inability to implement structural pathway changes

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		Investment EOI in September 2021 to be part of the New Hospitals Programme The Programme announcements have been delayed and a wide range of developments have happened in parallel to support capital investment in the Trust Additionally, the Trust has secured upwards of £150m over the past two years in strategic capital in particular with a focus on ED/AAU and Diagnostics. Linked to this is additional funding to improve energy efficiency	potential options identified to move forward if Trust does not receive National funding • Agreement with Place Board to have an aligned Strategic Capital Plan at Place	• Digital risks • Equipment risks • BLM and CIR issues mean time cannot be wasted on large scale developments – short term spend not affordable or deliver VFM • Options need to be accelerated within Group model to look at smaller scale incremental schemes • Will need to align with Place Strategies and be supported Politically to be successful	*required to keep services sustainable, poor patient and staff experience* ***Mitigation:*** *developed SOC and business cases to support phased investment and agreed with Joint Board need to look at smaller business cases aligned to planned care, HAS and HCCP strategies*
1.3 and 4.1	**Planned Care Strategy**	The Trust is providing leadership through the CAP for the development of a Planned Care Framework for the	• Planned Care Strategy Framework approach, assumptions and deliverables agreed at CAP Board • Leadership and Programme team identified	• Dependencies with other projects at Trust/Sub System and Place • Need to ensure don't duplicate effort of other	• Management of conflicting priorities across ICS, Sub System, Collaboratives, Place, Organisation

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		delivery of Planned Care across the ICS The Programme Plan, Structure and Assumptions have been agreed	• Data structure/sharing arrangements in place • Briefings of Place Boards undertaken and engagement approach identified • Network engagement approach agreed • Engagement with wider workstreams – outpatients/diagnostics/digital – commenced	teams – e.g. GIRFT programme • Data availability/and analytics resource	***Impact;*** *System pressures create a change in focus from long to short term action* ***Mitigation;*** • *Ongoing engagement with CAP, Clinical Networks, relevant elective Programmes, Place Boards*
1.3, 3.2 and 4.1	**Collaboration of Acute Providers**	The Trust is an active member of the CAP and is taking a leadership role in a number of workstreams • Diagnostics: CDCs • Planned Care	• Active engagement in CAP Board and leadership groups • Work plans and resources in place	• Delivery timescales of programmes • Competing delivery priorities • Multiple programme reporting to Trust, sub system, Place, CAP and ICB – duplicates effort	
1.3, 3.2 and 4.1	**Place Boards**	The Trust is an active member of the Place Boards in: • North Lincolnshire • North East Lincolnshire	• Leadership of multiple Place workstreams including • Workforce planning • Capital Investment/Planning • Clinical change and pathway design	• Multiple competing priorities – demand on team and ability to serve multiple relationships • Tension of priorities of Trust, Sub System, Place and ICB	

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		• East Riding of Yorkshire			

NLG(22)106

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	6 June 2023
Director Lead	Lee Bond, Chief Financial Officer
Contact Officer/Author	Ellie Monkhouse, Chief Nurse: Joint Clinical Lead Dr Kate Wood, Medical Director: Joint Clinical Lead Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee: Author
Title of the Report	**HTF Trustees' Committee Highlight Report –** 17 May 2023
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 17 May 2023 and worthy of highlighting to the Public Trust Board.
Background Information and/or Supporting Document(s) (if applicable)	HTF Trustees' Committee Terms of Reference
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Only on Health Tree Foundation Charitable Funds
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 June 2023
Report From:	Health Tree Foundation Trustees' Committee held on 17 May 2023

Highlight Report:

Trust Staff Room Enhancements

- Further to discussion at the two previous HTF Trustees' Meetings, the HTF Charity Manager provided a comprehensive update on the proposed way forward to enhance certain staff room facilities across the Trust. She described how a priority list of 20 staff rooms had been created with help from Deputy Chief Nurse and Associate Chief Nurses. One Staff Room for each site had been chosen at random from the list to start the programme and the HTF would fund improvements to flooring, walls and vinyls or murals for wall decorations, at a cost of £2k - £2.5k per room depending upon need. Trustees approved the plans Lucy Skipworth had described. Trustees further agreed that the plan would be publicized across the Trust to brief staff and manage their expectations.

Pennies from Heaven - NHS

- The Charity Manager described the 'Pennies from Heaven NHS' proposal. This is a scheme that allows employees to donate to their hospital charity directly from their monthly pay, a sum that will always be under £1. 'Pennies from Heaven' makes it simple for charities to receive donations by distributing funds on the employer's behalf. This is a scheme that is used successfully by several NHS Trusts and Trustees approved its use with the proviso that it be reviewed after one year.

Quoracy

- The HTF Trustees' Meeting was unable to remain quorate for the full duration of the meeting.

Confirm or Challenge of the Board Assurance Framework:

Action Required by the Trust Board:

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

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

NLG(23)107

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	6 June 2023
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Audit, Risk & Governance Committee Highlight Report – April 2023**
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk and Governance Committee at its meeting on 20 April 2023: 1. **Going Concern Report 2022/23** – The Committee endorsed the view that the Trust is a going concern for the 2022/23 annual accounts process. **For Board to Note.** 2. **Draft Annual Accounts 2022/23** – Approved for submission to NHSE by the required deadline. No External Auditor as yet, working with NHSE to secure one for audit of 2022/23 financial statements. **For Board to note.** 3. **Draft Annual Governance Statement 2022/23** – Initial draft submitted for review and consideration, however pending updates on a number of sections. Will be finalised in due course and submitted for final approval. **For Board to note.** 4. **Draft Head of Internal Audit (HoIA) Opinion 2022/23** – Limited amount of Internal Audit work still being completed but overall draft opinion is 'Significant Assurance'. Final HoIA Opinion due in June 2023. **For Board to note.** 5. **Mandatory Training** – Every effort being made to push IG training to ensure required 95% compliance attained. On a positive note, fraud awareness eLearning training which became mandatory for all staff on 18.1.23 reached 75% compliance at 31.3.23. **For Board to note.** 6. **Annual Health and Safety Policy Statement** – Endorsed and approved for submission to the Board. **For Board to note.** 7. **Trust Scheme of Delegation and Powers Reserved for the Trust Board / Standing Financial Instructions** – approval given to extend existing versions to 31.12.23 to allow time for review to incorporate Group structure requirements. **For Board to note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 20 April 2023

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

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 June 2023
Report From:	Audit, Risk & Governance Committee – 20 April 2023

Highlight Report:

1. **Going Concern Report 2022/23** – Following discussion the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise for 2022/23.

2. **Draft Annual Accounts 2022/23** – Received by the Committee, with key points highlighted in writing and discussed by the Assistant Director of Finance – Planning and Control. Approved for submission to NHSE. The Trust does not currently have an External Auditor (despite going out to the market twice during 2022) and the draft accounts will remain unaudited until such time as an Auditor is secured, which the Trust are working with NHSE on to secure a firm at the earliest opportunity. The Committee thanked the Assistant Director of Finance for the very thorough briefing and commended both the quality of the financial statements and the speed of their production, noting it to be a good indicator of a strong finance team.

3. **Draft Annual Governance Statement (AGS) 2022/23** – The Committee received the initial draft, noting that some sections required further updates. The final draft would be received by the Committee in due course for approval and inclusion in the Trust's Annual Report for 2022/23.

4. **Draft Head of Internal Audit (HoIA) Opinion 2022/23** – The overall draft opinion is one of 'Significant Assurance'. Audit Yorkshire advised that a limited amount of work was still being completed, with the final HoIAO coming back to the Committee in due course. This opinion forms part of the final AGS. The Committee was pleased to note an overall positive position with the implementation of internal audit recommendations this year.

5. **Mandatory Training** – The IG Team have been encouraging staff to complete their IG training through targeted communications, with a view to ensuring the required 95% compliance is achieved by the Trust for the DSP Toolkit submission – 88% compliance at 12.4.23. On a positive note, the fraud awareness eLearning training which became mandatory for all staff on 18.1.23 reached 75% compliance at 31.3.23. The Committee noted this excellent progress after just two months of the training becoming mandatory.

6. **Annual Health and Safety Policy Statement** – Received and approved for submission to the Board.

7. **Trust Scheme of Delegation and Powers Reserved for the Trust Board / Standing Financial Instructions** – The Committee gave approval to extend the existing versions of these two corporate documents to 31.12.23 to allow time for them to be reviewed and updated to reflect new Group structure requirements once a Group CEO is in post and has made decisions on the Group structure.

Confirm or Challenge of the Board Assurance Framework:
N/A - Q4 BAF not available for this meeting.
Action Required by the Trust Board:
The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed. **Simon Parkes** **Non-Executive Director / Chair of Audit, Risk & Governance Committee**

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	6 June 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Board Assurance Framework (BAF) 2022-23, Quarter Four Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of the quarter four 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. 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 highlights and lowlights of each of the principal risks, d) note all the current risk scores for quarter four, e) agree the revised target risk scores for: SO1-1.1 = from 10 to 15 SO1-1.2 = from 10 to 15 SO1-1.6 = from four to eight SO2 = from four to 15 f) agree to transfer all the strategic risks into the BAF 2023/24, g) agree that a review of the BAF risks, structure and format are undertaken as part of the work relating to the Group Model and Strategy.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ✓ Other: Board Committees

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

Board Assurance Framework – Quarter Four, 2022/23

1. Purpose of the Report

1.1. The Board Assurance Framework ('BAF') is the key source of information that links the Trust's strategic objectives to risk and assurance. It brings together in one place all of the relevant information on the risks relating to the Trust's strategic objectives. The Trust's BAF is based on the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Trust Board to resolve issues or concerns and improve control mechanisms. The purpose of this report is to outline the strategic risks that have been identified as part of the BAF.

1.2. The report outlines the risks, the controls and assurances as well as the immediate and longer terms actions being taken to address the identified risks. The following Board Committees i.e. Workforce Committee, Quality and Safety Committee, and the Finance and Performance Committee reviewed the BAF at their respective committee meetings in May 2023 and agreed a number of updates and changes to risk scores.

1.3. 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**.**

2. Strategic Objective Risk Ratings: 2022-23 Quarter Four

2.1. The table below illustrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2023:

2022-23						
Strategic Objective / Quarter	Risk Rating				Target Risk by 31/03/2023	Risk Appetite Score
	1	2	3	4		
SO1-1.1	15	15	15	15	15	4-6
SO1-1.2	20	20	20	20	15	4-6
SO1-1.3	12	12	12	12	8	4-6
SO1-1.4	20	20	20	20	20	4-6
SO1-1.5	12	12	9	6	6	4-6
SO1-1.6	16	16	12	12	12	4-6
SO2	20	20	20	20	12	4-6
SO3-3.1	15	20	20	5	20	8-12
SO3-3.2	12	15	15	15	15	8-12
SO4	12	12	12	12	8	8-12
SO5	12	12	12	12	8	8-12

2.2. Principal Risks – Highlights and Lowlights

2.2.1. **SO1-1.1: 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.**

The Quality and Safety Committee agreed the risk rating of 15 for the quarter four position and the target risk rating for 31 March 2024 should increase from 10 to 15 due to the strategic threats and the overall healthcare environment challenges. There is also a number of very high-level risks related to divisions and departments within the Trust, that may have an impact on the delivery of the strategic objective: i) No 3162 – quality of care and patient safety based on nurse staffing and, ii) No 3164 – nurse staffing (high number of registered nurse and support worker vacancies), both scored at 20.

However, positive external assurance has been received: improved ratings from the CQC inspection in December 2022 with good for Goole Hospital and the Safe domain improved from inadequate to requires improvement, and the maternity CNST standards compliance submission.

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

The Finance and Performance Committee agreed the risk rating for the quarter four position of 20 and that the target risk score for 31 March 2024 should be moved from 10 to 15. This is due to the completion of the new Same Day Emergency Centre and the Theatre refurbishment will support the delivery of the constitutional and other regulatory performance targets. However, a key gap in control is the high levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas. This could impact on providing treatment, care and support which is as safe, clinically effective and timely as possible.

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

The risk has only been reviewed by the Director of Strategic Development due to the disbanding of the Strategic Development Committee. The target risk score was not achieved due to the impact within the Integrated Care System, the future remit and responsibilities of the Collaborative of Acute Providers Board, the emerging ICS strategies and the delay in the consultation of the Humber Acute Services Programme.

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

The Finance and Performance Committee agreed the risk rating of 20 for the quarter four position. This is due to the Capital Programme funding for 2023-24 being impacted by the Critical Infrastructure Risk and BLM: the Six Facet total figure is £117M and the Backlog maintenance is £107M.

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

The Audit Risk and Governance Committee at its meeting on 23 February 2023 reviewed key elements of the strategic risk for the quarter three period, being IT Business Continuity / Disaster recovery programme, information governance and cyber. The Committee agreed the risk score of nine at its meeting.

Due to the disbanding of the Strategic Development Committee the risk to the delivery of the Digital Strategy has not been reviewed. An update on progress against the Digital Strategy will be presented to the Board in August 2023.

The Chief Information Officer undertook a review of the strategic risk for the quarter four period on 17 April 2023. All actions for 2022/23 were completed which resulted in the risk score reducing to six, with the target risk score by 31 March 2023 being met.

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

The Finance and Performance Committee agreed that the target risk score for 31 March 2024 should be increased from four to eight. The quarter four risk score of 12 was agreed, due to two outstanding actions from 2022/23, being: i) major incident table top training and, ii) review of evacuation plan.

2.2.7. **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.**

The Workforce Committee agreed the risk rating for the quarter four position should remain at 20 for quarter one 2023/23 and the target risk score by 31 March 2024 be increased from four to 15. This is due to the number of High-Level Risks that could have an impact on the delivery of the strategic objective, in particular: i) No 2976, High registered nursing vacancy levels and ii) No 3015, Insufficient estate resources to manage the workload demand. The implementation of the People Strategy is ongoing, with a target date of quarter four 2023/24.

2.2.8 SO3-3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities

The Finance and Performance Committee agreed the quarter four risk rating position of five and the target risk score for 31 March 2024 remaining at 20 due to financial challenges for 2023/24. The target risk score for 2022/23 was achieved due to the release of the balance sheet to support 2022-23 forecast outturn.

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

The risk has only been reviewed by the Director of Strategic Development due to the disbanding of the Strategic Development Committee. There remains a significant risk with capital investment which is due to availability of capital funding to meet our requirements, impact of capital decisions on accessing new hospitals programme funding and impact of national reports (Ockenden) on potential capital investment requirements.

2.2.10 SO4: The risk that the Trust is not a good partner and collaborator.

The risk has only been reviewed by the Director of Strategic Development due to the disbanding of the Strategic Development Committee. The target risk score by 31 March 2023 of eight was not achieved due to the impact within the Integrated Care System, the future remit and responsibilities of the Collaborative of Acute Providers Board, the emerging ICS strategies and the delay in the consultation of the Humber Acute Services Programme.

2.2.10 SO5: The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

The Workforce Committee agreed the current risk score of 12 against a year-end target of eight by 31 March 2023. This is due to two outstanding actions remaining for 2022/23: refreshing the coaching model and refresh of the appraisal process. The Committee also agreed a risk rating of 12 for quarter one 2023/24 reducing to eight by 31 March 2024.

3. BAF Review

The Trust Board is asked to consider that a review of the BAF risks, structure and format are undertaken as part of the work relating to the Group Model and Strategy.

Board Committees will be asked to review the risks and the risk ratings (current and target) during quarter one. These will be presented to the August 2023 Board meeting.

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 highlights and lowlights of each of the principal risks,

d) note all the current risk scores for quarter four,

e) agree the revised target risk scores for:
SO1-1.1 = from 10 to 15
SO1-1.2 = from 10 to 15
SO1-1.6 = from four to eight
SO2 = from four to 15

f) agree to transfer all the strategic risks into the BAF 2023/24,

g) agree that a review of the BAF risks, structure and format are undertaken as part of the work relating to the Group Model and Strategy.

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

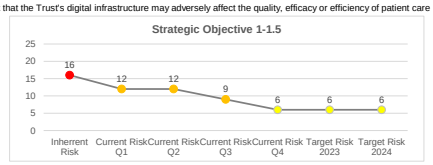
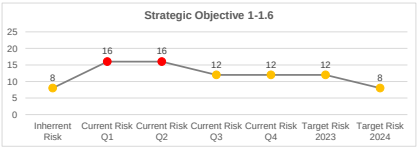
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity 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	5
Likelihood	3	3	3	3	3	3	3	3
Risk Rating Score	15	15	15	15	15	15	15	15

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 23 May 2023, January 2023, 10 October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Quality and Safety Committee

Risk Owners: Chief Medical Officer and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan 2022/23
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Place Quality Meetings - N Lincs, N E Lincs, East Riding
- SI Collaborative Meeting with ICB, with Place Representatives
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare Live
- Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group
- Nursing Metric Panel Meeting
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing and Midwifery Board
- NICE Guidance implementation monitoring and reporting processes
- Learning from deaths process
- Mortality Improvement Group

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
- CQC action planning, monitoring and assurance of action completion processes

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance
- NHSE External Review of Safe Staffing Establishment and Recommendations - February 2022
- Maternity Birth Rate Plus Review - 2022
- Internal Audit - CQC action plan compliance – Significant assurance
- Improved ratings in CQC inspection (Dec 2022 report) with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement
- Maternity CNST standards compliance submission

Planned Actions

Action	Quarter / Year	Assurance
Birthrate plus review	Q2 2024	Blue
Audit of stop and check safety huddle compliance	Q3 2022/23	Blue
Business case completed for Transition post	Q3 2022/23	Blue
Continue to develop metrics as data quality allows	Ongoing	Blue
Delivery of deteriorating patient improvement plan	Q4 2023/24	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Annual establishment reviews across nursing, midwifery and community settings continue	Q4 2022/23	Blue
Update IPC BAF as national changes and requirements	Q4 2022/23	Blue
Review policy and embed supportive observation	Q4 2022/23	Blue
Review of Ward Assurance Tool and Web V pilot	Q4 2022/23	Blue
Pilot of 15 Steps Star Accreditation Programme	Q4 2022/23	Blue
Management of Influenza outbreaks	Q4 2022/23	Blue
Preparation for trust requirements for the newly proposed LPS	Q4 2022/23	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green
Implementation of the Learning From Patient Safety Events incident reporting requirements (we are in testing phase).	Q2 2023/23	Green
Review and implement changes to Audiology Service	Q2 2023/24	

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.
- Transition from SI reporting framework to PSIRF approach.
- Resource for supporting improvement and delivery of Quality Priorities & CQUINS

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Gaps in Controls

- Estate and compliance with IPC requirements B12- see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust
- Paediatric audiology service

Gaps in Assurance

- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Safety and delays on cancer pathways
- Patient safety risks increased due to longer waiting times. (Refer to SO1-1.2)

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
No 2347 Deteriorating patient risk, Surgery = 15
No 2992 Lack of Changing Places facility at SGH = 16
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

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	5
Likelihood	4	4	4	4	4	4	3	3
Risk Rating Score	20	20	20	20	20	20	15	15

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 May 2023, 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 Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2022-23

External:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- NHSE Intensive Support Team
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022

Planned Actions

Action	Quarter / Year	Assurance
Further development of the ICP with HUTH	Q4 2021/22	Blue
Consultant led ward rounds, further development and implementation (ECIST)	Q4 2021/22	Blue
Winter Planning for 2022/23 - ongoing	Q2 2022/23	Blue
Review and relaunch of the Daily Operations Meetings - ongoing	Q2 2022/23	Blue
Establishment of pathway for YAS to access the North Lincolnshire SPA in the same way as EMAS	Q2 2022/23	Blue
Progress P1 of HASR Plan - Haematology, Oncology, Dermatology	Q2 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	Blue
Outcome of the Urgent Care Services Review for South Bank of ICS agreed	Q3 2022/23	Blue
Introduction of Pathway to enable referrals into SPA from technology enabled care providers to reduce ambulance calls and conveyancing	Q3 2022/23	Blue
Further developemnt of the ICP with HUTH - Dermatology	Q3 2022/23	Blue
Introduction of LLoS reviews in Medicine Division	Q3 2022/23	Blue
Consultant job plans to be signed off for 2022-23	Q3 2022/23	Blue
Opening of new ED build at SGH	Q4 2022/23	Blue
Diagnostic and cancer pathways reviewed and implemented	Q4 2022/23	Blue
Progress with implementation of General Internal Medicine Model	Q2 2023/24	Yellow
Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties	Q2 2023/24	Amber
Validation of all RTT Clock Stops back to 100%	Q2 2023/24	Amber
Develop divisional dashboards	Q2 2023/24	Yellow
Consultant job plans to be signed off for 2023-24	Q2 2023/24	Red
Completion of theatre refubishment programme	Q2 2023/24	Green
Implementation of 2023/24 Outpatient Clinic Configuration aligned to 2023/24 Activity Plan and NHS Operational Planning Guidance, reducing follow up activity and increasing capacity for new patients	Q2 2023/24	Green
Implementation of Gynaecology Service Review	Q3 2023/24	Green
Expansion of Community Discharge and Admission Alternative Development workstreams (Virtual Ward capacity, Short Term care capacity and OPAT capacity)	Q3 2023/24	Green
Implementation of Criteria to Admit within ED to support reduction in admissions and use of alternative pathways	Q4 2023/24	Green
Review of pathways for High Intensity Service Users	Q4 2023/24	Green
Implementation of Clinical Frailty Score in ED	Q4 2023/24	Green
Review Dementia pathways in ED	Q4 2023/24	Green
Implementation phase 3 of AAU business case	Q4 2023/24	Green

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 64 weeks, 62 days and 104 days breaches.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to inability to access scanner and reporting teams externally
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS requires significant system change. Early adopters from July 23, with mandatory submission from July 24
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - not meeting constitutional standards and impact on diagnostic capacity
- Risk of no contracting for independent sector work
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Replacement of ward A1

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.
Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- High levels of staff sickness
- High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas.

Gaps in Assurance

- Quality of reports to board assurance committees
- Quality and timeliness of data
- Recruitment and development of Consultants, specialist nurses

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2773, Lack of scanning capacity s leading to a risk of delayed diagnosis = 16
No 2949, Oncology Service = 20
No 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover)

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	4	4	4	4	4
Likelihood	3	3	3	3	3	2	2	2
Risk Rating	12	12	12	12	12	8	8	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 Apriil 2023, 21 February 2023, 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 Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC, 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 (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
CIC / SDC / NED / Governor reviews	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
Citizens Panel reviews	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
To undertake continuous engagement process with public and staff	Q1 2023/24	Green
Stakeholder Mapping	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
NHSEI Gateway review	Q4 2023/24	Green
ICB Executive Assurance Board / ICBoard Approval	Q4 2023/24	Green
Final report from Clinical Senate review (due Q1)	Q1 2023/24	Green
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 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	5
Likelihood	4	4	4	4	4	4	4	4
Risk Rating	20	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: 24 May 2023, 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	Ouarter / 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
Completed Backlog Maintenance programme fiscal year	Q4 2022/23	Blue
Completed Core Capital Programme	Q4 2022/23	Blue
Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24	Red
Completed Ward 25 defects	Q4 2022/23	Blue
Commenced refurbishment of SGH ED (completion end of Q3)	Q3 2023/24	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, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
- Grimsby 21% CIR of the BLM
- Goole 11% CIR of the BLM
- Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance:Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk				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	3	3	3	3	3
Likelihood	4	3	3	3	2	3	2	2
Risk Rating	16	12	12	9	6	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: April 2023**,** January 2023, October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Audit, Risk and Governance Committee

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Strategy and Development Committee
- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Significant Assurance, 2021

Positive Assurance:

- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Significant Assurance, 2021

Planned Actions

Action	Quarter / Year	Assurance
Completed IT BC / DR Programme initiation with Gap Analysis report outline required vs. current capabilities approved at Digital Strategy Board in March 2023..DSPT Ref: IA-20724	Q4 2022/23	Blue
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Pkus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23.	Q3 2023/24	Yellow
IPR - further review of current IPR for adding Digital, Finance and Estates KPI. S, Review in April 2023 (this may be deferred) - report to the Board, defer being put into IPR, Divisional IPRs being developed.	Q3 2023/24	Yellow
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	Q1 2023/24	Green
The Data Warehouse with core activity data sets will be completed and running on the new platform by May 2023 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q2 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q1 2023/24	Green
Completed IT Business Continuity Policy and Procedure	Q1 2023/24	Green

Future Risks

- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit compliance - in progress

Gaps in Assurance

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk				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	4
Likelihood	2	4	4	3	3	4	3	2
Risk Rating	8	16	16	12	12	16	12	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 May 2023, 18 January 2023, 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: 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:

- National and Regional exercises testing emergency plans, business continuity and planning assumptions (e.g. Artic Willow, Mighty Oak)
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, 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	Blue
Business Intelligence monitoring re: pandemic	Ongoing	Blue
Rolling Schedule of annual business continuity plans	Ongoing	Green
Winter Planning for 2022/23	Ongoing	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	Blue
CBRN training aligned to New DPOWH ED transition plan	Q4 2022/23	Blue
Relaunch of loggist training and provision	Q4 2022/23	Green
Major incident table top training	Q4 2022/23	Yellow
National Exercise Mighty Oak (national power outage)	Q4 2022/23	Blue
Review and update of Escalationand Surge Policy	Q4 2022/23	Blue
Review of Evacuation Plan	Q4 2022/23	Yellow
Review of Major Incident Plan and Critical Incident Plan	Q1 2023/24	Green
Roll out of new Major Incident Triage Tool (MITT)	Q4 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

- No 2562, Constitutional A&E targets = 20
- No 3164, Nurse staffing = 20
- No 2976, Registered nursing vacancies = 25
- No 3063, Doctor vacancies = 16

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.
- Participation in national, regional and ICS/LRF exercising and testing of emergency plans.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5	4	4	5
Likelihood	3	4	4	4	4	2	3	3
Risk Rating	15	20	20	20	20	8	12	15

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Workforce Committee

Last Reviewed: 22 May 2023, January 2023, 14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

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
Development and Sign off of Performance Metrics to support roll out of Leadership Strategy and Culture Transformation	Q2 2022/23	Blue
Continued implementation of People Strategy by 31 March 2024	Q4 2023/24	Green
Delivery of people priorties with the Trust priorites 22/23	Q4 2022/23	Blue

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 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment

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	5
Likelihood	2	3	4	4	1	1	4	4
Risk Rating	10	15	20	20	5	5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 May 2023, 9 January 2023, 19 July 2022, 18 May 2022, 31 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2022/23
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSE
- Internal Audit Reports - Internal Control - significant assurance

External:
- Financial Special Measures Meeting - Letter from NHSE related to financial special measures and achievement of action plan
- Approval received at ICS Level for 2022-23 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2022/23

Planned Actions

Action	Quarter / Year	Assurance
Work with system partners, specifically community and local authorities to ensure that our local systems are working in unison to tackle the issues of system flow	2022/23	Blue
Agree financial recovery plan to meet 2022/23 year-end target	Q4 2022/23	Blue
Release of balance sheet flexibility to support 2022/23 forecast outturn	Q4 2022/23	Blue
Number of planned initiatives in 2023-to help facilitiate improvement with medical staffing		
There is specific workforce planning ongoing - linked to Workforce committee (refer to SO2)		

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems
- Vacancy levels in medical and nursing driving an unplanned level of spend
- Inability to transform planned care pathways, including outpatient follow-ups and theatre productivity

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- 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
- Fully formed CIP
- Fully formed transformtion planned care
- Inability to recruit and retain staff to meet financial plannnig assumptions
- Have we systems in place to facilitate level of recruitment
- Systems and processes in place to facilitate reduction in turnover rate
- Uncertainty of existing systems to recruit and retain staff.

Gaps in Assurance

- Trustwide Budgetary Control System, not working to deliver financial balance with current plans
- Recurrent delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the lack of flow
- Individual organisational sustainability plans may not deliver system wide control total

No assurnce recruitment or retention will iprove

Links to High Level Risks Register

No 3074, Financial Risk - Medicine CIP 2022/23 = 16
No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20
No 3174, Trust doesnot receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE.

Future Opportunities

- Closer ICS working
- Provider collaboration and formation of the Group
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	5	5	5	5	5	5
Likelihood	3	3	3	3	3	3	3	3
Risk Rating	15	12	15	15	15	15	15	15

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 April 2023, 21 February 2023**,** 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 - HAS Assurance Reviews
- NHSE Financial Special Measures Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE attendance at AAU / ED Programme Board
- NHSE Assurance Review Feedback
- CiC Minutes

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Green
Agree forecast spend for current year as part of wider ICS capital planning exercise	Q4 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
Develop integrated bid across N and NE Lincs for implementation of CDH aligned to ICS Core Programme	Q4 2022/23	Blue
Review and seek if there are ways of applying for future rounds of PSDS funding	Q4 2022/23	Green
Present Strategic Capital to Joint Trust Board 4 April 2023)	Q1 2023/24	Blue

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	Current Risk Q2	Current Risk Q3	Current Risk 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	4
Likelihood	3	3	3	3	3	2	2	2
Risk Rating	15	12	12	12	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 21 April 2023, 21 February 2023, 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 Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process

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 (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Action	Quarter / Year	Assurance
CIC / SDC / NED / Governor reviews	Q4 2022/23	Blue
Citizens Panel reviews	Q4 2022/23	Blue
Clinical Senate reviews (final review held 27 Feb 2023)	Q4 2022/23	Blue
To undertake continuous engagement process with public and staff	Q4 2022/23	Blue
Evaluation of the models and options with stakeholders	Q4 2022/23	Blue
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
HAS Programme:		
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Green
Clinical Senate Final Report due Q1	Q1 2023/24	Blue
Stakeholder Mapping	Q1 2023/24	Blue
To undertake continuous process of stocktake and assurance reviews	Q1 2023/24	Blue
NHSE and Clinical Senate review		
Joint OSC - reviews	Q1 2023/24	Green
NHSE Gateway review	Q1 2023/24	Green
ICS Board approval	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4	4	4	4
Likelihood	4	3	3	3	3	2	2	2
Risk Rating	16	12	12	12	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 22 May 2023, 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
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	Green
Introducing a managerial core skills programme for newly appointed managers 2022 and beyond - February 2023	Q3 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
- HAS

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 (22-May-2023)

No	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
1620	11/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas: Medical Gas Pipeline System, Mark 4 bedhead terminal outlets - Trustwide	There is a risk of losing bed head medical gases due to Mark 4 medical wall terminals outlets (Oxygen, Vacuum Medical Air, Nitrous Oxide) being obsolete with limited spare parts due to damage caused through clinical activity. The loss of medical gas pipeline behind the bedhead terminal outlets at SGH & GDH, could result in loss of oxygen supply and suction ability to an entire ward for an extended period time.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Med Gas	20	1 Monthly	28/05/2023	Ongoing monitoring of alarms.	Limited spares availability.	Approved ISO9001 contractor and QC pharmacist and access to limited terminal spares through approved spares supplier.
1774	05/06/2014	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Poor condition of Fuel Oil Storage Tanks - SGH	If the Trust lost gas supplies to the SGH site the boilers would have to be fuelled by oil. The material state of the oil storage tanks has resulted in the oil being contaminated and if called upon, could damage the boilers. The strategic risk are the boilers failing to provide heat and hot water due to main hospital site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation	16	1 Monthly	28/05/2023	Emergency generator fitted with own fuel supply.	No replacement plan for SGH.	External condition report.
1851	28/04/2015	30/09/2023	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Shortfall in Capacity within the Ophthalmology Service	The current risk, is the capacity does not meet the demand and the service is unable to meet this. Therefore, this impacts on ability to see patients within the clinical time scales.	Tom Foulds	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Ophthalmology	15	1 Monthly	15/06/2023	Work with the ICB to secure additional capacity in the independent sector.	Recent investment will not mitigate the shortfall in capacity	
2035	22/08/2016	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Equality Act 2010 compliance - Trustwide	The Trust has received numerous claims for slips, trips and falls from the state of the Trust's roads, pathways and corridors. These both damage the Trust's reputation and lead to financial loss. A number of facilities (lifts, toilets) are non-compliant with current regulations which may result in patients and staff being unable to move through the hospital sites safely and with dignity and respect.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety	16	1 Monthly	28/05/2023	Estates continually monitor the condition of the roads and pathways, repairing potholes as required. Larger resurfacing scheme are limited to BLM or other capital works funding when available.	Currently none, funding is required to provide adequate assurances. Staff to be made aware of the hazards of parking and moving around this area, as the site is not designated a car park.	The current control measures are not effective, it would need the "car park" to be closed to prevent further incidents.
2036	12/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ventilation and Air Conditioning - HVAC - Trustwide	There is a risk of failure of the heating and ventilation system due to aged infrastructure resulting in a negative impact on the effective delivery of patient care and pose a risk to the Trusts elective recovery plan in critical areas; theatres, ITU etc...	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation	15	1 Monthly	28/05/2023	Planned preventative maintenance (PPM) in place for inspection and maintenance of all ventilation plants.	Limited BLM funding resulting in no long term replacement plan. Capital plan 22-25 capture theatre upgrades	Validation and flow checks carried out by 3rd party accredited contractor.
2038	23/12/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Fire Compliance	There is a risk failure of the fire alarm resulting in failure to detect fire/smoke leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Fire Safety	20	1 Monthly	28/05/2023	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	28/02/2023	31/03/2024	To provide care which is as safe, effective, accessible and timely as possible	Buildings, Land and Plant	Building Management Systems (BMS) Controller failure/upgrade	There is the risk of failure of elements of the Building Management Systems (BMS). The BMS is the trusts advanced warning system which adjusts and controls the sites ventilation, heating and hot water services, therefore, temperature control of both the hospital environment and water systems could become significantly compromised.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Building Management	20	1 Monthly	28/05/2023	Continued monitoring of the system for operation (by Estates Staff).	Reactive to ongoing BMS failures. Current BMS runs on outdated windows 7 support system. Cyber security risk and patch update	There are limited assurances on controls highlighted by continued BMS failures.
2244	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within tWT (62 days) will result in poor patient experience and may have the potential for clinical harm in some specialties. The Trust consistently achieves the 14 day and 31 day standards. The likelihood of continuing to not achieve the 62 day standards is high due to some elements of the diagnostic or staging pathway being outside of the control of NLAG and sitting with the tertiary provider. Risk register also relates to Risk ID 2008.	Denise Gale	Abolfazl Abdi	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Cancer Services	16	1 Monthly	06/10/2021	(1) Weekly Cancer RTT waiting time meeting to challenge and review all cancer PTLs (62 day 1st, screening, consultant upgrade, 31 day 1st, subsequent surgery, subsequent drugs) (2) Automated RAG rated PTL (updated twice daily to reflect current position and available to all Divisional Managers). (3) 62 day Cancer Improvement Plan has translated into the Cancer Transformation Programme (2 year programme commencing 2021) (4) Cancer performance/ backlog is reported weekly to Operational Management Group (5) Improved visibility on all aspects of cancer pathways through the Cancer Power BI Performance report (which is updated daily and available to all Divisional Managers/clinicians. (6) Cancer Trackers attend Divisional Huddles in some specialties (Colorectal/Gynae) as a point of escalation. (7) A trust-wide clinical harm review process is in progress	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm	62 day backlog and 104+ days waits monitored weekly at Operational Management Group
2245	20/06/2017	31/03/2023	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	Surgery, Critical Care & Clini	Surgery (All)	16	1 Monthly	14/06/2023	(1) Capacity & demand plans have been developed for all specialties as part of the business planning 22/23 which highlight our risk specialties and gap between capacity and demand, use of the IST tool working with NHSI and strategy and planning.	Data quality and validation of clock stops.	Currently covering all clinics and wards with the use of agency and locums to mitigate the risk of rota gaps. North East Lincs and N Lincs council of members routinely review the data published.
2272	25/09/2017	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Environmental	EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide	There is a risk that the EHO could instruct that the ward based kitchen is unfit for food preparation and issue a prohibition notice which would prevent food/drink being prepared on ward areas. This would result in a delay to patients receiving food and drink.	Keith Fowler	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Catering	16	1 Monthly	28/05/2023	1) Food preparation boards, minimal ward based food preparation of low risk food. Hazard Analysis of Critical Control Points HACCP. 2) Ward refurbishment programme 3) Quality Matron Environmental Audits 4) Flo-audits	Funding for major ward refurbishments.	Funding for major ward refurbishments. EHO currently assess each site and awards cleanliness standard up to and including 5*, these outcomes are for public communication and awareness.
2300	07/12/2017	31/12/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Information Governance	Insufficient processes in place to ensure records management /quality against national guidance	The Trust has insufficient processes in place to ensure records management / quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards.	Susan Meakin	Christopher Evans	Trustwide - All Sites (DPoW, S	Digital Services	Digital Services	Information Governance	16	1 Monthly	15/06/2023	Oversight by Trust's IG Steering Group and is managed via the Group's Action Log which is reviewed monthly.	None	The IG Steering Group monitor the progress of this actions

2347	24/11/2022	31/03/2023	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance : Overdue Follow-ups	There is a risk that there is insufficient capacity to meet demand in a number of specialities which risks overdue follow up position deteriorating Failure to review patients in clinically specified timescales.	Jennifer Orton	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Surgery (All)	15	1 Monthly	14/06/2023	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.
2550	27/01/2023	30/09/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Staffing Levels & HR	Pharmacy staffing	Due to the number of vacancies and maternity leave at this time, the clinical pharmacy service is unable to maintain its current level of service delivery. The impact on service delivery is likely to be in effect for a number of months. The service has been recruiting to posts and continues to do so. Within the pharmacy workforce the applicants have been primarily from pharmacists due to qualify in August therefore resulting in a short term gap as staff have left now and will be replaced in August. With the pharmacy technician workforce multiple attempts have been made to recuruit to fixed term and permanent posts with little success.	James Hargraves	Simon Priestley	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Pharmacy	15	1 Monthly	03/05/2023	We are trying to source locum cover for both pharmacists and technician posts but have had minimal response from locum agencies. We are working with existing staff to offer bank contracts and additional shifts, again with minimal uptake.	Difficulty recruiting permanent and locum staff. Difficulty retaining staff. Difficulties continue with finding and appointed appropriately experienced locum pharmacists. Situation not helped by current high cost locum rates (£40-£50 per hour) in community making hospital work financially unattractive)	We will have 1x locum pharmacist commencing on the Scunthorpe site in August 2022 for minimum of 3 months.
2562	13/01/2023	08/09/2022	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	Medicine	Emergency Care	20	1 Monthly	27/05/2023	- Daily Operations Centre Meetings - Establishment for medical staffing in ECC increased to 14 Consultants, 12 Middle Grades, 10 Juniors - Additional consultant coverage up to midnight on shop floor 7 days a week to ensure compliance with RCEM guidance - Additional 3rd middle grade shift overnight 7 days a week to support operational pressures - Daily analysis of challenges and performance Update: 18.06.21 * ECIST support provided and action plan produced * Implemented NHS 111 First Initiative * EMAS direct streaming to SDEC now providing an alternative to going through ED and improving the patient experience * EMAS patient self-handover protocol now in place allowing ambulance crews to leave appropriate patients at ED reception to end the handover and avoid delays * Frailty service at DPOWH went live on 12th May to reduce frail patients within ED and provide an improved pathway for the patients Update: 20.07.2021 * Senior Medicine Management oversight tiers implented to improve support to ED and timely escalation Update: 09.11.2021 * New Urgent Care Service (UCS) model implemented at SGH from 18th October 2021 - phased approach to implementation due to need to build workforce numbers and clinical skills * Newly revised and relaunched IAAU/SDEC SOP to reduce barriers for patient pathway from ED and reduce patient wait times Update: 10.01.2022 * UCS model due to be implemented at DPOWH from 18th January 2022 Update: 10.03.2022 * UCS model implemented at DPOWH and sustaining 100% performance for this cohort of patients, with improved patient care and experience	- Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED - Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skillmix - Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience - Inappropriate attendances to ED due to lack of access to alternative, more appropriate services - Update = 02.03.2021 = COVID 19 has had and is continuing to have a significant impact on the Trust's ability to maintain its constitutional A&E targets, primarily due to maintaining the flow of patients requiring isolation beds, additional PPE and social distancing requirements and delays in diagnostics - Lack of physical capacity within the ED to see patients when exit block occurs resulting in long patient waits in ED and ambulance handover delays	- Emergency Care Quality and Safety Meeting oversight - Medicine Governance Meeting oversight - Agenda item on PRIM - Recruitment plans to recruit to medical staffing vacancies through new ED specific recruitment strategy - Additional medical staff booked by Trust to support covid implications and delayed patient stays within the ED - Additional HCA staff booked by Trust to support covid implications and delayed patient stays within the ED - Implementation of phase 1 of AAU in Nov 2019, followed by phase 2 of integrated AAU in Oct 2020 has improved SDEC provision and patient flow * D2A - audits. Update: 10.01.2022 * 12hr DTA Breach Validation to identify root cause of breach and to check whether patient harm occurred Update: 08.02.2022 * UCS pilots at each site are showing improvements in patient care, exeperience and performance against the 4 hour target
2576	10/03/2022	30/09/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Paediatric Medical Support Pathway for ECC - 'Fastrack'	There is a risk that children and young people are not triaged and assessed within the 15 minute standard as a result of acuity and activity within the Emergency Depratments which may lead to prolonged wait times for nursing and medical assessment within the Emergency Departments which may lead to a sick child not being recognised thus causing a level of harm	Deborah Bray	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Paediatrics	16	1 Monthly	20/05/2023	>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	Surgery, Critical Care & Clini	Cancer Services	16	1 Monthly	14/06/2023	Weekly Cancer RTT waiting time meeting to challenge and review the PTL.	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm.	104+ waits are reducing week on week, clinical harm review being undertaken on all 104+ patients.
2623	28/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Failure of windows - Trustwide	There is the risk of patient harm due to failing aged windows and window restrictors supported by DoH Alert EFA/2013/002. Many of the windows are the original windows installed (in excess of 40 years) and do not meet HBN 00-10 Part D: Windows & associated hardware requirements, which is retrospectively applied.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Buildings	20	1 Monthly	28/05/2023	Periodic planned maintenance.	Due to the windows been in poor state it is difficult in determining when these could fail.	Labour management system
2655	11/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers	Risk is loss of heating and hot water on site. The steam raising boilers are 31 years old and could fail. Boiler failure would result in SGH closing down all clinical services until temporary boilers could be connected to site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation	20	1 Monthly	10/06/2023	The management of the energy centre (steam boilers) is outsourced to Equans.	Equans contract has expired. Renewing annually.	Adhoc repairs are effective. No significant loss of service.
2719	22/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety - Oversized water distribution pipes	There is the risk of micro bacterial water infections from under utilised water services due to legacy oversized water distribution pipework which could result in patient(s) contracting infections whilst in hospital.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	20	1 Monthly	28/05/2023	Risk assessments undertaken at two yearly intervals by external competent specialist contractors.	Lack of funding for infrastructure upgrading.	Hydrop defect portal giving real time data on progress of defects.
2773	21/04/2023	31/08/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Clinical Harm	Cause - Lack of scanning capacity is leading to a risk of delayed diagnosis Impact - inability to deliver timely diagnostics for patients on diagnostic pathways, and lack of clinical capacity & agreed pathways is impacting on ability to perform harm reviews. The impact of this is failure to meet waiting times standards, leading to an increased risk of clinical harm.	Ruth Kent	Ruth Kent	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Radiology	16	1 Monthly	21/05/2023	Risk stratification process agreed with groups. Escalation process reiterated to clinical administration staff Monitored via activity meetings and updated via RMT Close working with operational management team, heads of service and clinical leads where appropriate to agree booking priorities Wiating lsits recovering since new scanners opened, CT & MRI not triggering waiting list validation according to national guidance. Non obs ultrasound has become a concern - separate risk has been added for this.	Clinical framework for appointing within current capacity	Monitored and update via COVID-19 management meeting. Added to action plan and risk log of above meeting. Discussed at Trust level Recovery plans and increasing capacity to support reduction of waiting lists

2898	14/03/2023	01/12/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Staffing Levels & HR	Medical Staff - Mandatory Training Compliance	Mandatory Training compliance for medical staff. There is a risk to patient safety if medical staff do not complete their mandatory training before each element has expired. Due to the volume of doctors demonstrating low compliance across all grades, this has impacted upon the divisional CQC improvement plan.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)	16	1 Monthly	13/04/2023	* Feb Data - Core: 63% Role Specific: 52%. * Rota Coordinators providing more directed support to all level doctors across Medicine to allocate/support training time for them to complete MT * MT raised at SMT, Board Meetings, Workforce SMT and separately at AGM/Speciality/Clinical Lead/Line Manager Level * Workforce Development plans are being developed for each Speciality within Medicine which is being supported by the Medicine Quad, HRBP and AGM down to Clinical Leads. * Reviewed at Divisional Workforce Meeting Updated - 14.03.22 Identification of 2 least compliant staff members in each area each month and target set for compliance to be met HRBP meeting monthly with the rota co-ordinators to identify 10 least compliant doctors and allocate time on the roster to complete Divisional Clinical Leads to work with divisional SMT to develop recovery plans for their specialities Training incorporated at the Quality & Safety meetings Individuals with low compliance being contacted and targets for completion set on-going at ward review meetings Linking in with course leads to look at prioritisation and alternative ways of completing training e.g. targeted cohorts New rotational doctors commenced training prior to starting in post	Potential failure to meet CQC requirements Staff not adequately trained with potential to impact on patient care and staff H&WB	* Report collated by HR Business Partner. * Improvement plan led by AMD / ACOO. * Compliance monitored at Divisional Board / Divisional Governance Meetings. * Reviewed at Divisional Workforce Meeting * Reported via Performance Review Meetings.
2905	07/04/2021	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW	There is a risk that the following areas may not be able to receive essential supply of electricity in the event of a power failure due the age of generator (1979). This will affect clinical procedures and potential persons within the lifts becoming trapped, therefore directly affecting patient safety. - Ramp Plant Room (Med Gas Compressors +) - Theatre Plant Room (All Theatres) - Lifts - I.T and I.T Server - X-RAY - Theatres - Pathology If this risk materialises, the hospital would need to close	James Lewis	Simon Tighe	Diana, Princess Of Wales Hospi	Estates and Facilities	Estates and Facilities	Estates - Electrical	16	1 Monthly	28/05/2023	Monthly test to start and run Diesel Generator for a period of 90mins	Non-compliant with HTM 06-01;17.88 Maintenance programmes should include a longer test run to establish the generator Engine's mechanical performance. A test to prove the generator engine's condition up to 110% full load should be carried out annually. The period of the test should be not less than 3 hours and ideally 4 hours. The Trust is currently only able to conduct an 80% max load test. Tests can currently only be ran for a period of 90 minutes. Potential frailty of equipment was highlighted in the 2019 Load Bank Test as it damaged a Cooling Pump & Radiator on a similar set. Non-compliant with BS7671:2018;414.2.1 Live parts shall be inside enclosures or behind barriers providing at least the degree of protection IP2X	Minor and major equipment services logged in compliance folders.
2949	12/05/2023	31/03/2023	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Oncology Service	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 2)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a shortage of chemotherapy nurses at DPoW and difficulties in training new chemotherapy nurses.	Angela Lamming	Jill Mill	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Oncology	20	1 Monthly	11/06/2023	1)Currently looking for locum consultants to back fill some of the work, and a locum SpD has been secured, starting week commencing 30/11/2020. Interviewing for a further 5 SpDs. 2)Ongoing work around the management of clinics including clinic redesign, telephone clinic management, practitioner support, adequate time slots etc. Support offered to all staff from management. 3)Covid19 steering group in place, with CSS Health Group and SS Division input into command structure. 7no. Covid19 + beds still in place on C30 and position monitored closely to establish requirements into the future. 4)Liaison between HUTH and NLaG Senior Management Leads to ensure oversight of the waiting times and actions to mitigate avoidable delays. Plan is to develop a single joint activity / waiting times report whc will be produced monthly and reviewed at the joint Oncology meetings. 5)Very small number of patients affected, who could be admitted at HUTH to receive inpatient chemotherapy delivery. 6)Where clinically appropriate, SACT delivery from Lloyds community infusion clinic to reduce demand on SGH dat unit. Consider reducing the number of days SGH day unit opens to consolidate staffing. Continue to access external Level 6 SACT training for RN on Amethyst Unit at DPOW to increase chemo trained workforce.		* Risks reviewed weekly at the joint NLaG & HuTH Oncology meeting and updated accordingly.
2951	23/03/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide	There is the risk of failure of aged (40 years plus) Electrical and/or mechanical LV components which could cause power interruptions to key areas. The impact of such failure is for clinical departments to experience reduced capacity or ability to treat and/or carry out diagnostic investigations on patients, leading to possible harm. This risk became a tangible issue on Dec 22 when a power cable failed causing widespread power interruptions.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Electrical	20	1 Monthly	28/05/2023	Monitoring switch gear regularly to ensure the situation is not deteriorating.	Lack of annual switching.	Periodic inspections carried out annually.
2952	04/08/2021	07/12/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Fire ring main - Trustwide	The fire ring main is legally required to serve only water services for fire fighting, the ring main has a number of building fed from it thus making it non-compliant with regulations and could lead to enforcement action by Humberside Fire and Rescue Service.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	16	1 Monthly	28/05/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		Hydrop defect portal giving real time data on progress of defects.
2953	22/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Sensor & Spray taps - Trustwide	Due to the installation of sensor and spray taps and the inability to flush for the required time period, there is the risk of legionella which could impact on the health of the building occupants (patients/staff).	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	16	1 Monthly	28/05/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.	Linked to on-going refurbishment works.	Hydrop risk assessment report which identifies location of taps.
2955	12/04/2023	30/06/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - 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	Estates and Facilities	Estates - Med Gas	15	1 Monthly	28/05/2023	Daily monitoring of the oxygen consumption.		Medical Gas Policy DCP026

2959	12/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Replacement/Repairs of flat roof - Trustwide	There is the risk of failure of flat roofs across the sites. A number of roofs have failed across the site. Roofs of note include the SGH IT roof which houses trustwide servers and a roof over a new £1m MRI unit. A roof failure in either of these areas would result in significant risk to trustwide infrastructure and service delivery impacting elective recovery.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Buildings	16	1 Monthly	28/05/2023	Staff report any roof leaks to the facilities department when they occur.	Limited BLM funding prevents full replacement of flat roofs and only enables patch repairs.	Document will provide targeted spend profile to minimise roof failure.
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	Family Services	Obstetrics / Maternity	16	1 Monthly	25/05/2023	Daily staffing meetings for oversight of issues Thrice daily Operational meetings to escalate staffing issues SafeCare Live Process to escalate short staffing - request for bank staff / agency staff 24/7 theatre access is managed by surgery division Maternity Services Escalation Policy	Challenges in acquiring midwives via agencies due to limited numbers and trust location Acuity of unit changes requires demand for additional staff and difficult to plan	Any incidents relating to staffing compromise are monitored via weekly incident review meeting and any issues relating to safety being compromised are escalated at time of event.
2976	01/11/2022	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Staffing Levels & HR	Registered Nursing Vacancies	High Registered Nursing vacancy levels - a lower number in the UK market impacting upon the delivery of patient service, travel and accommodation issues causing some difficulties for international recruits.	David Sprawka	David Sprawka	Trustwide - All Sites (DPoW, S	People and Organisational Effe	People & Organisational Effect	Recruitment	25	1 Monthly	21/06/2023	Funding accessed through NHSi to facilitate international recruitment providing additional pipelines.		
2992	18/11/2021	31/03/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Equipment	Changing Places facility at Scunthorpe General Hospital	There is a risk of emotional harm and distress to patients and families who visit the trust and unable to use appropriate toilet facilities. This is due to no adapted Changing Places facility at Scunthorpe General Hospital. This could result in reputational damage from complaints, safeguarding section 42 Care Act enquiries and patient harm due to psychological distress and deterioration in skin integrity.; breaches in the Human Rights Act could lead to reputational and cost implications.	Victoria Thersby	Victoria Thersby	Scunthorpe General Hospital (S	Chief Nurse	Chief Nurse	Safeguarding Adults	16	1 Monthly	01/06/2023	There are disabled toilet facilities within the Trust	Complaints by members of the public and patients attending the outpatient department	
3015	11/04/2023	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Staffing Levels & HR	Insufficient estate resources to manage the workload demand	Failure to recruit technical capital project team members to support current major capital project delivery programme which is impacting on the estates operational teams ability to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. It is anticipated that this risk will be reduced in 24/25 when capital funding reduces. The impact to the Trust if not actioned; inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance, lack of Engineer resource to complete mandatory work and project works, ineffective management of Pre-Planned Maintenance, ineffective management of water systems due to shortage of water APs (SGH), inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing), ineffective management of the estates leading to reactive maintenance (firefighting), inability to implement proactive management systems (MICAD helpdesk), impact to patient safety, loss of workforce due to on-going work pressure and employee market shortage (supply/demand), reduced staff morale, inability to support wider project delivery, durther degradation and serious incidents within the estates, loss of financial resources due to settlement of claims (mainrity of	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety	20	1 Monthly	28/05/2023	Resources prioritized in a reactive manner	Minimal controls in place, competing priorities for both capital and operational compliance work, resulting in poor ability to manage both within either a safe or responsive realm.	Internal policies and procedures in place
3036	17/03/2022	30/06/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	There is a risk to patient safety, quality of care and patient experience due to delayed admission to ward beds due to challenges with patient flow throughout the Trust.	Simon Buckley	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	16	1 Monthly	08/06/2023	LLoS is monitored on an ongoing basis through the following meetings; Medicine Divisional Board Medicine Governance Daily Operation meetings Deprtmental Board rounds and Huddles ED 95% standard compliance		
3045	16/03/2023	/ /	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Medical Workforce Vacancies in Gastroenterology	Following departure of 2 consultants in Gastroenterology there is insufficient workforce to deliver the range of services. Resulting in: - Failure to meet constitutional targets (RTT &Cancer) - Delays in patients being seen both as inpatient & outpatients - Increased waiting times - Increase LOS - Failure to fulfil emergency GI Bleed Rota - Lack of training and supervision - Unable to provide a Barrett's oesophagus service and registry in the Trust for appropriate follow up of these patients. The patients with Barrett's are being managed by gastroenterology, surgery and even some patient's are with primary care.	Simone Woods	Simone Woods	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Gastroenterology	16	1 Monthly	02/06/2023	Staff on the GI bleed rota will travel to the opposite site where needed to attend a patient with a GI bleed or patient will be transferred to the alternate site for treatment if feasible.	When short notice leave applies this puts additional pressure on the current provision for the service	

3048	13/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Operational	Challenges to recruitment of acute care physician vacancies in Acute	This risk is to highlight the difficulties in workforce recruitment and the increased pressures on staff, which has been exacerbated by the Covid-19 We have vacancies for acute care physicians (ACP) Trust-wide and it is proving very challenging to fill these posts. The cause has been due to a national shortage of ACPs and lack of applicants for the posts when we have advertised them. The impact would result in failure to recruit the required ACPs and this will delay the planned expansion of acute medicine service with extended hours with senior clinician presence on the shop floor and could result in failure to launch phase 3 of the IAAU development plan for 2023. There is a risk that due to the pressures created by having less workforce and increased demands placed on services as a result of not having a balanced workforce, this may result in the current ACPs becoming exhausted, leading to gaps in rotas and therefore not sufficient senior medical staff to ensure quality and safety of patients. In addition, this may also result in doctors withdrawing from our hospitals, exacerbating staffing issues.	Lynsey Chessman	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	General Medicine	16	1 Monthly	14/06/2023	Actively trying to recruit more clinicians through networks		
3063	14/03/2023	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Doctors Vacancies within Medicine Division	1.lack of substantive practitioners as a result of difficulties recruiting may lead to patient safety issues (lack of continuation of care due to the number of locums who may choose the leave at any time). 2. an increased financial burden for the Trust due to higher costs for locums (circa double the cost of Consultants on Trust contract). 3. There are fluctuating but significant number of vacancy posts required in Medicine.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)	16	1 Monthly	13/04/2023	weekly workforce panel workforce SMT specialty business meetings review and oversight if data	development of specialty workforce plans	workforce panel workforce SMT Div Board workforce improvement plan
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	Medicine	Finance	16	1 Monthly	28/04/2023	General budgetary Financial Management - Includes reporting, variance analysis and actions / recommendations.		
3129	23/02/2023	/ /	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Overdue follow-up and new patients waiting lists for Paediatric patients at SGH	There is a risk of possible delays in diagnosis and treatment for Paediatric patients who have been waiting for a long time, as a result of a backlog from the Covid 19 pandemic (clinics being cancelled and staff shortage/ sickness). This may lead to complications and side effects which can be avoidable if patients are seen on time.	Nicki Chatterton	Umaima Aboushofa	Scunthorpe General Hospital (S	Directorate of Operations	Family Services	Paediatrics	15	1 Monthly	30/03/2023	To risk stratify the cases overdue by 20 weeks and try to priorise these patients.	Ensure patients are seen and safe.	Feeding into weekly performance and activity meetings. This is also being discussed / reviewed within the Teams. Discussed at PRIM.
3131	30/12/2022	/ /	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Delay in assessments being carried out for children with health and educational needs (under 5 years of age)	There is a risk that children are not diagnosed in a timely manner to be able to put the appropriate support package in place due to the delay in assessment being carried out (currently a wait of 2 years).	Deborah Bray	Vijayalakshmi Hebbar	Diana, Princess Of Wales Hospi	Directorate of Operations	Family Services	Paediatrics	16	1 Monthly	20/05/2023	Working collaboratively with the ICB to put a plan in place to ensure the health assessments are carried out as quickly as possible and that parents are sign-posted to healthcare professional, GPs and health visitors.	Unable to proceed with increased capacity due to limited resources across health and education.	Issues are incident reported and specific issues will be addressed depending on the issue raised at the time of the incident. Complaints and PALS management.
3158	02/05/2023	30/06/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	(EPR) Badgernet - ability to view scans	There is a risk that Obstetricians will not have access to electronic scan reports when the new maternity services EPR (Badgernet) is implemented, as a result of the systems incompatibility with the current Viewpoint package, which may lead to an adverse impact on patient safety in terms of potential for high risk pregnancies.	Nicola Foster	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Obstetrics / Maternity	15	1 Monthly	01/06/2023	MITS Project Board in place MITS Data Migration and Warehousing Strategy in place Digital Midwife and CNIO in place providing oversight EPR project management and digital projects development monitoring systems in place	Current incompatibility of procured IT systems	MITS Project Board
3161	05/04/2023	31/05/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Clinical	There is a risk of patient deterioration not being recognised and escalated appropriately.	There is a risk that patients deterioration is not recognised and the recording and monitoring of NEWS is not consistently completed to guide further actions appropriate to the trust Deteriorating Patient Policy, including the use of risk assessments (Sepsis screening tool) to identify required clinical responses in a timely way.	Joanne Foster	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Nursing (All Specialties)	15	1 Monthly	11/06/2023	1.Divisional progress against targets is monitored via the Deteriorating Patient & Sepsis Group.		
3162	08/02/2023	31/05/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Quality of Care and Patient Safety based on Nurse Staffing Position	The Registered Nursing vacancy position in Medicine, against current, agreed establishment creates significant issues with producing a robust nursing roster. Reliance upon a pipeline of Newly Registered Nurses and Internationally Educated Nurses creates skill mix issues when set against numbers of leavers. The Nurse vacancy position within Medicine has a direct impact on quality of care and patient safety. There is a finance risk associated with the use of Bank & Agency Nurses in order to fill the gaps in the rosters. Service developments and new build areas (IAAU/SDEC/ED's) and investment in the establishments required have increased demand for Bank/Agency and vacancy in substantively funded posts. Medicine are also staffing escalation beds which adds further risk. Patient harm, increased sickness, staff retention are possible outcomes as a result.	Joanne Foster	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Nursing (All Specialties)	20	1 Monthly	11/06/2023	1.Recruitment pipeline for Internationally Educated Nurses Recruitment pipeline and engagement with newly registered nurses	Inability to safely redeploy	
3164	21/02/2023	31/03/2024	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce	Staffing Levels & HR	Nurse Staffing	There is a risk that the Trust will be unable to maintain safe nurse staffing levels as a result of the high number of registered nurse & support worker vacancies and ongoing requirement to support unestablished escalation beds, which may impact on the ability to maintain patient safety and delivery of high quality care, leading to poor patient and carer experience and reputational damage.	Jennifer Hinchliffe	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	Chief Nurse	Nursing (All Specialties)	20	1 Monthly	08/06/2023	SNCT acuity data collected twice a year with formal Chief Nurse establishment reviews undertaken annually	High number of nurse vacancies leading to shortage of nursing staff available to cover required shifts and reliance on bank and agency staff. Increased RN and HCSW turnover rates. Diversity of IEN pipeline and ability of ward to support high numbers of IENs due to impact on skill mix.	Nurse staffing dashboard accessible and contains KPIs re vacancy position, agency usage, nurse sensitive indicators etc.

3168	26/04/2023	28/07/2023	To provide care which is as safe, effective, accessible and timely as possible	Corporate Business	Newborn Hearing Screening Service cross-site (reduced management time / no management cover)	There is a risk that, when the local hearing screening manager is on leave or absent, there is no-one to carry out local hearing screening manager tasks which could result in a lack of service provision as there is no-one within the team who is trained to cover these duties. There is a risk that babies' screening may be missed or escalations may not be followed, if not managed timely, which may result in a late diagnosis of hearing loss. Management tasks for the QA / Public Health England will not be completed which could result in a delay in picking up gaps in the service and screener performance. If there is reduced capacity within the team, this also reduces the amount of time the local screening manager has for managerial tasks. There is also a risk of burnout to the team.	Alison Hilder	Vijayalakshmi Hebbar	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Newborn Hearing Screening	16	1 Monthly	26/05/2023	Escalating to matrons (including the Antenatal and Newborn Screening Manager).	Escalation to highlight increasingly prominant risk. This has also been highlighted in the QA visit in September 2022.	
3174	22/03/2023	30/06/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Financial	National Cost Collection - patient level community data	Trust doesn't receive system one information to be able to submit costs at a patient level as per the mandatory requirements of NHSE/I.	Damian Kitchen	Lee Bond	Trustwide - All Sites (DPoW, S	Finance	Finance	Finance	15	1 Monthly	16/06/2023	regular contact with information department for progress updates		escalation to internal digital management

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	6 June 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Strategic Development Committee**
Purpose of the Report and Executive Summary (to include recommendations)	**Introduction:** At the joint Trust Board development session between NLAG and Hull University Teaching Hospitals on 2nd May it was agreed to rename and rescope the current Committee in Common, known as Humber Acute Services Development Committee. The committee will now be called the Group Development Committee in Common, the individual terms of reference of the new committee have been amended and are to be approved by the Trust Board at its meeting on 6 June 2023. The Group Development Committee in Common, as part of the revised TOR will oversee the strategic direction of both Trusts, authority delegated by each Trust Board. To this end the Strategic Development Committee of the NLAG Trust Board will no longer be required and the responsibilities of the committee will be transferred accordingly. In the interim period, it is proposed that the strategic risks SO1-1.3, SO1-1.5, SO3.2 and SO4 be reported directly to Trust Board, until such time as the Group Meeting structure is implemented. The Trust Board is recommended to approve the disbanding of the Strategic Development Committee. **Recommendation:** The Trust Board is asked to: a) approve the disbanding of the Strategic Development Committee, b) note the Trust Constitution will be updated in the future to reflect this change c) agree that the strategic risks SO1-1.3, SO1-1.5, SO3.2 and SO4 will be reported directly to Trust Board, until such time as the Group Meeting structure is implemented.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Director of Strategic Development

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

*Board Assurance Framework (BAF) Descriptions:

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

NLG(23)110

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6 June 2023	
Director Lead	Sean Lyons, Chair	
Contact Officer/Author	Sean Lyons, Chair	
Title of the Report	**Interim Chief Executive Cover Arrangements**	
Purpose of the Report and Executive Summary (to include recommendations)	To formally brief the the Trust Board on the Chief Executive cover arrangements for the period from 26 May – 14 August 2023	
Background Information and/or Supporting Document(s) (if applicable)	'Case for Change' for the move to a group leadership model and associated briefing notes	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Remuneration & Terms of Service 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)	To be confirmed as part of the interim selection process and agreed through the Remuneration & Terms of Service Committee	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Ensures ongoing Chief Executive level leadership on these issues	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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

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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.
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Northern Lincolnshire and Goole NHS Foundation Trust

NLaG Chief Executive Cover Arrangements

1. Introduction

1.1 Following the announcement that Peter Reading, NLaG Chief Executive, would leave the trust to take up a new role with another NHS organisation from 1 June 2023 (although due to leave his last working day would be 26 May 2023), the Trust has been required to put in place cover arrangements.

1.2 To provide stability at a time of operational pressure and until Jonathan Lofthouse, the newly appointed joint Chief Executive commences in post on Monday, 14 August 2023, it was agreed through the Trust's Remuneration and Terms of Service Committee that the cover would best be provided by one of the NLaG Executive Directors.

1.3 This paper provides details of the specific arrangements and processes which have been agreed.

2. Cover Arrangements

2.1 From the 26 May – 14 June 2023, the normal acting up arrangements which have operated during periods of Chief Executive leave have and will apply with the following Executive Directors covering one week each:

Week 1: Dr Kate Wood, Chief Medical Officer

Week 2: Mr Shaun Stacey, Chief Operating Officer

Week 3: Jug Johal, Director of Estates & Facilities

2.2 From 14 June – 14 August 2023 and following receipt of expressions of interest and a selection process, the Trust will formally appoint one of the NLaG Executive Directors to cover the role. Further information in respect of the outcome of this process will be notified to the board in due course.

2.3 The above arrangements were agreed to ensure a smooth handover, stability, and no loss of senior leadership cover.

3. Trust Board Action Required

3.1 The Trust Board is asked to:

- formally note the outcome of the Chief Executive recruitment process and the appointment of Jonathan Lofthouse as joint Chief Executive of NLaG and HUTH and the commencement date of 14 August 2023;

- note the immediate Chief Executive cover arrangements put in place to cover the period from 26 May – 14 June 2023;

- note and support the proposal to formally appoint one of the NLaG Executive Directors to cover the Chief Executive role on an interim basis from 14 June – 14 August 2023.

Sean Lyons,
Chair – HUTH & NLaG
June 2023

NLG(23)111

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 6th June 2023	
Director Lead	Jug Johal – Director of Estates & Facilities/Health Inequalities Lead	
Contact Officer/Author	Bill Parkinson – Associate Director of Safety & Statutory Compliance	
Title of the Report	**Annual Health & Safety Policy Statement**	
Purpose of the Report and Executive Summary (to include recommendations)	Annual update of public health & policy statement for Trust for approval	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Audit Risk & Governance
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

Directorate of Estates & Facilities

HEALTH & SAFETY AT WORK POLICY STATEMENT

Reference:	DCM081
Version:	
This version issued:	
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	
Owner:	Jug Johal, Director of Estates & Facilities
Document type:	Miscellaneous
Number of pages:	4 (including front sheet)
Author / Contact:	Bill Parkinson, Head of Safety & Statutory Compliance

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.

HEALTH AND SAFETY AT WORK POLICY STATEMENT

Northern Lincolnshire & Goole NHS Foundation Trust recognises its health and safety duties under the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations 1999 (as amended) and Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

In keeping with the Trust's Strategic Plan the transformation of the services and it's sites the Trust is committed to the health and wellbeing of employees, contractors, patients and other members of the public. This will be achieved by providing a working environment, appropriate controls and suitable training which satisfy the health and safety standards set out in regulations, practices and procedures, codes of practice, contracts and specific Northern Lincolnshire & Goole NHS Foundation Trust policies.

During this period of transformation there is likely to be some disruption in relation to some services, traffic and patient flows and car parking arrangements until the works are completed. The Trust will look to keep these disruptions to a minimum and will not be to the detriment of the health and wellbeing of anyone. Regular updates on progress and forewarning of any temporary changes will be issued at the earliest opportunity to give suitable advance notice to service users and staff alike. However, it is recognized that there may be changes which may occur at short notice and service users and staff are asked to accept these as part of the overall move towards the Trust objectives. As these projects near completion further risk assessments will be undertaken to identify any residual risks and mitigating actions that may be present going forward.

This Health & Safety Policy Statement outlines the Trust's commitment and approach to the management of health & safety and does not provide the detail on the management of specific health & safety risk topics. Policies and procedures covering the assessment and control of specific health & safety risks (e.g. Occupational Road Risk, Lone Working, Violence & Aggression etc) are in place. These documents are maintained within a central document control system, which ensures that a consistent approach is adopted, that suitable consultation and approvals processes are in place and that documents are regularly reviewed and updated, and are made available to staff as appropriate.

Whilst the Chief Executive is ultimately responsible for the implementation of effective health and safety arrangements, as outlined in the Trust's Risk Management Strategy, the Director of Estates & Facilities has delegated responsibility from the Chief Executive for all elements of in relation to health & safety (whilst accepting that the Medical Director and Chief Nurse have delegated operational responsibilities within their areas). The Deputy Director of Estates & Facilities in turn has responsibility for the central co-ordination of these arrangements, with the day to day management of health & safety management at local level being devolved to Directorates.

The Trust Board and Directors/Managers therefore collectively and individually accept their duties and responsibilities arising from the Health and Safety at Work etc Act 1974.

The Trust recognises that a proactive approach to the management of health & safety risks is considered an essential element in a good safety management system. As part of its approach, the Trust has in place a system of formal and informal inspections, visits and audit processes which include Directors and Governors. Where appropriate, the Trust also sources external verification of its health & safety management arrangements.

In complying with its duties to its employees as outlined in the Health and Safety at Work etc Act 1974 and the Management of Health and Safety Regulations 1999 (as amended) the Trust is committed to:

- Introducing, developing and maintaining safe systems of work which employees and others working for the Trust are expected to follow and also to reviewing and improving existing systems to further raise standards
- Increasing the knowledge and skill base of its employees in relation to health and safety, ensuring that staff are competent to identify, assess and manage health and safety risks within their working environment
- Supporting Directorate/Division forums to ensure active involvement in health & safety matters and performance
- Using internal data acquired from reactive sources (e.g. incident reports) as well as proactive systems (e.g. inspections, site visits and audits) together with information from managers and staff and external sources (e.g. legislation updates, etc) to allow the Trust to review the robustness of its safety management system and afford the opportunity to benchmark its performance against other Trusts
- Setting both annual and longer-term strategic objectives as part of the business planning process in order to further develop and improve health and safety arrangements/standards
- Maintaining a robust incident/accident reporting system, which facilitates learning lessons through corrective action and re-audit and the identification of the underlying or root causes of failures identified.
- Developing Key Performance Indicators (KPI) to assist with the identification of health & safety performance both positive and adverse. Using adverse performance to introduce measures to improve health, safety & wellbeing within the organisation.
- Ensuring that equipment is purchased to required specifications, meets all statutory requirements and that staff using equipment have received adequate instruction and training and importantly that inspection and maintenance occur as required
- Maintaining a comprehensive Trust-wide Risk Register and Central Risk Assessment System which includes specific health and safety risks and which are used to assist in the setting of priorities and the allocation of resources as well as in the development of health and safety planning
- Developing a positive safety culture throughout the organisation through our vision and values and strategic objectives
- Implementing a strategy to promote and improve the mental health and wellbeing of staff within the Trust
- The provision of health surveillance for its employees where appropriate
- The appointment of competent personnel to support and advise staff in all areas of health and safety
- The development of a safety management system to a recognised certified standard

In accordance with statutory provisions the Trust will ensure that adequate resources are allocated to achieve the above commitments.

In addition to the responsibilities of the Trust as an employer, all employees and other persons working for the Trust, e.g. volunteers and contractors, are expected to participate and co-operate with the systems of work implemented in order for the Trust to discharge its statutory duties. This also involves taking reasonable care of themselves and others who may be affected by their actions (or omissions), including the safe and appropriate use of equipment (including safety equipment) and reporting any safety issues appropriately.

The Trust Board, both directly and through its designated sub-committees will monitor performance against agreed health & safety objectives with any issues escalated where required.

Formal monitoring of the Trust's Safety Management System is undertaken through a variety of measures as mentioned above. A formal audit plan is also in place and outcomes are reported to and are monitored by the Trust Health, Safety & Fire Group and, as required, the Audit, Risk & Governance Committee and Trust Board.

As the Trust moves towards greater collaborative working with Hull University Teaching Hospitals NHS Trust it will look to improve safety management within both organisations utilising resources and expertise accordingly.

This Health and Safety Policy Statement will be reviewed annually, or sooner should the need arise.

Peter Reading	**Jug Johal**
Chief Executive	**Director of Estates & Facilities**
Version: 11.9	**Reviewed & Re-issued**

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

NLG(23)114

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6th June 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, February & March 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance and Performance Committee Minutes from the meeting held on Wednesday 22nd February 2023 and approved at the meeting on Wednesday 22nd March 2023; and the Minutes from the meeting held on Wednesday 22nd March 2023 and approved at the meeting on Wednesday 19th April 2023	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: **Wednesday 22 February 2023, TEAMS**

Present:		
	Gill Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director (NED)
	Jug Johal	Director of Estates & Facilities
	Lee Bond	Chief Financial Officer
	Dr Peter Reading	Chief Executive Officer
	Shaun Stacey	Chief Operating Officer (COO)
	Brian Shipley	Operational Director of Finance

In Attendance:

Annabelle Baron-Medlam	Compliance & Assurance (item 6.1)
Richard Peasgood	Executive Assistant to COO
Anwer Qureshi	Divisional Medical Director (item 7.2)
Ann-Marie Hall	Associate Director of Urgent Care and Emergency Care and Flow Improvement (item 7.2)
Ashy Shanker	Deputy Director of Planning & Performance (item 7.4)

(Notes produced from recording Lynn Arefi, Exec Assistant)

ITEM

1. Apologies

There were no apologies for absence

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 26 January 2023

The minutes of the meeting held on the 26 January 2023 were reviewed; Lee Bond to be added to the apologies, once this amendment was made the notes were accepted as an accurate record of the meeting.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

21.12.22

5.3 Terms of Reference (ToR) discussed with NEDs and further amendments to be made following the annual review of ToRs. *Further Action: meeting to be arranged for Lee Bond, Shaun Stacey and Gill Ponder.*

7.1 Revised format of Finance Report was available for the February meeting. NEDs confirmed they were content with the new format. - CLOSED

8.1 On February agenda – CLOSED

9.1 Unplanned Care – request for dashboard information had been made through Informatics. Scheduled for April meeting.
9.3 Elective Recovery Self Certification – on April agenda

28.01.23
8.3 Planned Care Improvements – meeting set
8.4 Planning Guidance – on February agenda CLOSED
9.1 Finance Report deep dive on Clinical Supplies– due March

5.2 Finance & Performance Committee Workplan

The Committee received and noted the Workplan. Gill Ponder advised that the BAF deep Dive this month was scheduled to be on Strategic Risk 3.2. As this was now aligned to the Strategic Development Committee, the Finance & Performance Work Plan would be updated to reflect this.

ACTION: Richard Peasgood Workplan to be updated

5.3 Terms of Reference

The Committee noted that the Terms of Reference were due to be reviewed as part of Board reporting framework so would not be discussed on this agenda.

6. Presentations for Assurance

6.1 **Care Quality Commission (CQC) Progress Report**

Annabelle Baron-Medlam was welcomed to the meeting and firstly spoke to the circulated Management and Recommendation of the Actions from the 2019/22 Inspection report which was taken as read and Annabelle Baron-Medlam went on to note the following.

The purpose of this report was to provide an overview of the actions following the publication of the Care Quality Commission's (CQC) Inspection Report from their inspection in 2022 for Northern Lincolnshire and Goole Hospitals NHS Trust, including the review and recommendation of management of all open and closed actions from the 2019 inspection report, plus the newly merged action plans from the latest inspection. In addition, an overview of the recommended change to the rating terminology used for all actions.

Following the publication of the CQC Report in December 2022, the Trust had 152 actions in total, 93 'must do' and 59 'should do'. These actions were identified across all three sites - removing duplication; this equated to 87 actions. A review of the 70 open 2019 actions resulted in recommendation of the following.

- 26 actions be closed and be transferred to the Quarterly Monitoring Assurance Process
- 15 actions should remain open
- 29 actions would be merged into the 'new' action plan

All closed actions which were currently on the Quarterly Monitoring Assurance Process were reviewed and the following recommendations made:

- 10 would be re-opened
- 32 to cease quarterly review
- 6 to continue quarterly review as limited assurance only provided
- 17 to remain on the quarterly review process as the service not assessed by CQC in 2022.

Annabelle Baron-Medlam then moved on to the CQC Progress report which was taken as read. The paper, which detailed the review, management and recommendations of CQC actions from 2019 and 2022 inspection reports, had been produced and submitted to the Trust Management Board and all Board Committees. Divisions had engaged fully with the Compliance Team to agree the final plans to commence from February 2023 onwards and established baseline assurance ratings.

A number of assurance templates were with the Executive Team for sign off which related to the 2019 actions. Assurance papers were in the process of being written for those 2019 actions where significant assurance was received from the 2022 report and those would be closed.

External oversight of progress continued to be provided through the NHSEI Quality Board and regular engagement meetings with the CQC.

Annabelle Baron-Medlam then went on to note that risks to delivery of CQC improvement plans included the lack of capacity within corporate teams and divisions to do the work with competing priorities, however the Compliance team continued to support plans and actions wherever possible. This was particularly impacted currently during the winter months due to operational pressures on the clinical teams and periods of Trust-wide 'Operational Pressures Escalation Level (OPEL 4). A further risk was Identifying recurrent funding for the financial cost of implementation for some funded actions. It was noted that delays in some actions were due to the requirement for system wide collaboration which, despite the best efforts of the Trust, had delayed progress.

Lee Bond referred to the first paper and queried that some of the actions under Finance & Performance had been duplicated within the 10 actions. Annabelle Baron-Medlam confirmed that the actions were the same but applied to individual divisions.

Fiona Osborne requested if future reports could highlight any changes from the last report, if nothing had changed, it would be helpful to see this. Annabelle Baron-Medlam added that in future reports there would be the addition of "an arrow" indicating whether ratings had moved. Gill Ponder asked when any additional narrative was in the report, if this could be highlighted for ease of reading. Fiona Osborne then went on to ask if the divisions were fully involved in creating the action plans and what was the level of ownership. Annabelle Baron-Medlam confirmed that divisions have had full engagement with all actions being agreed with regular update meetings taking place to ensure momentum was kept in place.

Shaun Stacey went on to add that there was such an impact on Workforce and suggested that vacancies were cross referenced with finance. Lee Bond noted his support for this. Fiona Osborne suggested that a referral was sent to Workforce for a quarterly report in terms of a dashboard but added it would also be useful for these statistics under the CQC report. Gill Ponder suggested that this should be discussed at Trust Board level, as the Committee had recommended that in its last Highlight Report to Trust Board and agreed to highlight the Committee's concerns to the Workforce Chair.

The Committee thanked Annabelle Baron-Medlam for the update.

ACTION: Gill Ponder to meet with Workforce Committee Chair

7. Review of NLaG Monthly Performance and Activity Delivery (IPR) (SO1.2/SO1.6)

Shaun Stacey expressed his apologies to the Committee noting that the Integrated Performance Report (IPR) was not up to the expected standard and noted there were several inaccuracies on how the numbers had been reported. The format of reporting would be improved for this report going forward.

2.10pm Anwar Qureshi and Anne-Marie Hall joined the meeting.

7.1 Unplanned Care

Shaun Stacey took the paper as read and proceeded to outline the highlights within the report on Unplanned Care. The Emergency Department (ED) continued to be challenged throughout the month with demand versus capacity for admitted patients creating a number of flow problems. The impact of poor flow continued to show in ambulance delays over 60 minutes, which had resulted in 621 delays in January which was a slight improvement from December and it was hoped that February figures would also show improvement. There were 801 patients waiting over 12 hours in January. Although there was a slight improvement, it was not where we would expect or want it to be. There was improvements in patients discharged home but still not where expected due to acuity of patients. Outpatient Parenteral Antibiotic Therapy (OPAT) capacity was still restricted based on the complexity of treatment required by some patients. Concerns remained with staffing, with a continued high spend in agency both in medical and nursing and support of unfunded beds and vacancies across clinical areas. Shaun Stacey went on to add that there was some real challenge around the inconsistency and approach to patient flow. Urgent Care Service (UCS) reported 99% performance, but as it only operated for 12 hours this had no impact on the overall ED 4 hour performance.

Challenges throughout the month with Same Day Emergency Care (SDEC) operation had also been seen, especially attributed to management of frailty, due to workforce problems and inability to access rapid diagnostics due to the downtime of Magnetic Resonance Imaging (MRI) and CT scanning equipment at Scunthorpe Hospital. Overall SDEC remained positive.

Average Length of Stay remained stable, but this masked the chronic medical length of stay which was much higher, this would be included within the IPR going forward.

Shaun Stacey went on to note that flu and COVID continued to affect emergency and elective services from both a workforce and emergency care facility perspective.

Fiona Osborne queried the Right to Reside patient figures and the deteriorating position. Shaun Stacey confirmed that the Trust remained in the top 10 in the country. The challenge was around the consistency of the numbers with the biggest problem being Lincolnshire with a large number of patients, along with residential care issues.

7.2 Patient Flow Improvement Group

Ann-Marie Hall was invited to expand on the key highlights contained within the report. Ann-Marie Hall went on to note that delivery against performance compared to the region continued to be a challenge, this being mostly due to acuity of patients. The attendance admission rate had increased slightly from December (16.32%) to January at (16.77%). The 4-hour performance increased in January to 57.6% from 53.10% in December. This needed to be 76% by the end of March 2024 which would be a real challenge. The Trust were working on improvements; developing a Quality Improvement (QI) project, working with the site teams to improve handovers, utilising space and staffing along with flow through the department. Lee Bond queried the ambulance handovers at Diana, Princess of Wales Hospital (DPOWH) and would this model be the same at Scunthorpe General Hospital (SGH). Anwer Qureshi went on to add that there were a couple of reasons that impact handovers; space and pathway driven. Even though the flow at SGH Emergency Department (ED) is slightly better it was a space and process impact. Improvements cannot be attributable to the physical building it is the pathway work along with the space.

Performance for UCS against the 4-hour target had increased slightly from December (98.64%) to (99.75%). Ann-Marie Hall went on to highlight that the Urgent and Emergency Care (UEC) recovery plan briefing and financial guidance for 2023/24 had been released. Achievement of the new national target of 76% in 4 hours is greatly affected by the opening and closing hours of the UCS; not being 24/7 results in a drop in 4 hour performance and increased pressure across the department between 8.00pm and 8.00am. The QI programme would commence with an initial meeting on 15 February. It was noted that the business case for the staffing of the new ED builds to be submitted due to revised establishment required for

safe staffing of new footprint and address the inability to staff extra shifts that had been agreed to support the current demand and acuity. Questions around the business case were posed and Shaun Stacey confirmed that there were two cost pressures that were driving the ED overspend; UCS was only funded for 12 hours per day and there was a need to run this model for longer and the need to support the Rapid Assessment and Treatment (RAT) modelling which was not part of the ED staffing model. Anwer Qureshi went on to share the heat map which showed the increase in the 4hour performanceif UCS was opened all night.

Fiona Osborne asked for assurance that the key learning from medical staffing costing in the business case had been recognised within the programme management structure for larger projects, so all costs would be included at the outset for future projects.. Shaun Stacey confirmed that this has been taken on board for any future projects. Shaun Stacey went on to add that the funding for that service sat within the Primary Care arena and the Trust did not always gain the benefits.

Ann-Marie Hall drew the Committee's attention to the success of the Virtual Ward which had reached 10 patients and had been very successful from the perspective of the patient journey. Meetings were being held to extend that service. In conclusion, Anwer Qureshi noted that there was still a lot of work to be done within Community, East Midlands Ambulance Service and Single Point Access to use the pathways that were in the community rather than the activity coming into the ED. It was noted that there was a sustainable patient flow and ambulance handover improvement plan, engaging clinicians and staff, which would hopefully make a difference. Gill Ponder thanked Ann-Marie Hall and Anwer Qureshi for the update and suggested that the format of the report continued with the addition of the progress against planned milestones going forward.

2.35pm Anwer Qureshi and Ann-Marie Hall left the meeting

7.3 Planned Care

Shaun Stacey took the section of the paper as read and went on to highlight the key issues; the approach was being sustained but the demand for urgent care beds, along with staff sickness, were reducing the beds available for planned care.

Referral to treatment (RTT) waiting times remained static. DMO1 performance had stabilised but there were still problems with MRI capacity to meet increased demand. It was noted that 2 week wait demand for diagnostics was still a challenge.

The unvalidated Cancer position still demonstrated poor performance, but there had been a small improvement seen. A deep dive had been carried out into Cancer which looked at daily, weekly and monthly performance reporting and the impact on services. That had shown a slight deterioration in the 62 day performance, but the Trust were demonstrating "grip" to pull that back. A furtherreview with NHS England would take place in 3 months time.

Anaesthetic pre-assement continued to cause problems and work continued with Getting It Right First Time (GIRFT). Shaun Stacey went on to advise the Committee that theatres 7 and 8 at DPOW and theatre A at Scunthorpe Hospital had closed as refurbishment work had commenced. The benefits of the work would not be seen until late July. Changes to theatre sessions had been made as mitigation until the refurbished theatres re-opened.

Fiona Osborne queried the request to test was still at 14 days, but the Trust Board agreed in November that that would move to 7 days., so would it be possible to update that as soon as possible. Shaun Stacey wouldremind the team of the request.

Lee Bond referred to the DMO1 delay with MRI and asked if the other diagnostics were in a better position. Shaun Stacey advised that specific delays were in cardiac Cath lab, due to workforce challenges and ultrasound demand versus capacity. The Trust continued to work on improvements with partners wherever it could. Gill Ponder went on to ask about progress against the the target to have no 78 week waits by the end of March. Shaun Stacey confirmed

that the Trust was on trajectory to meet the target, but there was a risk that, through validation near the end of the month, we would find a patient waiting 78 weeks. Validation of patients would continue.

2.40pm Ashy Shanker joined the meeting.

7.4 Draft Operational & Finance Plan

Ashy Shanker was welcomed to the meeting and summarised the presentation which provided an update on the progress of the Annual Business and Operational Planning process for 2023/24, which followed on from the draft ICS submission made on the 16 February 2023. Ashy Shanker advised the Committee that the figures were continuing to change as part of incremental refinement of plans following feedback received from the ICS and subsequent internal challenge posed on the services/ Divisions.

It was reported that significant challenges still remained in terms of agreeing the productivity levels that each specialty would deliver and then the workforce requirement to make sure it was delivered. In addition, a process was underway to identify potential areas requiring investment. Each division had made a planning submission and those were being worked through in the context of setting an over-arching financial plan for 23/24. It was agreed that a further update would be provided at the next meeting of the Committee.

Fiona Osborne referred to workforce and vacancies; when the activity plans were put together what were the baseline assumptions; current run rate or run rate plus planned appointment,?were those staff available to be in place from 1 April and were those posts being advertised. Gill Ponder also asked if the numbers in the financial and operational plan were underpinned by a workforce plan that HR were confident of delivering. Ashy Shanker confirmed that that was an area of risk; respiratory consultant recruitment was ongoing but subject to market demand and capacity. The workforce plan was currently in draft and work was ongoing. Fiona Osborne asked if a workforce plan analysis had been provided to generate those operational plans and mapped to the current workforce levels to be clear on the gap. Ashy Shanker confirmed that services were aware of gaps to deliver activity through working with HR. Gill Ponder asked if they were confident that the workforce plan took into account retention. Ashy Shanker advised that there was an inherent risk with that and it had not been fully mitigated. Shaun Stacey went on to add that the Trust needed to be very cautious about what was planned as the Trust were aware of how difficult it was to recruit. Currently, there was no monitoring of retention which did affect the delivery of the plan.

Gill Ponder questioned, given the discharge difficulties we were experiencing, would it be realistic to assume that non elective length of stay would reduce from 5 days to 4 days. Ashy Shanker confirmed that there was recurrent monies from the region to fund community pooling schemes. If those schemes worked, then there would be a good chance to get people discharged.

Ashy Shanker asked the Committee to note the following risks to delivery of the plan:

- Robust performance monitoring system – Theatres, Outpatients, and reporting
- Theatres not back in full operation by August 2023
- Remaining theatres also require refurbishment
- ERF allocation not deployed as WLIs
- Efficiency targets require transformational change – therefore inherent risks to delivery
- PIFU, 25% reduction in Follow ups, CHN model
- Significant dependence on the Independent Sector
- Workforce plans had not delivered in the past
- True clinical leadership and engagement that resulted in delivery

Lee Bond noted several key highlights within the finance section of the plan. Referring to lost income and non-recurrent expenditure, the Trust was forecast to release £19.6m in non

recurrent balance sheet technical support in year. That removed all technical balance sheet reserves. The Trust also were forecast to deliver £3.1m in non- recurrent Cost Improvement Programme (CIP) in year. It was noted that in addition, the Trust also carried significant underspends further supporting the in-year position, predominantly within Midwifery and Community Nursing of £2.87m. Full year effects of committed investments of £6.0m had created an underlying deficit of £41.7m as the Trust exited 2022/23.

Moving on to growth and inflation Lee Bond noted that inflation funding had been received at 2.9% (£12.1m). The Trust had assessed the impact of inflation to the cost base to be £16.2m, with incremental pay pressures calculated at 2.60% versus 2.1% provided in tariff. Initial workings suggested that utilities would rise by £1.5m, £1.2m over inflation provided for in tariff.

It was also noted that other inflation was currently accounted for using planning guidance which could result in additional pressures if we see inflation of more than 10% as contracts come up for renewal.

The Trust had received initial growth funding at 0.9% of £3.7m, with an assumption of corresponding expenditure. It was noted that there was potential release of further growth funding to be confirmed. The part year effect of bed capacity funding received in 2022/23 had been allocated recurrently of £1.4m. The full year effect of this funding was yet to be confirmed. It was noted that the expenditure had been included at this point of £2.9m. Lee Bond added if not received in addition to the Virtual Ward funding, then the Trust would be reliant on escalation beds to meet demand. This cost was not currently assumed in the plan.

It was also noted that the national 2022/23 CIP requirement had been set at 1.1% (£4.6m) plus a convergence factor requiring further savings of £3.0m, £7.6m in total. Currently, a 2.2% efficiency target of £11.9m plus £2.4m to fund Acute Assessment Unit (AAU) Phase 3 investment, £14.3m 2.6% total was included within the plan and the Trust currently had schemes identified at £10.1m against that target.

Lee Bond advised that included within the plan were committed investment schemes of £6.0m. The Trust would prioritise further investment requirements through its business planning process totalling approximately £7.2m. £4.5m had been included within the plan. Those were uncommitted and could be replaced with different priorities once the prioritisation process had concluded. Implications of increased capital spend would mean that the Trust would incur an additional £1.5m of Public Dividend Capital (PDC) (interest paid on Government capital). In addition, depreciation would increase because of the additional capital received into the Trust by £5.3m. Whilst this was welcome for the capital programme, it would place further pressure on balancing of the Income & Expenditure (I&E) position.

Moving on to activity plans and Elective Recovery Fund (ERF,) Lee Bond added that the Trust's draft activity plan was currently at 92% of the 2019/20 baseline from within its core funded capacity. Divisions were planning to increase capacity through internal waiting list initiatives or through IS capacity that increased the activity levels to 106%. At worst case the tariff values represented additional funding required of £10.1m. The Trust had been initially allocated £8.7m of ERF as per 2022/23. In theory, that would be to achieve 104% of the 2019/20 baseline. Lee Bond added that further ERF funding wayet to be allocated to achieve the 107% target. Lee Bond added that therefore it was imperative that the Trust maximised and improved its current core capacity plans.

Summarising the presentation, Lee Bond reiterated that the Trust would have been in a £20 million deficit without the technical balance sheet reserves in 2022/23. The Committee's attention was drawn to the following opportunities to close the gaps:

- Assess ERF and activity position – The Trust must look to increase its core capacity closer to 19/20 baseline levels and reduce potential reliance on internal and IS premium capacity. It required confirmation of allocated funding to achieve 107%.
- Continue review and check of profile assumptions on agreed investments.

- Review all new proposed investments through prioritisation process.
- Consider further CIP requirements. Note we are assuming 2.6% already.
- Confirm additional FYE Bed capacity funding and Community Discharge programmes.
- Confirm SDF Funding and expenditure for VW, Cancer Alliance & Lung Health Checks (neither I&E included in the plan at this stage)
- Confirm Depreciation Support Funding (Estimated £1.4m not currently in plan)

7.5 Assurance Confirmation & Board Highlights

The Committee thanked Ashy Shanker and Lee Bond for the presentation and noted their concern about the level of risk in the Operational Plan and the fact that the Trust would have been in a £20 m deficit without the technical balance sheet reserves.

8. Review of NLAG Monthly Financial Position (Finance Report SO3.1/SO3.2b)

8.1 Finance Report Month 10

Lee Bond took the paper as read with the following highlights noted:

The Trust achieved a £0.7m surplus in January 2023, which was £1.3m ahead of plan. This brought the year to date deficit to £1.8m. The year to date position was supported by £11.3m non recurrent technical CIP, which was £5.6m above plan. Additional sources of income had been received in 2022/23 and these were offset by increased costs, for example the Trust had received £7.8m additional clinical income to fund pay awards, this was substantially offset by higher pay costs. Increased reliance on premium temporary staffing covering vacancies and sickness, together with increased demand from non elective pathways, premium waiting list capacity and additional escalation beds were the key factors which contributed to the clinical pay overspends.

Bank Incentives had increased supply but at a cost (£0.5m Year to Date) with no corresponding reduction in nurse agency spend. Additional activity was also driving higher than planned clinical non-pay costs, however these had normalised following the high months witnessed in November and December.

Food costs had increased by an equivalent of 5 wards, due to patients held in EDs and escalation beds.

Slippage on planned IS contracts partly offset the additional Waiting List Initiative capacity in Medical Staffing.

Lee Bond went on to note that the Trust was forecasting an unmitigated £7.4m year-end deficit based on the current run rate. The Trust had non-recurrent flexibility of £4.6m, leaving a potential residual un-mitigated deficit of £2.8m. Despite that, confidence remained that the financial plan for the year would be delivered.

The Trust was also forecasting to achieve its Capital spending plan in 2022/23, but there was a longer term issue with costs on the SDEC/IAAU projects. That would be reviewed at a future meeting.

8.2 Recovery Support Programme (RSPf)

It was noted that meetings continued, but a letter had not been received. Lee Bond would update the Committee on progress towards exiting from the RSPf..

8.3 Business Case Assurance

There were no business cases to be discussed that month. Lee Bond added that there would be a Community Diagnostic Centre draft business case presented to the Committee sometime in April.

8.4 Assurance Confirmation & Board Highlights

- Continued concerns over risks for year end
- Delivery of month 11 and 12 plans was critical
- Workforce issues continued to be a risk to the delivery of finance and operational plans

9. Estates & Facilities (SO 1.4)

9.1 Water

Jug Johal took the report as read. The report provided the Finance and Performance Committee with an update on the Estates and Facilities governance model and focused on Water Systems in terms of risks and associated assurance. Jug Johal advised that the paper also provided an update on the Improvement Notice issued to the Trust by Anglian Water. The Committee was asked to note the report and mitigation actions that were being undertaken by the Directorate. A subsequent update to this report would be issued in May/June 2023 to the Committee following evaluation of the latest Hydrop Trust wide water risk assessment and annual Premises Assurance Model (PAM) review. Jug Johal drew the Committee's attention to page 8 of the report and the progress that had been made at Diana Princess of Wales Hospital in terms of the defects which was a direct result of capital investment in water last year.

Jug Johal advised the Committee that the Trust had recently received a letter from HSE that they would like to make a visit to the Scunthorpe Accident & Emergency system. The date of the visit was yet to be confirmed.

Gill Ponder referred to page 10 regarding the silver copper treatment and the significant improvement in positive water samples, but positive samples were a cause for concern. Jug Johal agreed to report back to the Committee on this.

***Post Meeting Note**: SGH The 2020 replacement of the silver copper treatment plant at SGH had yielded some improvements in the water treatment. That, coupled with removal of some pipework at SGH, hds seen a significant reduction in the quantity of out of specification water sample returns. Additional works were still on-going to remove affected areas.*

9.1 Deep Dive into the Electrical Cable Failure at SGH

Shaun Stacey took the paper as read and proceeded to run through the highlights. On the 14 December 2022, an electrical infrastructure failure occurred at SGH at approximately 08:10. That interruption to the electrical supply impacted several areas across the site including Butterwick House, SGH. The interruption to Butterwick House caused the IT datacentre to lose power as the Uninterrupted Power Supply (UPS) batteries were designed to provide power for a short period of time until the emergency generator started up. However, the generator did not operate due to where the electrical failure occurred. The loss of power to the IT datacentre resulted in IT servers going down for all sites and Community Services across the Trust for a short period of time.

The power interruption also affected the heating source on the Stroke Unit and Hyper Acute Stroke Unit (HASU) at SGH. After assessment of potential risk, the decision was made to move the patients from those units to another location within SGH for up to 24 hours until further checks on the heating system could be completed. All critical services were

maintained and continued to be delivered throughout the incident and there was no patient harm caused.

Shaun Stacey asked Finance and Performance Committee to note the report for information along with the action plan at Appendix A based on lessons to be learned from the incident.

Peter Reading went on to add that the Emergency Preparedness, Resilience and Response (EPRR) business continuity plan had not worked. He had asked John Awuah for an immediate review of the EPRR response. There was a need to ensure that site management were properly briefed about how to respond in the absence of any telephonic or other communication site wide. Gill Ponder requested that the paper was broadened to include the two specific issues highlighted – confirmation that site management were fully briefed and able to invoke business continuity plans immediately when necessary and the separate specific point about the fuel gauge fault at DPOW and how that should have been picked up from testing.

ACTION: Shaun Stacey/Jug Johal additional points to be included within the paper.

9.1 Assurance Confirmation & Board Highlights

- Water investment positive and visit from HSE
- EPRR report but further questions asked and will be reviewed in March

10. Finance & Performance Committee Governance Documents

10.1 SO 3 – 3.2 BAF Review not discussed, as that strategic risk was now monitored by the Strategic Development Committee, so it should be removed from the Workplan.

11 Items for Information

11.1 Performance Letters to Divisions – PRIMS

Received and noted by the Committee.

12 Any Other Urgent Business

None raised.

12.1 **Matters to Highlight to other Trust Board Assurance Committees**

None identified.

13 Matters for Escalation to the Trust Board

Items for the highlight report to the Trust Board were discussed at the end of each section of the agenda and are listed in the minutes above. The Committee had previously requested a Board discussion of workforce issues and their impact on achievement of operational and financial plans.

13.1 Review of Meeting

The Committee agreed that it had been a very valuable discussion especially focussing on the Operational Plan. Gill Ponder would pick up NED attendance at the Committee.

Action: Gill Ponder to raise NED attendance at the Committee

14 DATE & TIME OF NEXT MEETING:

WEDNESDAY 22 March 2023 1.30pm TEAMS

Meeting Attendance 2023/24

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Gill Ponder	√	√										
Fiona Osborne	√	√										
Lee Bond	√	√										
Jug Johal	√	√										
Shaun Stacey	√	√										
Ian Reekie	x	√										
Richard Peasgood	√	√										
Simon Parkes	x	x										
Brian Shipley	√	√										
Annabelle Baron	√	√										
Abdi Abolfazl	√	x										
Ashy Shankar	x	√										
Shiv Nand	√	x										
Dr Peter Reading	x	√										

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: **Wednesday 22 March 2023, TEAMS**

Present:	Gill Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director (NED)
	Jug Johal	Director of Estates & Facilities
	Lee Bond	Chief Financial Officer
	Dr Peter Reading	Chief Executive Officer (from 3.05pm)
	Shaun Stacey	Chief Operating Officer (COO)
	Simon Parkes	Non Executive Director
In Attendance:	Ian Reekie	Lead Governor
	Simon Tighe	Deputy Director of Estates & Facilities (item 8.2)
	Annabelle Baron-Medlam	Compliance & Assurance (item 6.1)
	Richard Peasgood	Executive Assistant to COO
	Ashy Shanker	Associate Director of Planning (item 7.3)
	Lynn Arefi	Exec Assistant (for the notes)

ITEM

2. Apologies

Apologies were received from Brian Shipley

7. Quoracy

It was noted that the Committee was quorate.

8. Declarations of Interest

There were no Declarations of Interest declared.

9. To Approve the Minutes of the Meeting held on 22 February 2023

The minutes of the meeting held on the 22 February 2023 were reviewed. It was noted that Ian Reekie had been omitted from the attendee list. Fiona Osborne referred to page 5 and requested wording to be changed - remove the paragraph …..*within programme management structure for larger projects*…and "*has this been logged" as* a new sentence. Subject to these amendments the minutes were accepted as a true record of the meeting.

10. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

21.12.22

5.3 Closed
9.1 Due April
9.3 Due April

26.01.23

9.1 Keep open for confirmation

22.02.23

5.2 Closed
6.1 April
9.1 Closed

5.2 Finance & Performance Committee Workplan

The Committee received and noted the Workplan. Gill Ponder suggested that, if the Terms of Reference were agreed at today's meeting, the Workplan would then be updated to reflect this in readiness for April's meeting. The Committee's Self Assessment would also be coming out to members shortly and the outcome of the consolidated responses would be discussed also at April's meeting. It was noted that the updated ToR, workplan, self assessment and action plan would be presented at the June Trust Board.

ACTION: Richard Peasgood Workplan to be updated

5.1 Update on the outstanding actions on the Electrical Cable Failure at SGH

Shaun Stacey took the report as self explanatory. The Post-Incident Report of the electrical infrastructure failure that occurred on 14 December 2022 was presented to the Finance and Performance Committee on 22 February 2023. Following this meeting the Committee requested that the report was updated and returned to the Committee with additional detail on the Switchboard business continuity plan issues identified, the consideration of two-way radios in contingency plans and the lessons learned from a separate incident involving a fuel gauge during generator testing.

Within this report the following additions to the previous submission had now been included:

Appendix C – Information on the issues identified with the implementation of the Switchboard business continuity plan during the incident, the revised contingency actions post-review and the alternatives considered

Appendix D – The EPRR Extended Generator Test report produced by the Estates and Facilities Directorate carried out on 23 November 2022, including findings, actions and recommendations.

Shaun Stacey added that this should now conclude the presentation and the position on this issue. Shaun Stacey proposed that, from an assurance perspective, the actions should be brought back to the Committee in approximately 10 months to confirm all the actions listed within the follow up had been done and the sites tested and checked regularly. Jug Johal reiterated that the Trust Board were very well sighted on the two separate incidents.

Fiona Osborne referred to page 21 of the action plan. It recommended that critical departments should have radios, but on page 14 of the main report it stated that "2way radios were considered but rejected because of wards and department training and rarely used radio batteries being flat when needed. Shaun Stacey added that the question the paper was trying to answer was why radios were not issued. The reason behind that was radios would not and are not an appropriate means of communications for ops and medical staff etc. Unless the radios are used and charged regularly, when they are required, the batteries are dead. It was confirmed that from an EPRR perspective, 2-way radios would not be recommended.

Fiona Osborne noted that she had assurance and was comfortable with the explanation within the report.

Gill Ponder asked if the Trust ran the same risk in using mobile phones as with the radio batteries. Shaun Stacey confirmed that all staff used their mobile phones regularly, so the biggest risk was keeping the phone number list up to date. Going forward that would be checked on a regular basis. Telephony was noted as being regularly tested.

1.45pm Annabelle Baron-Medlam joined the meeting.

5.2 F&P Committee Workplan

As the Workplan would need updating to reflect the revised Terms of Reference no discussion was held.

5.3 Terms of Reference

The Committee received the amended draft Terms of Reference and noted that input had been received from Committee members. There was one point of clarity on terminology and consistency in that the "Committees" are Committees and not sub-Committees – that had been clarified with Helen Harris. Shaun Stacey went on to note that Lead Directors were down as COO and CFO and asked if the Director of E&F should be listed as a lead as well. Gill Ponder would clarify the Constitution with Helen Harris.

ACTION: Gill Ponder to speak to Helen Harris to clarify the Constitution.

11. Presentations for Assurance

6.2 **Care Quality Commission (CQC) Progress Report**

Annabelle Baron-Medlam was welcomed to the meeting and took the Committee through the highlights of the circulated report. Annabelle Baron-Medlam noted that the key changes to the report included indicators which had been added to all actions for ease of reference. It was noted that the total number of actions had increased, from 116 to 123, with the total number of actions awaiting rating decreased from 45 to 7. The number of actions with a full or significant assurance rating had increased from 14 to 25 with one action added to the action plan for Surgery, (2019-35CC dedicated intensivist for ICU) to ensure that the action remained monitored. Annabelle Baron-Medlam noted that one action had been removed from the Medicine Division action plan (2022-MED07 Medicine Reconciliation) because the action was already on the Pharmacy action plan.

Three assurance papers had been submitted to the CQC in relation to 2019 End Of Life actions, along with one position paper.

Gill Ponder asked if there were any Finance & Performance areas that were cause for concern that required support. Annabelle Baron-Medlam confirmed there were no concerns and that there was good engagement with addressing the outstanding actions.

The Committee thanked Annabelle Baron-Medlam for the update.

9. Review of NLAG Monthly Financial Position (Finance Report SO3.1/SO3.2b)

9.1 Finance Report Month 11

Lee Bond spoke to the Month 11 Finance Report and went on to note that the Trust had an in-month surplus of £0.5m, which was £0.3m ahead of plan. This resulted in a Year-to-Date (YTD) deficit of £1.3m which was noted as £2.2m adverse to plan. Lee Bond advised that the position was supported by the Trust receiving £5.5m in additional surge funding (£2.75m in month) which reduced its reliance on technical savings. Lee Bond added that the Trust was still confident of reaching the year end in a balanced position even taking into account the unknown costs of the impending strike action.

Lee Bond then went on and informed the Committee that spending on bank and agency staff this year had reached £62m; this was noted as £5m above last year's cost. This showed no signs of improvement and the key challenge remained in recruitment and retention of staff. Fiona Osborne asked if the bank incentive scheme had been a success and if there had been more take up. Lee Bond confirmed that uptake in month 10 was good but unfortunately it had

not been sustained within month 11. The bank incentive scheme had now come to an end and there were no plans to repeat the exercise. It was disappointing that we had not seen a reduction in agency spend.

Lee Bond went on and advised that the Trust had delivered £25.6m CIP (Cost Improvement Plan) against a Year to Date target of £20.4m. It was noted that that had been achieved through higher non-recurrent technical reserves (£5.2m above plan) with the core programme £0.9m behind plan at February.

Moving on to Capital Investment Lee Bond noted that the actual spend to 28 February was £25.89m, £25.66m of this related to Trust funded schemes and £0.23m for donated and grant funded schemes. Although the plan appeared to be a little behind plan Lee Bond confirmed he was confident in delivery before the year end.

Fiona Osborne referred to CIP summary and the fact that the divisions were behind budgets but also have "overspent". As the Trust were "reaching the edge" of what could be done on technical adjustments, she asked how that challenge would be addressed for next year. Simon Parkes asked what the Committee needed to do to ensure there was greater focus on CIP. Lee Bond agreed that the numbers were increasingly getting worse and the issues were mainly centred around the new ED at both sites and the variable costs being driven by staffing issues, vacancies, bank and agency which is expensive. It was again noted that the Committee had requested a Board level workforce session to discuss recruitment and retention for the forthcoming year.

IAAU Overspend

Moving on to the IAAU Overspend, the paper was taken as read and Jug Johal briefly went on to summarise that the project had been under significant affordability pressure from Outline Business Case (OBC) and throughout. A significant contributing factor had been the inclusion of significant enabling schemes, the required scope of which far outweighed what was anticipated in the OBCs. It was noted that circa £5.7m of additional Trust funding had been allocated over the course of the project in support, but that only sought to resolve the affordability issue present at the time of entering into Stage 4 contract and still left an insufficient contingency to manage the remaining project risks. The project had to accommodate significant challenges within the existing infrastructure to establish site resilience, particularly at SGH where works included oxygen infrastructure trenching, a new generator and transformer, HV ring main cabling and trenching and asbestos clearance within the undercroft to allow infrastructure works to be carried out as planned.

Jug Johal advised the Committee that, based on the current forecast overspend and the assessment of residual Trust risk on the project, it was estimated that an additional funding allocation of £4,093,357.33 would be required to offset the current overspend and allow sufficient contingency to manage the remaining risks.

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

The Committee queried the extra £1m and asked if that had been factored into 2023/24 plans and were told that that was the current worst-case scenario and that it was hoped that the overspend would be less than that. Jug Johal advised that it was not in the 2023/24 plans and some other projects may have to be delayed to enable these projects to be completed.

Lee Bond acknowledged that it had been a "learning curve" for all teams involved. There had been many issues which potentially the Trust should have been aware of. A solution was needed to finalise these departments which would have financial implications to be managed over 2023/24. Lee Bond confirmed that he would manage the financial risk and that it would be reported back to the Finance & Performance Committee.

Both Lee Bond and Jug Johal were thanked for the update. The Committee agreed that the issue would be included within the Trust Board highlight report, particularly as the risk had increased from £3.0 to £4.0 million.

Gill Ponder advised that the Update on the Deep Dive into additional spending on clinical supplies would not be discussed at that meeting, as the spend had reverted to normal and was no longer a cause for concern

7.2 Recovery Support Programme (RSPf)

It was noted that meetings continued to progress the Trust's position. Lee Bond added that a decision on the potential for exit from the RSPf was expected within a few weeks.

7.3 Draft Operational and Finance Plan

Ashy Shanker was welcomed to the meeting and took the circulated report as read. The report provided an update and approval on the progress of the Annual Business and Operational Planning process for 2023/24 after the draft ICS submission which was made on the 16 February 2023. Ashy Shanker briefly outlined the operational section of the presentation, drawing attention to the Counting and Coding changes section and the key areas of risk which included:

- Mutual aid – our plans did not include mutual aid provision. Any activity accepted would be facilitated through Waiting List Initiatives (WLI) funded in addition to submitted plan
- Capacity in the Independent sector and tertiary centres
- Workforce plan delivery – recruitment, retention and sickness
- Surge in acute activity – infections
- Ringfencing of elective capacity
- 8 + 4 escalation beds at SGH, 18 + 4 escalation beds at DPoW,15 at Goole
- Goole elective HVLC Hub in 2023/24 was included in the plan
- Clinical engagement
- Evidence base of service developments/improvements
- System level delivery – Primary care, local authority and community care capacity
- Implementation of Lorenzo PAS

Fiona Osborne referred to the narrative and asked Ashy Shanker how realistic the delivery of the plan was. Ashy Shanker confirmed that the plan was owned and signed off by the divisions and clinical leads and added that she was reasonably confident on delivery. Monitoring systems had improved during the past year which would help.

Moving to the charts within the report, Simon Parkes added that he thought the trajectories were "optimistic". He added that he was struggling to get any sense of confidence that it was a realistic plan and how the Committee could be assured and confident the plans were sufficient to enable the Trust to deliver. Ashy Shanker confirmed that regular monitoring and monthly reporting would take place to give the Trust the opportunity to pick any issues up early.

Both Lee Bond and Shaun Stacey agreed that there was a "massive risk" which would be an issue until a stable workforce was in place.

Moving on to the Finance section of the plan, Lee Bond went on to note the highlights of the report. Referring to the Income and Expenditure slide, Lee Bond added that when the draft plan was submitted there was a £44m deficit, that deficit had been reduced to approximately £20m. It was highlighted that that was still 3.9% of turnover and was the highest percentage in the ICB. Lee Bond added that there was a concern externally about NLaG's ability to deliver the plan at a deficit of £20m.

It was noted that the plan would be subjected to a confirm and challenge process and the following key risks to the financial plan were noted:

- CIP Delivery – The Trust had an extremely challenging CIP target of £36m. Current assessment of the scoped plan had £16.5m as high risk with £10.9m currently unidentified.
- ERF – The Trust had a core capacity plan of 94% and would therefore be heavily reliant on premium capacity either via IS or internal WLI payments in order to deliver the activity plan. It must look to maximise its core activity nearer to 19/20 base levels and reduce its reliance on premium capacity.
- Inflation – Known inflationary pressures for incremental pay and energy were currently included within the plan. However, other expenditure inflation was currently provided for using planning guidance percentage uplifts. Any deviation to these assumptions would present additional cost pressures not included within the plan.

7.4 Business Case Assurance

There were no business cases to be discussed by the Committee at that meeting.

7.5 Assurance Confirmation & Board Highlights

- IAAU overspend
- Continued concerns over risks for year end
- Delivery of month 12 plans was critical
- Workforce issues continued to be a risk to the delivery of finance and operational plans

8. Estates & Facilities (SO 1.4)

8.1 Lifts

Simon Tighe took the report as read and noted that the report provided the Finance and Performance Committee with an update on the Estates and Facilities governance model and focused on Lift management in terms of risks and associated assurance. In summary, the lifts were generally in a good condition, but would require investment to ensure they were kept in adequate working condition over the next 5 years. The theatre lift at SGH, whilst operational, required upgrading to ensure it met the increased requirement of the clinical teams and it was unfortunate that, due to funding availability, that would now be delivered 2024/25. The Committee was asked to note the report on the safe management of the Trust's lifts systems. Committee members had no further questions because they were assured by the content of the report and the summary presented to the Committee.

8.2 Highlight Report from Oxygen Assurance

Simon Tighe advised that the report was pulled together by Ashley Leggott and Matt Overton. The circulated report provided assurance on actions taken after the medical gas SI (Serious Incident) in November 2020 during the covid pandemic and resulting investigation. Shaun Stacey reiterated that the oxygen levels were monitored and checked 4 times a day on all sites and, if there was a risk, actions were immediately taken to mitigate or investigate what the risk to the flow was. Full oxygen training had now been undertaken and the Trust was confident of a wider level of competence. The Committee briefly discussed the paper and agreed that the ongoing annual monitoring of testing 3 times each year would be done at the Audit, Risk and Governance Committee, as recently agreed by the Board.

8.3 Assurance Confirmation & Board Highlights

It was agreed that Lifts and Oxygen Assurance would be included within the Trust Board highlight.

9. Review of NLaG Monthly Performance and Activity Delivery IPR

9.1 Unplanned Care

Shaun Stacey took the paper as read and opened for questions. Gill Ponder asked, as the new ED at both DPoW and SGH were now open, if an improvement in ambulance handover times was expected. Shaun Stacey advised that volatility on ambulance handovers continued and on a daily basis did show some improvements. There was still a huge demand on the EDs and there was a delay caused by exit block out of ED. Staffing issues had also been a problem.

Fiona Osborne referred to the action on the Urgent Care page of the report and the review of the Urgent Care Services across NLAG and asked if there had been any progress, or anything unexpected. Shaun Stacey advised that that would be discussed further at the Committee next month. The Trust may hopefully see additional funding for the UCS for 24/7 opening

9.2 Planned Care

Moving on to Planned Care Shaun Stacey noted that Cancer performance was showing early signs of improvement, although the 62-day position was still a work in progress as the numbers included referrals where diagnostics had been completed and cancer had been ruled out. The Diagnostic performance had improved on the January position, but further progress was still required. A question was asked by Gill Ponder about the RTT 78-week March 2023 projected month end position. Shaun Stacey informed the Committee that there were likely to be some breaches, as the Trust had just taken on further Gynaecology mutual aid from HUTH.

Shaun Stacey advised that Theatres 7 and 8 at Grimsby as well as Theatre A at Scunthorpe were now closed for refurbishment, which would affect RTT Treatment until they reopened in July 2023.

Improved performance was noted in the sending of summary letters to General Practitioners.

9.3 Patient Administration Transformation Delivery

Report was taken as read. Shaun Stacey noted that there would be a more detailed report submitted to the Committee in June. Gill Ponder referred to “27% virtual consultations” and asked why the overall trend was moving in a downward direction. Shaun Stacey confirmed that 27% was a good position to be in but the Trust needed to drive more clinicians to use this system.

Fiona Osborne referred to the recommendations at the end of the report “ …..the Committee is urged to confirm allocation of funding…” and noted that F&P was an assurance committee and did not have the authority to confirm. Shaun Stacey apologised and advised that that referred to TMB where the report had been presented prior to coming to the Committee.

9.4 Assurance Confirmation & Board Highlights

Unplanned Care

- Improvement in ambulance handover
- SDEC performance of 43% compared well to national performance of 28%
- UCS 99%
- Continued depression of 4-hour performance
- Boarding in ED
- Occupancy (pressure)

Planned Care

- Cancer Performance improvement
- 62-day work in progress
- DMO1 performance improvement in month
- 78-week position risk
- Theatre closures – risk to activity

- Increase in outpatient summary letters
- High level non-face to face appointments

10 Finance & Performance Committee Governance

10.1 SO1-1.2 BAF Review

The report was taken as read and Gill Ponder queried the mitigations for gaps in control and assurance which did not seem to be evident on the BAF in the current format. As there were so many gaps listed, she wondered if the current risk score of 15 was accurate. Shaun Stacey confirmed that he thought it was an accurate reflection of the current position, but the risks were still there and maybe 15 was a low score which might be raised at the next formal review of the BAF.

Items for Information

11.1 Performance Letters to Divisions – PRIMS

PRIM meetings were stood down in February and therefore there were no letters to review.

14 Any Other Urgent Business

None raised.

12.1 **Matters to Highlight to other Trust Board Assurance Committees**

None identified.

15 Matters for Escalation to the Trust Board

Items for the highlight report to the Trust Board were discussed at the end of each section of the agenda and are listed in the minutes above. The Committee had previously requested a Board discussion of workforce issues and their impact on achievement of operational and financial plans.

13.1 Review of Meeting

It was agreed that the meeting was very useful with a good balance and very detailed discussions leading to a better understanding of planning and what the Trust Board could expect to see from April. Planning for delivery needed to be stronger than last year across the Trust, due to the additional challenges in 2023/24 It was suggested that all regular papers were taken as read to allow more time to gain assurance on deep dive items.

14 DATE & TIME OF NEXT MEETING:

WEDNESDAY 19 APRIL 2023 1.30pm TEAMS

Meeting Attendance 2023/24

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Gill Ponder	√	√	√									
Fiona Osborne	√	√	√									
Lee Bond	√	√	√									
Jug Johal	√	√	√									
Shaun Stacey	√	√	√									
Ian Reekie	x	√	√									
Richard Peasgood	√	√	√									
Simon Parkes	x	x	√									
Brian Shipley	√	√	x									
Annabelle Baron	√	√	√									
Abdi Abolfazl	√	x	x									
Ashy Shanker	x	√	√									
Shiv Nand	√	x	x									
Dr Peter Reading	x	√	√									

NLG(23)115

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 June 2023	
Director Lead	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee	
Contact Officer/Author	Lee Bond, Chair Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes of meeting held on 9 March 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 9 March 2023 and approved at its meeting on 17 May 2023.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **9 March 2023 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF Trustees
	Gill Ponder	Non-Executive Director
	Tony Burndred	Governor
	Shaun Lyons	Trust Chair
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Jug Johal	Director of Estates and Facilities
	Melanie Sharp	Deputy Chief Nurse
	Jamie Lewis	CEO HEY Smile Foundation
	Paul Marchant	Chief Financial Accountant
	Clare Woodard	Head of Smile Health
	Lucy Skipworth	HTF Charity Manager
In attendance:	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin (For the Minutes)
	Heather Lamont	CCLA Representative

Item 1 03/23 **Apologies for Absence**

Apologies for absence were received from: Susan Liburd, Kate Wood and Ellie Monkhouse. In addition, Neil Gammon welcomed Jamie Lewis, the recently appointed CEO of HEY Smile Foundation, who manage HTF operations for NLAG.

Item 2 03/23 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 03/23 **Minutes of Meeting held on 3 November 2022**

The minutes from the meeting held on 3 November 2022 were approved.

Item 4 03/23 **Matters Arising**

All matters arising were covered within the action log.

Neil Gammon took the opportunity to publicly thank Nicola Glenn, Jug Johal and his team for all the hard work put into opening the new Emergency Departments at both DPOW and SGH.

Item 5 03/23 **Review of Action Log**

The action log was updated accordingly.

Item 6 03/23 **Items for Discussion / Approval**

6.1 HTF Trustees' Committee – Membership and Terms of Reference Review

Neil Gammon highlighted the changes made and asked members of the meeting to review them, with approval being accepted subject to the changes noted below.

Kate Wood noted an amendment needing to be made to her job title (Chief Medical Officer).

It was highlighted that the document refers to having 3 NEDs, however there are currently only 2 NEDs who attend this committee meeting. After discussion took place, it was agreed to highlight this anomaly to the Trust Board and ask them to confirm their decision for two NEDs to sit on this committee. Neil Gammon agreed to put this on the agenda for the next committee meeting.

Action: Neil Gammon

6.2 Wish Ref 102/22 – Siemens Healthineers SGH MRI Innovision

Lucy Skipworth provided a brief background to this wish being requested and agreed by this committee to fund in 2022 and referred to the lengthy timeline of the wish process. Unfortunately, the original quote expired within this timeframe and with a new quote being sought, the price has nearly doubled. Lucy Skipworth explained that she has been in contact with Siemens to re-negotiate the price, however they were not able to reduce the new quote given. Neil Gammon expressed his disappointment at not meeting the quote deadline but felt it needed to come back to the committee to agree next steps and decide whether the funding would still seek approval from members noting the significant price increase.

Jug Johal was shocked to see such a large increase and asked whether there would be any other suppliers who provide this piece of equipment. Clare Woodard explained that it needs to be supplied solely by Siemens due to compatibility requirements.

Lee Bond too, expressed his disappointment regarding the new quote provided by Siemens but was unsure as to why this process was not fast tracked by colleagues due to the known quote expiry date. He noted that this was an example of poor practice in which we need to improve and offered his apologies to the HTF. Gill Ponder shared Lee Bond's disappointment and thought the process needed to be streamlined to avoid this happening in the future. Neil Gammon understood the committee's frustrations however noted that processes do need to be followed to ensure IT compatibility, for example.

Further discussions took place whereby Jug Johal and Lee Bond agreed to use their contacts at Siemens to try and obtain some discount on the new quote.

Action: Jug Johal / Lee Bond

Trustees agreed to fund this wish at the increased cost because fundraising had already taken place for the specific item and there were sufficient monies within that fund. However, they expressed their considerable disappointment at such significant additional funding needing to be spent.

Item 7 03/23 Updates from Health Tree Foundation

7.1 HTF Manager Update Report

Lucy Skipworth spoke to the report and highlighted the following key updates expanding the discussion where necessary:

- Health Tree Foundation Team Updates
- NHS Charities Together: Development Grant – The HTF applied for this £30k grant in which they were successful. Although it is not for the Trustees to dictate what this money is used for, they were asked to voice any suggestions based on their experience. Neil Gammon is due to attend the NHS Charities Together event in London soon and Clare Woodard will be meeting with a Northern branch to discuss best practices.
- NLAG Our Stars Update
- Community Engagement – Every child within the Keelby area has received a fund-raising pack which was given out at the school to raise awareness of the Charity.
- Improvement to Staff Rooms, Rest Areas and Kitchens – Improvements to Ward 6 in SGH is underway with staff having their input to the design.
- Fairchild Legacy
- Wishes over £5k Signed Off by Executive Clinical Champions
- Circle of Wishes
- Grant Funding Applications for 2023
- Corporate Partnerships
- Annual Survey – The survey was sent out in December 2022 with a total number of 32 responses received. This was unfortunately down from last year, however Clare Woodard noted that this survey does not often have a huge uptake.

7.2 Risk Register

Lucy Skipworth advised members that no new risks had been added recently, however this register is an on-going live document which will be updated when necessary.

Item 8 03/23 Sparkle Programme

8.1 Sparkle Update

Lucy Skipworth expanded on the report and encouraged members of the committee to visit the pond area at their leisure. Peter Reading commented on how he regularly passes the pond area with patients and staff enjoying the view. Neil Gammon thanked the HTF and the Estates and Facilities team for all their hard work.

The HTF are investigating using QR codes to display on walls around the Trust sites to encourage quick and easy donations.

Item 9 03/23 **Finance Update**

9.1 Finance Report – February 2023

Paul Marchant presented the Finance report and highlighted the key points, including;

- Income for the 11 months to February 2023 was £842k which includes £501k of NHSCT grant income; this is not in the plan but has now been included in the full year forecast. When NHSCT grant income is excluded, income is £341k, which is £494k less than budget.
- Expenditure for the 11 months to February 2023 is £1,236k which includes £471k of NHSCT grant payments, when these are excluded expenditure is £765k, which is £299k less than budget.
- Equipment purchased in the 11 months to February includes; DPOW & SGH A&E Departments £88k (Feature Ceilings, Charge Boxes, Sensory Floors & Notice Board TVs) Hamilton MRI Ventilator £27k, MotoMed Exerciser £7k and ECG & trolley £7k.
- The CCLA investment fund was revalued on 31st December resulting in a loss of £9k. Investments will be revalued again at 31st March 2023.
- Fund balances after commitments are £857k.

9.2 Finance and Fundraising Plan 23/24 & 24/25

Paul Marchant presented the proposed Finance and Fundraising Plans for 23/24 & 24/25 and highlighted the key points, including;

	23/24	**24/25**
• Income	£952k	£1,005k
• Expenditure	£1,270k	£1,301k
• Net expenditure	£318k	£296k
• Closing Fund Balance	£992k	£696k

KPI's for every £1 spent

	23/24	**24/25**
• Charitable Activities	£0.75	£0.75
• Fundraising	£0.20	£0.20
• Governance	£0.05	£0.05

Lucy Skipworth expanded on the fundraising plans for the next two years, with a targeted approach to encourage support from donors, those thinking about leaving a legacy, corporates, schools & partner charities. The team will promote a different fund zone each month to increase Circle of Wishes expenditure.

Following a discussion by Trustees the plans were approved.

9.3 CCLA Investment Update

The chair welcomed Heather Lamont from CCLA to the meeting to present the investment update. The following key points were highlighted:

- 2022 has been a brutal year for investors. Tightening monetary policy and war in Ukraine have weakened valuations in most equity sectors with the exception of energy stocks
- Despite all the ups & downs in value, income remains steady at £45k (a yield of 3.05%).
- The fund objective remains to provide a long-term total return benchmark of inflation (CPI) plus 5% pa.
- As inflation and higher interest rates bite, growth will be limited. A global recession may well be avoided. The UK is weaker than other major economies and recession here still appears likely.
- Inflation will fall from current levels but tighter monetary conditions will persist.

The long-term relative performance of the portfolio remains strong, the focus remains a portfolio of high quality, real economic assets, selected on the basis of fundamental characteristics and attractive valuations with the aim of delivering strong risk-adjusted returns over time.

9.4 Annual Report & Accounts 2021/22 – audited version

Paul Marchant presented the audited Annual Report & Accounts for the year ended 31/3/22. These had been reviewed by Trustees at the committee meeting held in November 2022 and approved by Peter Reading and Neil Gammon on 1/12/22 to enable submission to Charity Commission by the due date of 31/1/23.

Trustees were asked to note the following;

- Annual Report & Accounts Year ended 31/03/22
- HTF Letter of Representation dated 01/12/22
- Mazars Audit Completion Report Year Ended 31/03/22

Item 10 03/23 **Any Other Business**

None.

Item 11 03/23 **Matters for Escalation to the Trust Board**

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Terms of Reference – gain a decision regarding either 2 or 3 NEDs.
- MRI Wish – quote inflation.
- The need for the Trust Board to suggest a large charity appeal around which fundraising efforts could coalesce.
- Finance and Fundraising Plan 2023/24 & 2024/25

Action: Neil Gammon

Item 12 11/22 Date and Time of the next meeting:

Wednesday 17 May 2023
9.30am – 12.00pm
Via MS Teams

Attendance Record:

Name	March 2022	May 2022	July 2022	Sept 2022	Nov 2022	March 2023
Neil Gammon	✓	✓	✓	✓	✓	✓
Peter Reading	✓	✓	✓	✓	✓	✓
Terry Moran						
Linda Jackson						
Gill Ponder	✓	✓	✓	✓	✓	✓
Mike Proctor	✓	Apols	Apols	Apols		
Maneesh Singh	✓	✓	✓			
Lee Bond	✓	✓	✓	Apols	Apols	✓
Jug Johal	Apols	-	✓	✓	✓	✓
Kate Wood	✓	✓	Apols	✓	Apols	Apols
Ellie Monkhouse	✓	Apols (Rep)	Apols	Apols (Rep)	Apols (Rep)	Apols (Rep)
Christine Brereton	-	✓	-	-	-	
Paul Marchant	✓	✓	✓	✓	✓	✓
Andy Barber	-	-	-	-	-	-
Victoria Winterton	Apols	✓	✓	-		
Clare Woodard	✓	✓	✓	✓	✓	✓
Adrian Beddow	-	-	-	-	-	
Ian Reekie (Governor)						
Tony Burndred	✓	-	-	-	-	✓
Susan Liburd					✓	Apols
Simon Leonard					✓	✓
Lucy Skipworth					✓	✓
Total	**10**	**10**	**9**	**7**	**8**	**10**

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 June 2023	
Director Lead	Kate Wood, Chief Medical Officer Ellie Monkhouse, Chief Nurse Fiona Osborne, Non-Executive Director	
Contact Officer/Author	Fiona Osborne, Chair of Quality & Safety Committee	
Title of the Report	Quality & Safety Committee Minutes – March and April 2023	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for March and April 2023.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 28 March 2023 from 1.30pm to 4pm
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Sue Liburd	Non-Executive Director
In attendance:	
Richard Dickinson	Associate Director of Quality Governance
Mel Sharp	Deputy Chief Nurse
Ashy Shanker	Deputy Chief Operating officer
Simon Thackray (item 74/23)	Joint Associate Medical Director, Cardiology
Nicky Foster (item 75/23)	Deputy Associate Chief Nurse, Midwifery
Simon Priestley (item 77/23)	Chief Pharmacist
Fiona Moore (item 79-80/23)	Head of Quality Assurance
Belle Baron-Medlam (item 81/23)	Interim Inspection Compliance & Assurance Manager
Ian Reekie	Governor (observing)
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

068/23 Welcome and Apologies for Absence

Apologies for absence were received from: *Dr Kate Wood, Mr Kishore Sasapu, Dr Peter Reading, Dr Stuart Baugh, Jane Warner (Nicky Foster to rep), Ellie Monkhouse (Mel Sharp to rep), Shaun Stacey (Ashy Shanker to rep),*

069/22 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that there were three papers that had been deferred; the CNST paper was an update but was not available yet. Ellie Monkhouse had asked for the Annual Safe Staffing review paper to be deferred because although the operating planning was moving incredibly fast there was a final review required to align it to the 2023/24 bed base data that had recently been released. The Lung cancer update had also been deferred for the second time which had prompted Fiona to reflect on the cancer review and deep dive process for this Committee going forward. The original reason this Committee started looking at Cancer Services was to look at it in parallel with the Finance and

Performance Committee. Fiona would arrange a meeting with Kate Wood and Shaun Stacey to review the methodology of cancer reviews to ensure the Committee had the most robust approach.

Action: Fiona to meet with Kate Wood and Shaun Stacey to review the Committee cancer deep dive methodology

In addition, due to apologies received and the number of deputies in attendance it would not be suitable to discuss the Committee's Terms of Reference or the Committee's effectiveness therefore those items would also be deferred freeing up more time for discussion of the other agenda items.

Attendees would still be asked for a two minute introduction of the papers emphasising any key points before moving on to questions.

070/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

071/23 To Approve the Minutes of the Previous Meeting held on 1 March 2023

The minutes were accepted as an accurate reflection of the previous meeting.

072/23 Matters Arising

In the January Committee meeting there was a query about how ULHT managed to have a much better turn around for their cancer samples than our lab. Kate Wood had followed up on this and there were two aspects to this.

- A transport delay which added up to half a day to the turnaround time.
- ULHT had an assigned a person to chase the samples through on behalf of the individual services.

After discussion with Kate Wood, Fiona Osborne asked for an action to be noted for the Ops team to explore how the NLaG process could be improved to match the advantage ULHT had by having this additional person.

Action: The Ops team to explore how the NLaG process could be improved to match the advantage ULHT had by having this additional person

073/23 Review of action log

148/23 Improved communication - this was linked to Quality priorities which would be discussed later in the meeting.

046/23 Data collection – Fiona Osborne had asked for this to go on the next NED agenda as a formal item. Also, an IPR review was now underway and they had asked for our responses.

290/22 End of Life – Sue Liburd attended the EoL briefing from Dr Kate Wood. Action closed.

328/22 Nursing Assurance Report - referral to Workforce team about recruiting times/waits. Action closed

Regular Reports

074/23 Cardiology Update

Simon Thackray referred to the report distributed which was taken as read and highlighted the key points.

Simon was employed jointly as a Cardiologist by NLaG and HUTH.

Simon worked at NLaG for five years up until a few years ago and knew it was very difficult to attract, recruit and retain substantive Cardiologists so they ended up with a revolving door of locums. Locums are great but there is not that continuity of care that patients deserve and some are very expensive. The negative for NLaG was locums who would stay for a few months and then leave, not always bringing best practice with them. Simon had been very keen for joint recruitment with NLaG and HUTH and they had now reached a position where they were able to put joint appointments in place.

Previously there would be two or three consultants at DPoW and SGH so working cross site there was not a daily input of patient care and it was very difficult to persuade people to cross cover each other's patients. Most hospitals around the country had gone with a group of approximately eight people. The shape of our workforce now was three or four at NLaG, Simon and then five at Hull and they were interviewing a couple more which would take us up to full establishment. They would end up doing one week in nine on the Wards which was manageable.

Simon reported the paper was to increase the patient focus for the Cardiology service and wanted to use C1 Glover at DPoW but they were trying to make sure the experience for patients at SGH was as good as for those at DPoW. There were two consultants at SGH who had Cardiology training who worked within Acute Medicine and were able to provide that Acute Physician input. The service had two Advanced Clinical Practitioners (ACPs) based at SGH to help with the triage and management of patients and three soon to be specialists at SGH.
If any immediate treatment was needed at DPoW patients would go to the Cath lab based at DPoW. There would be a small group of patients who would need to be moved to DPoW or Hull for example for by-pass surgery. Simon estimated it would be one patient a week that would need to move across to DPoW. The number of patients going from SGH to DPoW would be implicit in this arrangement.

Within this proposal there would be a Saturday and Sunday Cardiology in reaching service at both sites increasing the consultant on service to 7 days per week. They were not yet able to provide a 24/7 service but towards the end of the year would be looking to do an overnight Cardiology on-call service whereas at the minute they had to ring Hull.

With regards to safety, both Medicine and Acute Medicine had supported the proposal and Simon was confident assurance was given. The amount of joint working that had gone into this with everybody on board made Simon confident for the workflow.

From a workforce point of view this was an optimal way of using and keeping the work force as the turnover in the past had been difficult to manage. It also allowed people to do some subspecialties work which was a nice ratio so would improve the flow of patients through the organisation and would improve safety. Adequate training of the ACPs meant they would have one consultant to go to which would give more clarity for the patients. Simon was assured the proposal was safe and would see how it goes as we go along.

Fiona Osborne asked if this was a model that had previously been undertaken pre-covid. Simon confirmed this model had been operated for eight months pre-covid but previously it was five days a week and this was a seven day a week model.

Kate Truscott mentioned that there were staffing Registrars at SGH but not at DPoW. Simon clarified there used to be one at DPoW but they were not getting well supervised so had been taken away. This model should improve the number of trainees, they would have four at SGH as NLaG were 'red carded' with Health Education England (HEE) and they wanted to ensure there was that supervision before we had a Registrar for DPoW. Sue Liburd asked if there could be a rotation between the two. Simon did not think that currently that could work as the Registrars were there to learn about Medicine not Cardiology but for one week in three they would bring them to the Cath lab at DPoW.

> **Post meeting note from Dr Kate Wood:** *Kate was not familiar with the terminology 'red carded' which had been used at the meeting. NLaG have no GMC active monitoring against the Trust, having had this stood down last year. Our GMC National Training Survey was improving, and the relationships with HEE were good. Historically (approx. 5 years ago) the position was different, and some Cardiology trainees were removed from NLaG. The minutes implied that this was a current position, and Kate wanted it to be clearly stated that this was a historical position.*

Kate Truscott asked if there were any consultant grade non medics. In response Simon advised that the ACPs were a recent development and it was difficult to get the funding for them. Kate Truscott felt very assured by what Simon had said and thanked Simon for a very comprehensive update.

Sue wanted to build on Kate Truscott's question about the Cardiology red notice for HEE and asked if this model would seek to improve NLaG's record for training and supervision. Simon felt this workforce proposal would help if we got long term substantive recruitment they would be more committed to helping trainees. There was a possibility we would get slightly more negative feedback as they do not want to go out to DGHs, which was a cultural change. Simon suspected that some of them were reflecting frustrations that as Cardiologists they had to dually accredit to General Medicine.

Sue asked if there was anything they could do to encourage any of the long term consultants to take on substantive posts. There were five trainees coming through who looked like they might commit to the region. Being able to advertise joint posts meant people could do a bit at each and having that mix was great and our jobs

were quite attractive to people. We lacked cardiac CT scanning in this area and Simon had finally got the resource/funding for the go ahead.

Sue asked if there were any potential digital problems in delivering the service and patient safety. In response Simon advised that there were some problems but WebV in NLaG for clinicians was the superior system. The system in HUTH (Lorenzo) functionally was less optimal but Simon assured the Committee there were no safety concerns for clinicians. Simon stated any digital issues were outside of that proposal and the proposal dealt with the optimal patient journey.

Ashy Shanker supported the paper but asked if the transfer of patients from SGH to DPoW and the numbers mentioned needed to be picked up in terms of transport. with regards to the number of beds C1 Glover had 26 beds but they needed to be careful that it did not add to the congestion at DPoW. Ashy requested a meeting with Simon to discuss CT scanning.

Action: Ashy Shanker to discuss the CT scanning with Simon Thackray outside of the meeting.

Fiona Osborne commented that the bed configuration 26 beds at DPoW and 23 at SGH numbers were a very close margin if monitoring was moved to DPoW. Simon was anticipating that only Cardiology patients would be transferred and the numbers would differ. Simon stated beds were currently occupied both by Cardiology patients requiring monitoring and general medicine patients with cardiac issues as part of a wider set of other conditions. These patients due to their needs would be better served by general medicine specialists. The proposal delivers this.

Fiona referred to the third category patients who had heart failure, who may not be suitable for transport and asked if they would they be cared for at SGH by a Cardiologist. Simon remarked that we had always needed to move poorly patients around the system as the Cath lab is in Grimsby. If they were too unstable to transport from SGH to DPoW then they would be monitored at SGH and would be end of life whether this proposal went forward or not. There was no deterioration to the patients from that.

Mel Sharp attends JNCC and their union colleagues had raised concerns that their unit was going to be closed. Mel was aware there had been a lot of work with the staff and wondered if the staff were engaged and fully on board now. In response Simon commented that the changes they had made over recent years had not been particularly popular with the nurses. i.e., Coronary Care Unit at SGH, the monitored beds from Coronary Care moved to Ward 23 and that was unpopular but there were patients who needed monitoring in an Acute Medical Centre. The monitored beds would be on AAU but we do not need to have a Coronary Care or AAU for monitored beds. They had engaged with the nursing staff but there were still a handful of nurses who were unhappy. Simon was due to talk with the two remaining nurses to see what they could do. Two of the Coronary Care nurses had moved to a different part of Coronary Care and Simon would like the other two to move to something different but he thought they were coming up to retirement age. Mel added that the two nurses who had moved were happy in their new roles.

Approval from committee members was given for this model and after the discussions were assured that patient safety would not be compromised because of the new proposal.

Simon Thackray left the meeting at 2.21pm

075/23 Maternity Safety Oversight Update (including Ockendon & metrics)

Nicky Foster gave a verbal update. The action plan from the first report from 2021 was now complete. Work from the second report continued and they were having monthly meetings to through the actions. It was a huge action plan, had completed 52 and eight were already on track. Following the positive assurance visit we are expecting a second visit in May.

Nicky invited any comments or questions.

Fiona Osborne noted a written report was due in May and wondered if that would be worth putting back to June so it could include the written feedback from the visit in May. The Committee agreed this.

Nicky Foster left the meeting at 2.23pm

076/23 Annual Safe Staffing Review

Item deferred.

077/23 Pharmacy Update

Simon Priestley referred to the document distributed which was taken as read and highlighted the key points.

The main dominating factor was workforce and particularly the Pharmacist workforce. Despite that they had managed to maintain their CQUINs.

It was the Pharmacists group where there are vacancies were mainly except for asceptics and with the addition of pharmacy support workers.

Simon invited any comments or questions.

Kate Truscott thanked Simon for the comprehensive report and was not surprised that he had highlighted that workforce was the major problem. Simon confirmed there were 8 vacancies out of an establishment of 9.6 WTEs. The vacancies were in the band six to seven range. There are two Deputy Chief Pharmacists, procurement lead and a number of different roles they needed to cover but that had a knock on effect of things and the management side to maintain the degrees of clinical work. At the moment they were developing staff to assist the Pharmacists.

Sue Liburd asked if there was less of a problem at the DPoW site. Simon thought there was slightly but they were moving towards being fully staffed . Doing chemo checking had balanced the work but on a day to day basis they faced the same

challenges but it was the Senior Management Team supporting SGH more as we had more staff at DPoW.

Sue asked in terms of supporting recruitment into those roles what sort of support were they getting. Simon had varying support, looked at skill mix, looked at the training up of ACPs in medicines reconciliation btu unfortunately they not been able to recruit in that area. They were out for advert for locum staff but nationally that was a problem and the locum rates are wanting to come in for 8a- c rates which was a lot of money. They had reviewed skill mix and had created some band three Pharmacy Support roles and had just gone through star chamber and agreed the principles so they could use that as well. They had a plan for e-job planning to try to help build with retention. Simon requested further support with talent acquisition and recruiting. The team are looked at recruitment in Europe and would like to do a promotional video. Had recently appointed but there were delays with occupational health and Simon wanted to speed that up to get them through the doors quicker.

Kate Truscott asked if there were any apprentice roles in that area. They used apprenticeships for retaining other staff but for Pharmacists they had to do the university course and training.

They had two Medicines Management Nurses; one was on a phased return and the other would be going off for a period of time but would hopefully be coming back. They also had a nurse on secondment which had recently ended but they were willing to help out through the bank, they had already gone out to advert to fill that.

Ashy Shanker mentioned vacancies and how they could try to improve that thinking about international recruitment. In the ICS they were looking more internationally not just in Europe and wondered if that was something they could explore further. Simon informed that they had an ICB working group for Pharmacy already but outside the EU Pharmacists tend to have to do a 12 month training course, a foundation training year followed by an exam before they can become a pharmacist. They were looking at options of how they could expedite training and bring that back to the regulator to see if they could provide some sort of undergraduate training but that would not be a quick win.

Sue Liburd mentioned the escaped Pharmacy errors and asked where they were typically picked up. Simon advised that very often the Wards would contact them directly to notify them there had been an error. It is always encouraged that errors are reported through Ulysses and the Pharmacy team out on the Wards and would occasionally identify other errors that had been made.

Fiona Osborne was not clear on the Pharmacists process if a patient's weight was not recorded and asked Simon to clarify. Simon explained that not all patients wanted their weight recorded. The SPO encouraged the pharmacists to ask the nursing colleagues if there was a weight recorded or available. There were two systems where the weights were recorded but the information did not transfer across the two. With regards to medication, Simon advised for many medications they were interested in the ideal body weight and for others actual weight. The system did not allow for actual and ideal body weight. Teams would check with WebV and check with nursing colleagues to see if there was a weight recorded if not they would still be encouraged to get them but the Pharmacy team was not

trained to estimate the weights. Not all drugs needed a weight but where it was weight based the dose needed to be at least an estimated weight.

Mel Sharp added that they did still have an ongoing issue with patients being weighed within six hours and they were addressing that looking at different training and education of staff but it was still a challenge.

Fiona thanked Simon for the update.

Simon Priestley left the meeting at 2.49pm

078/23 Lung Cancer Deep Dive

Item deferred

079/23 Quality Priorities & Quality Account

Fiona Moore referred to the report distributed which was taken as read and highlighted the key points.

Fiona had taken on board feedback from the last meeting and had produced a revised version. The deteriorating patient and sepsis had been split into two and communication with patients had been removed as a stand-alone quality priority as it was recognised that it threaded through all the workstreams. In terms of EoL and mental capacity would do that through the review process and case review on the quality of the handover.

Fiona Moore was looking for final sign off so they could work out those plans and details to decide if it would be signed off or not.

Fiona Osborne commented that KPIs were the biggest discussion last month with regard to communication, but that asked for confirmation if existing surveys could deliver the KPIs.

Richard Dickinson confirmed new surveys would be needed but these could not be delivered until the delivery plans had been defined. As an example, he was expecting that the expertise from each of the working groups would help. It might not be a one size fits. In addition, in planning they might put some interventions in place such as prompts but there was a variety of things that could be done and was where we could improve a communication strategy.

Kate Truscott asked how much involvement the patients and families had in the communication as having people involved at an early stage would be a much more meaningful approach. Richard went to explain that to set this up they needed to understand the feedback to construct the right question set, to involve the right people to have the right input to take things forward to help us make a proper assessment and decide what needed to be addressed.

The Committee approved the quality priorities

080/23 QIA

Fiona Moore referred to the report distributed which was taken as read and highlighted the key points.

There was only one QIA for the renovation to the mortuary and that had been approved. They were looking at access for the workers and had everything put in place for mitigation and risk.

Fiona Moore left the meeting at 3pm

081/23 CQC Framework

Belle Baron-Medlam referred to the paper distributed which was taken as read and gave a brief overview of the changes since the previous report.

Indicators had been added to all actions to show an increase or decrease in rating since the previous report.

The total number of actions has increased, from 116 to 123. This was due to a number of actions being split to provide more accurate reporting and assurance.

The total number of actions awaiting rating had decreased from 45 to 7 which was positive.

The total number of actions with a full or significant assurance rating had increased from 14 to 25 and 5 were linked to actions from this Committee.

One action that had previously been submitted to the CQC had been added to the Surgery action plan to ensure the final actions required are monitored and reported on.

One duplicated action had been removed from the Medicine Division action plan.

The pace was picking up with the actions and hopefully that would continue.

Ashy Shanker asked in terms of the action plan if there was an evidence based response in terms of how the KPI's were measured. Belle confirmed it was evidence based but was very varied depending on the action that went to the Divisional Governance for scrutiny and finally to Exec Team.

It was difficult with the CQC action plan as there was not a lot of information behind it so it was a case of having to go back and look at the regulations.

Richard Dickinson added that the report was something the CQC were supportive of and it had been developed over time and was a recommendation from NHSE/I to help others which demonstrated that our system was effective.

Fiona Osborne referred to page 16 and the action about medicine stored and administered safely and wondered if the business case got in in time for the deadline.

Action: Belle Baron-Medlam would follow that up.
Fiona mentioned that the Finance and Performance Committee report had more appendices included at the back of the report which Fiona thought was too much for this Committee but was keen that this report was not too onerous for Belle. Belle did not think it was too much of an issue and was nothing too untoward but it would be interesting to see further down the line if the actions got too onerous. This Committee was interested to see what had changed since last month but did not want to place a burden on Belle. If there was something that had not changed from last month Fiona would like to see why there was no change.

Belle Baron-Medlam left the meeting at 3.10pm

082/23 Nursing & Midwifery Assurance Report

Mel referred to the document distributed which was taken as read and highlighted the key points.

The number of escalation beds open including day surgery units and staffing continued to be a challenge and it remained a focus to try to close the escalation beds when able.

There continued to be a focus on vacancies with recruitment campaigns and it remained a focus.

Pressure ulcers – had seen a spike so the team did a thematic review of January to see why there was a seasonal increase but they did not find any trends. Having spoken to the ops teams they had seen an increase in the dependence and acuity and knew patients were waiting a long time in ambulances and ED. There had been a significant reduction in February in the numbers so the only thing they could put it down to was increased stay at home and the poorly condition they were coming to us in.

The number of open PALS maintained an all-time low position of 46 which was down to a trained nurse being able to significantly focus on the PALs but that role was due to finish at the end of March.

There were nine mixed sex accommodation breaches mainly due to a lack of beds to transfer patients out to.

Kate Truscott thanked Mel for the report and update but asked about community nursing and the impact of vacancies, the case load and therefore the impact on patients. Mel advised there was a dependency tool being used but they had reviewed all patients on their caseloads and found there was some very long standing patients who could be removed without a risk to the patients but it did continue to be a focus. The staff continued to use the Malenko system but issues were more cultural and not the system. Kate was assured with Mel's response.

Sue Liburd thanked Mel for the update and referred to the number of open PALS that were out of time or over time scale and wondered if they had been resolved or were being resolved. Mel and the patient experience lead met monthly and did not

believe they were still outstanding but Mel would come back to Sue. If it was felt a PALs was going on for a long time it would be moved over to be a formal complaint.

Action: Mel Sharp did not have the information to hand but would find out and provide an update.

Post meeting note: Mel Sharp advised that the longest standing PALs was currently at 30 days.

Fiona commented she had taken part in the 15 steps for Physiotherapy and commented that she could not produce a better leadership structure in their team if she tried.

Fiona asked about the bank incentive payments. In Finance & Performance Committee it had been presented to suggest that was not working because there was no reduction in agency spend however Fiona asked for confirmation that it had resulted in the shift fill rates in January had jumped to 99.6%. Mel confirmed this and the Committee agreed this would be included in the highlight report for the Trust Board.

Fiona thanked Mel for the update.

083/23 IPR

Mel Sharp referred to the paper distributed which was taken as read and highlighted the key points.

The Trust reported 20 for *C.Diff* previously and we were now at 21 with a few days to go. The Committee agreed this should be highlighted to the Board as the Trust target was very low and the result needs to be celebrated as being within target.

The PALs response had recovered and improved

The target for Pseudomonas cases had been exceeded but it was set extremely low and an external review found we could not have done any more with that.

Family and friends test (FFT) saw a seasonal reduction in feedback and the post was put forward in a business case as it would be a risk to the patients to not have them in post.

Fiona asked about the epidural infusion bags as there was minimal information. Richard noted that this alert came in the same week as another alert and it was more about ensuring we had epidural infusion supplies. We had sufficient supplies and had an alternative product available which had been sought and Richard was just doing some documentary sign off for changes to procedures, but this was more based on safety and there was no immediate risk to the Trust.

084/23 Key SI update including Maternity

Richard Dickinson referred to the report distributed which was taken as read summarised the key points.

Richard reported the good news that there had not been any Maternity SI's in month and the overall rates were favourable. Richard had done some background checks with the run rates previously, each year had approximately 80 but now had approximately 30. There had been some process changes and there were some demonstrations of improved rates over time.

Sue Liburd noticed that in the reports there were some deadlines for today/tomorrow. Richard knew one of the reports was signed off yesterday and a few other were due to be signed off. In terms of the background there was work to be done for various sign offs to get to the final stage. There was also another set of deadlines out of our control so in the pathway there were extra steps that were not visible but they had to wait for those before they could go out to the family.
The team continued to try to monitor and improve processes and that focus remained.

085/23 Potential Deviations from National Documentation

Richard Dickinson advised there were not any deviations to discuss.

086/23 PSIRF update

Richard Dickinson referred to the report distributed which was taken as read and summarised the key points.

Within the context of PSIF there was a lot to digest and a lot within the framework. The organisation was taking steps to get better acquainted with the framework and get into the granular detail. The update was in the report and Richard hoped at the next meeting they would be able to demonstrate progress.

Fiona Osborne commented about the pace as last month they had said we were behind, but now they were only slightly behind so it looked like it had moved at speed.

Richard updated that there were two implementation groups so it was gradual progress and outside of those groups Kelly Burcham and Richard were doing some stakeholder mapping. In between the meetings there was active work ongoing and the team were engaged with webinars with local and national networks.

087/23 Annual Review of Committee Effectiveness

Fiona Osborne advised that given there had been apologies from three Executive members of the committee Fiona did not think it was the right time to discuss this. The deadline for returns was 31st March to go back to Laura Coo. Fiona had also asked Laura Coo to input too as Fiona felt Laura's input was invaluable in keeping the Committee running.

088/23 Terms of Reference Review

Fiona would take any questions for the ToR to Helen Harris.

Highlight reports

089/23 Quality Governance Group (QGG)

Fiona asked for a discussion on the QGG Highlight report because she felt the report had improved significantly being clear on areas for escalation. Fiona asked for confirmation that escalation was to TMB and not for this Committee. Richard confirmed this. It was agreed the Committee would continue to review the escalation items and would ask for reports to be presented for assurance is required.

Richard Dickinson referred to the report distributed which was taken as read and talked through the actions from the March report.

Patient information leaflets – it was reported that the Divisions were going to be picking up the monitoring of the leaflets. This was a change from it being central and the Divisions were not happy with that but it was a decision from TMB and QGG had an escalation directly to TMB.

With regards to the patient information leaflets, a meeting was held on 24th March as the Divisions were concerned about how they would be able to manage the review dates and a positive way forward was agreed which Mel Sharp would feedback but that was for TMB to address.

Mel commented that signage was always an issue but Ade Beddows was looking to take this through TMB as well as it would cost a lot of money.

Staffing issues were noted for awareness.

The last point for awareness as part of the safeguarding training package there were some changes to the Prevent level 3 training which was aligned to those who would already be doing safeguarding level 3 and that would have some impact on the safeguarding team. It is guidance rather than mandatory and the intent is to move with our peer group and take the step forward. Sue Liburd added that at Workforce Committee they looked at core training and specialist training and this was mandatory for anybody who was a safeguarding lead but otherwise it was advisory training for everybody else.

A discussion took place about potentially moving the next safeguarding report forward but it was agreed that it should stay on the workplan to provide an update in June.

Fiona thanked Richard for the update.

090/23 Mortality Improvement Group (MIG)

The report was taken as read.

091/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

092/23 Quality Governance Group (QGG) minutes

Distributed for information.

093/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

094/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

095/23 Any Other Business

None raised.

096/23 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Fiona Osborne agreed to add the following points to the highlight report to the Trust Board.

- Cancer review – new methodology to challenge the cancer in terms of patient safety
- Approval of the Cardiology model
- Pharmacist levels needed to be highlighted
- Approved Quality Priorities
- Bank incentive scheme although not produced a reduction in agency costs it had improved shift fill rates.
- Celebration of the *C.diff rates and* that we had achieved our target

097/23 Meeting review

Sue Liburd thought it was great to have the space and time to be able to have more robust discussions. Fiona Osborne hoped it would change once the methodology for the Cancer deep dives and the Terms of Reference had been reviewed as this Committee had a substantial number of reports to look at each month.

098/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 25th April 2023
Time: 1.30pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 3.50pm

Annual Attendance Details:

Name	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023
Michael Proctor	x	✓	✓	✓	✓	✓	✓							
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	✓	✓	✓	x	✓						
Dr Kate Wood	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x
Ellie Monkhouse	✓	✓	✓	✓	✓	x	✓	x	✓	x	✓	✓	✓	x
Dr Peter Reading	✓	✓	x	✓	✓	✓	x	x	x	x	✓	✓	x	x
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓						
Jennifer Granger								✓	✓	✓	✓	✓		
Richard Dickinson												✓	✓	✓
Helen Harris	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Jan Haxby	✓	✓	✓	✓	x	x	✓	x	x	x	✓	x	✓	x
Shaun Stacey	x	x	✓	x	x	x	x	✓	✓	x	x	x	✓	x
Susan Liburd									✓	✓	✓	x	x	✓
Kate Truscott									✓	✓	✓	✓	✓	✓

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 25 April 2023 from 1.30pm to 4pm
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Sue Liburd	Non-Executive Director
In attendance:	
Dr Kate Wood	Chief Medical Officer
Ellie Monkhouse	Chief Nurse
Richard Dickinson	Associate Director of Quality Governance
John Awuah	Deputy Chief Operating officer
Lydia Golby	Deputy Director of Quality and Nursing, Northeast Lincolnshire Health and Care
Belle Baron-Medlam (item ../23)	Interim Inspection Compliance & Assurance Manager
Nicky Foster (item 109/23)	Deputy Associate Chief Nurse, Midwifery
Fiona Moore (item 11523)	Head of Quality Assurance
Ian Reekie	Governor (observing)
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

103/23 Welcome and Apologies for Absence

Apologies for absence were received from: *Shaun Stacey (John Awuah to rep), Dr Peter Reading, Jane Warner*

104/23 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that there was one paper that had been deferred; Annual Safe Staffing Review as it needed to go through TMB before this Committee. Two papers had been withdrawn:

- The Lung Cancer Highlight Report which in consultation with Execs, it had been agreed that the primary Committee to receive reports going forward would be Finance & Performance. This was because the single biggest impact to improve Cancer services was performance and although this Committee had been receiving Cancer reports for eight months no concerns over patient quality of acre or harm had been reported that had not been dealt with through the robust reporting systems already received by this Committee.

- A CNST report would come to this Committee in June once the year five requirements had been released and at that point an action plan should be underway.

For all agenda items attendees would still be asked for a two minute introduction of the papers emphasising any key points before moving on to questions.

105/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

106/23 To Approve the Minutes of the Previous Meeting held on 28 March 2023

Kate Wood referred to the comment about there being no SI's recorded in month, and although she was not in attendance thought that Richard had meant there had been no Maternity SI's in month. Richard clarified that was what he had meant.

Kate Wood referred to page four and the phrase 'red carded by HEE', Kate did not recognise what that term meant and the minutes suggest it was a current issue when it had not been the case for some time. Fiona Osborne confirmed that the minutes accurately reflected the discussion of the meeting but if it was not correct would be happy for a post meeting note to be added to clarify.

Action: Laura Coo to update the minutes to reflect the changes as discussed.

Action: Kate Wood to provide a post meeting note to Laura Coo for the March minutes.

The minutes were otherwise accepted as an accurate reflection of the previous meeting.

107/23 Matters Arising

There were no matters arising.

108/23 Review of action log

Fiona Osborne and Laura Coo had a conversation about what should be added to the Committee action tracker. The previous Chair had requested only actions that were not operational should be added whereas Fiona would like all actions raised at the meetings to be added.

148/23 Improved communication - this was discussed at the March meeting and could now be closed.

046/23 Data collection – this had been raised at the NEDs meeting and had been fed back to Digital. In addition, there has been the opportunity for Committee members to pass comments in the recent IPR review, therefore Fiona suggested for this action to be closed. Fiona would continue to ask the questions and would re-open it if required.

069/22 Cancer deep dives – Fiona had a conversation with Kate Wood and Shaun Stacey and had agreed that cancer would be primarily dealt with by the Finance and Performance Committee. Action closed.

072/23 Turnaround time for Cancer samples – John Awuah was aware and had discussed at length with Mick Chomyn. They had submitted a business case for seven day services and once that had been approved it would be solved. Kate Wood was happy for this action to be closed but would expect assurance to be raised through cancer reporting.

074/23 Cardiac CT scanning - a meeting had taken place between Ashy Shanker and Simon Thackray therefore this action could be closed.

081/23 CQC Framework - business case for medicines stored and administered safely – the information had been updated in the report therefore this action could be closed.

082/23 Nursing & Midwifery Assurance Report - number of open PALS out of time or over time scale - Mel Sharp had included a post meeting note for the March minutes therefore this item could be closed**.**

Regular Reports

109/23 Maternity Safety Oversight Update (including Ockendon & metrics)

Nicky Foster provided a verbal Maternity update.

From the initial report Ockenden report seven immediate and essential actions had been met.

From the second report there were 15 actions to work through including changes in policy, implementation of services and joint working. The Trust had already met three of those actions; preterm birth, postnatal care and bereavement care

Fiona Osborne asked what was happening with the procedural changes that were wider than the Trust. Nicky confirmed the Chief Nurse was assisting with those changes.

From a safety point of view the midwifery staffing position was improving, previously noted 41 wte vacancies across the two sites but that had reduced to 30 which was really positive.

The internationally recruited trained Midwives were starting with us they were really positive and happy to be here.

Ellie Monkhouse suggested it might be worth rethinking this agenda item going forward to bring similar information to that which was presented to the Board as Ellie thought it might be more useful to bring everything back into one place and one report. Ellie would keep the Board and Committee up to date on the maternity self-assessment tool and about the sustainability plan. Ellie needed to get something to the board in June and would appreciate this Committees support and felt a more structured paper for this Committee would be the best way forward. In addition, there was a maternity dashboard.

Fiona Osborne was happy to make the suggested changes and for this Committee to receive more regular updates given the challenges in maternity but felt that monthly updates would be too much. Usually, the Committee received more detailed verbal updates but appreciated this was Nicky's first update. Fiona suggested quarterly updates but Ellie did not think quarterly would support the wider oversight given the national interest in maternity and instead suggested for Maternity report to this Committee monthly for the next couple of months whilst working through the sustainability plan and then to go to bi-monthly.

Kate Truscott supported what Ellie had said and thought having a formal report would help to get over the hiatus with the changeover of staff and would find it helpful to have more frequent written updates. Sue Liburd endorsed a lot of what Ellie had said, we were moving at pace to get us out of special measures including the sustainability and maternity self-assessment plan. Sue did not feel the detail was relevant for Board and felt that this Committee had more time to scrutinise so given the pace would encourage to move to monthly reporting and to re-assess at the end of July as to whether to go to bi-monthly reporting at that point. The Committee agreed.

Nicky Foster left the meeting at 2pm

110/23 Annual Safe Staffing Review

Item deferred.

111/23 IPR

Kate Wood referred to the report distributed which was taken as read and highlighted that things such as antibiotic prescribing would not change on a monthly basis. From a VTE perspective Kate had asked again and had been assured that would be amended to reflect the great position the organisation was in.

As we move towards the new IPR Kate noted the out of hospital SHMI and was curious as to where the benchmark of 110 had come from and wanted to understand why we had that benchmark.

Ellie Monkhouse noted the C.diff, we ended the year at 23 against a target of 21 as unfortunately had a couple of cases in the last few days but NLaG are still one of the best performing Trusts in the country with regards to C.diff rates so it was still a significant achievement for the Trust given the various challenges we face.

Kate Truscott commented that there seemed to be a reduction in childhood observations and wondered why that was the case.

Kate Wood informed that there were a number of potential contributing factors. When it is recorded on paper, staff then have to transfer that onto digital and when that happened there would always be variants that does not always reflect reality but this was closely monitored through the Paediatric team.

Kate Wood asked if it would be helpful when we have the IPR discussion to do a deep dive into each of the quality priorities under the IPR which might provide some assurance and understanding of some of the issues and support with unblocking.

That matched what Fiona Osborne thought in terms of the flexibility and evolution of the QSC workplan.

Richard Dickinson added that through the Quality priorities they had identified they were trying to make sure they had a clear approach and would like to report on that on a quarterly basis so although he accepted Kate Wood's request for deep dives, Richard would also be providing updates as a catalogue of progress. Fiona liked the idea of taking one of the priorities each month and looking at it in more detail but was happy to take this conversation outside of the meeting unless everybody agreed with that direction. It was agreed the deep dives was the best way forward starting next month with the first Quality priority.

112/23 Nursing & Midwifery Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read.

Ellie had tried to give some narrative in relation to any concerns they had been picked out previously and pointed out that there was an interesting drop in fill rates since the bank incentive was dropped, the fill rates were quite poor. We do still have escalation beds open and currently had B4 beds open but some safety issues had been identified so Ellie needed to get that area closed. In relation to the pressure ulcer process a weekly review process was in place with the CCGs, Place and ICBs who provided some healthy scrutiny.

Kate Truscott added that this was in relation to something that was discussed at the previous meeting about a concern that some of the non-clinical aspects were being added to the clinical staffs time and wondered if they had found a way forward to help with that. Ellie advised that information was contained within the establishment review and formed part of the conversation that Ellie was taking to TMB around how we support our leaders to do the non-clinical aspect and that was contained within the establishment review.

Sue Liburd knew there was an improving narrative around the response in compliant deadlines but thought it was a bit of a concern that there were five complaints that had been re-opened in February and asked what impact that had on patients and in terms of reputation, were they closed down too prematurely. When Ellie first came to the Trust there was a huge back log of open complaints so the number of re-opened complaints was fairly low. They did a lot of work around the experience people went through with the complaints process and acknowledged that we did not always get things right. Ellie reviewed all complaints as they came through however for those specific five cases there were other contributing factors and a fairly reasonable response as to why they had been re-opened.

Fiona Osborne asked about the substantive fill rates for Laurel Ward in DPoW on page 12 and asked if there was something specific going on. Ellie advised that Laurel were currently in a bit of transition process and were looking at the care, they were not currently a full and substantive Ward which explained why the fill rates did not look good.

Fiona noted the shift numbers were the highest recorded numbers in 23 months and thought from the narrative it was recruitment to bank. Fiona asked about the recruitment scheme. Ellie advised that they had been very successful at recruiting a

pool of staff who they asked if they wanted to take up substantive posts but were happy to be taken into the bank pool.

Fiona Osborne mentioned the bank incentive scheme which Ellie had touched given it had resulted in excellent shift fill rates and knew it was discussed at Board but given the initial intention of reducing agency costs had not been fulfilled did that mean the incentives were off the table or would it be looked at in a different way to specifically target agency staff. Ellie thought that was a whole executive discussion as Ellie's opinion was obviously biased but we needed to understand our agency spend more before work could be started on how to reduce it. Sue Liburd had asked for Simon Neary to do a piece on agency spend for the next Workforce Committee which would include shift fill rates and agency spend. Kate Wood queried if that report would include medical staff as well as Kate did not feel we had that line of sight for the medical spend.

Ellie added beds with patients in them needed to be staffed safely regardless of the cost, but if she did not understand what the agency spend/costs were then she could not help to work through it. Whilst we had patients in beds who needed complex nursing care Ellie would continue to staff those beds.

Kate Wood understood the logic for this being discussed at the Quality and Safety Committee as the Committee needed to be assured that the Trust was providing the right quality of care but Kate did not believe there was the same assurance for the workforce and financial aspects.

Sue Liburd advised this would be discussed at the Workforce Committee by virtue of the fact that we needed to know and understand the agency spend which had been raised here. With regards to workforce and finance Sue agreed there needed to be a board level conversation and perhaps at TMB level too if that was necessary.

Kate Truscott supported what Kate Wood and Sue had said and knew there were conflicting priorities which was why it needed to be discussed at board level.

Ellie did not think that this Committee or the Workforce Committee could support that alone and could not collectively look at reducing the agency spend until we understood the information. Ellie had to make sure that our patients were cared for to the standards that Ellie sets and would continue to do that.

It was agreed this needed to be discussed further at Board and would be included in the highlight report.

Kate Truscott left the meeting 2.45pm

113/23 CQC Framework

Belle Baron-Medlam referred to the paper distributed which was taken as read and gave a brief overview of the changes since the previous report.

- The total number of actions had increased from 123 to 124 due to some actions splitting and merging.

- Two actions had been removed from the Divisional action plans and merged into one Trustwide action.
- There were no longer any actions awaiting a rating
- The total number of actions with a full or significant assurance rating had increased from 25 to 32
- Five assurance papers had been submitted to the CQC in relation to 2019 actions.
- One action from the 2022 report had been submitted to CQC
- The CQC received significant assurance from the recent internal audit.

Fiona Osborne referred to action 2022-MED 15 and the business case and noticed the description had been updated and asked if that proposal had been approved depending on the overall plan. Belle was due to get a copy of the business planning and had spoken to Simon Priestley about it and there was some mitigation in place as well as a supportive policy in place for that; The Policy for the monitoring of temperatures for the safe storage of medicines on wards and departments and that was updated for clarity around temperatures, particularly the process that wards should follow for extreme temperatures.

Kate Wood added that nobody was able to announce the outcomes from the business planning process due to the financial state of the NHS everything was on hold which was why mitigation was so important.

Fiona mentioned that this Committee had significantly more actions than the Finance and Performance Committee however they received very detailed information of what was going on in the background so Fiona asked if there was any interest from Committee members in seeing that information as well. All agreed it would be helpful to have that extra detail for information.

Belle informed that when Audit Yorkshire received the action plans it was very early and a lot of the actions did not have leads and timescale but that had now been achieved and there was only one action that did not have a timescale as it was very difficult to put a timescale to that. Another recommendation was for all board sub committees that discuss CQC assurance go through that action plan.

Fiona asked for any reference to Board sub-committees to be renamed with Committee. Kate Wood asked when that had changed and could be signposted to where it was announced as she was not aware. The NEDs were informed through their regular NED meeting which Helen Harris normally attends.

Action: Kate Wood to pick that up with Helen Harris for clarity

114/23 Register of External Agency Visits

Belle Baron-Medlam referred to the paper distributed which was taken as read and highlighted the key points since the last report in December 2022.

- There had been a reduction in External Agency Visits from 82 to 44
- Nine new visits had been added to the register
- Four action plans had been added to the hub page.
- 15 visits were recommended for closure

- Belle had amended the report to include graphs to see the information at a glance and had included a tracker for external visits.
- The audiology review had now been received although Belle had not received it yet

Fiona Osborne asked for members opinion on the Committees role for the external visits and asked if it needed to go through QGG rather than here as this Committee was an assurance Committee as some closure reports referred to QGG as the oversight Committee and others to this Committee.

From a background point of view Richard Dickinson commented that when they were trying to piece together the Paediatric Audiology screening he made some enquires to see if there was anything else we did not know and there was some weight to getting opinions from other services but Richard was not sure which Committee or group this needed to come to. Fiona's perspective was this Committee was not a sign off committee but was seeking assurance so normal functioning should happen in the normal management led hierarchical structure. Based on that it should go to QGG and this committee should seek assurance that the process was being followed through.

Kate Wood thought the assurance was that any external visit had been logged and signed off and did not want to start making an industry of bring closed actions here.

Fiona was assured by the report that external agency visits were being tracked but the felt the sign off needed to be QGG.

Belle agreed about the SOP and that the closure form could be updated and took the comments on board. It was agreed closure forms would go to QGG.

Belle Baron-Medlam left the meeting at 3.06pm

115/23 Quality Account

Fiona Moore referred to the report distributed which was taken as read. The draft Quality Account had been brought here today for review and it was quite descriptive. Fiona Moore had tried to stick to the national guidance which states we have to use NHS data against the latest mandated data. Following this meeting Fiona Moore would like to release this to our external stakeholders who would then be given six weeks to review and provide any comments back to us.

Kate Truscott congratulated Fiona Moore on putting this together there was a huge amount of content and knew that was not easy. Kate suggested that after comments had been received for it to be edited so that it flows in a different way i.e. charts to be on one page but that was a personal comment and nothing to do with the content.

Fiona Moore took that feedback on board and thanked Kate for recognising the effort that went into it. Fiona Moore had tried to stick as close to the guidance as possible whereas other reports might of strayed away from that and she had tried to take on board feedback from last year from the ICB colleges and from the Overview and Scrutiny Committee.

Richard Dickinson thought they were helpful comments and agreed there were a couple of tables that could be moved to one page i.e. page 60. Richard thought all of the information at the back in red was last years commentary so could be taken out and what remained would be a placeholder position.

Fiona Osborne commented that it was very well done, it was a big report and to have a report of that size with no material comments on content was really positive.

Fiona Moore left the meeting at 3.15pm

116/23 Key SI update including Maternity

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points.

Had investigations ongoing with external involvement including HSIB and the audiology report. The updates for action plans were described in the report as well as the updates with regards to Sis. There was a very robust process in place that feeds into this report.

There were no new SIs in Maternity and no new SIs that we are reporting to this Committee.

117/23 Potential Deviations from National Documentation

Richard Dickinson advised there were not any deviations to discuss.

118/23 PSIRF update

Richard Dickinson referred to the report distributed which was taken as read and went through the changes since the last meeting.

The paper illustrated the key areas being focused on, they were trying to introduce some of the terminology that would be seen moving forward throughout the updates. Page six illustrated the flow process which would be different to the SI process and would discuss further at the next PSIRF meeting on Friday.

Deteriorating patients and falls groups had been set up and Richard was looking at how to align them. Lydia Golby had met with the team to discuss a paper she was taking forward.

Richard was happy to take any questions.

Fiona Osborne asked about NLaG and ICB approval and if they were working with other Trusts. Richard wanted to work in partnership where it was reasonable and had worked with colleagues in Hull and the South of Lincolnshire so far. Kelly Burcham had visited Lincoln as well so whilst they were not having regional meetings they did have input from regional centres.

Richard informed the Committee that the August plan was about getting things in order and agreeing the right time so by August they hoped they would have that mutual agreement that their plans were appropriate and that the policy was in a reasonable state.

119/23 Annual Review of Committee Effectiveness

Fiona Osborne referred to the report distributed which was taken as read and discussed the comments received. Fiona would like to put together an action plan but would like to concentrate on those where the answer was "No".

1a – The terms of reference were being reviewed by the Board.

1c – More explicit mortality reporting. This Committee currently received MIG reports. There was a suggestion that a mortality report could be presented every six months or could assign an amount of time to go through the MIG highlight report at each. Kate Wood commented that the Terms of Reference stated about Mortality reporting so Kate thought there was something in the NQB guidance that stated this Committee needed to discuss it. Richard Dickinson agreed that a mortality report should be brought to this Committee on a regular basis. Kate Wood proposed to keep the MIG highlight report and then have a quarterly Mortality report as well including a summary of activity.

Action: Fiona Osborne to update the workplan

There was a comment about BAF driving the agenda which had already been discussed and Fiona felt that was progressing. Kate Truscott thought she had mentioned the BAF but only in as much as it would be reviewed but wondered what was the point in having the BAF if it was not going to be used. Fiona queried if the BAF was changing did the Committee members want to change the workplan today.

A discussion took place about the relevance of the BAF, Richard Dickinson had a few concerns about how the governance arrangements would work in a group structure and thought the risk register part of it was not a totally reliable source of information and did not think we had the challenge right.

Kate Wood thought the recommendation from this Committee was that the BAF gets a further review.

Ellie Monkhouse was concerned that if the BAF was rewritten now all it would contain was risks about the group structure so we needed to be mindful of that. Kate Wood and Ellie Monkhouse already reviewed the BAF regularly. The Committee discussed this further and agreed a case should be put forward for the BAF to be reviewed.

Action: Fiona Osborne to put a case forward to review the BAF to the Director of Governance

2b - The actionable comment about sufficient time at Board for key risk areas is outside of the remit of a Quality & Safety Committee effectiveness action plan.

2d – Had a partially met and a no. Fiona thought this was being fedback already and were in a position to keep reviewing and it was ongoing for this Committee

Fiona thanked everybody for the complimentary comments in the leadership section.

3a – There was a comment about the number of private meetings. Fiona advised that we only had Private QSC meetings where appropriate, had agenda sets after each meeting ready for the next one which were optional to attend. There was also a paper review meeting a week prior to each meeting to decided what happens with papers not received. Fiona also has conversations with Ellie, Kate Wood and/or Shaun Stacey the day before the meetings. There were additional meetings when required for things such as pressure ulcers to better understand the processes of the Trust. Fiona suggested two actions for the improvement plan; Fiona to ensure the purpose of a meeting was communicated when an invitation was sent and for Committee members to speak up and challenge when they felt a meeting was not required.

3b – Fiona agreed with the comment "If questions have been answered outside of the meeting, they should not be repeated in the meeting" with the exception of those items on the action log as the answer would be required to close the action. The Committee members agreed.

3c – Fiona agreed with the comment "The committee needs to understand that risks may develop that need assurance outside of the workplan" and stated that this Committee had the most flexible workplan of all the Committees. Ellie Monkhouse commented that QSC should be the most flexible Committee as it deals with quality of care. The Committee members agreed.

4b – This centred around extra committee meetings although these had not been necessary in the last year. For Cancer Kate Wood supported the suggestion to watch and see and see how things evolved.

7a – Fiona formally thanked Laura Coo for the administration side of the meeting and for Kate, Ellie and Shaun for their support in moving the reports on.

120/23 Terms of Reference Review (ToR)

Fiona Osborne referred to the Terms of Reference distributed and the comments received

5.1.2.5 – Fiona advised that the Board has a duty to receive the Annual Inaction Prevention Control report so as this section referred to reports delegated by the Board to this Committee it should come out. As DIPC, Ellie Monkhouse stated she would expect for the committee to have oversight of Infection Control but if not where would the challenge be. Fiona commented that this Committee did receive regular assurance through the Nursing report but by removing this report from the delegated reports section it that did not mean the Committee could not receive the annual report only that it would not receive it on behalf of the Board. Ellie would be concerned if the full report did not come through this Committee. Fiona thought it needed a deeper discussion at Board.

Kate Wood thought this item seemed to imply some things would be discussed here rather than at board i.e. CNST and Annual Quality Account and they needed to be discussed at Board. Fiona agreed that this is what it means. Ellie understood that people wanted a more strategic conversation at Board but we were losing sight of what the board needed to discuss.

Action : Laura Coo to set up a 30 minute meeting with core QSC members to discuss the ToR

Highlight reports

121/23 Quality Governance Group (QGG)

The report was taken as read.

122/23 Mortality Improvement Group (MIG)

The report was taken as read.

123/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

124/23 Quality Governance Group (QGG) minutes

Distributed for information.

125/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

126/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

127/23 Any Other Business

None raised.

128/23 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Fiona Osborne agreed to add the following point to the highlight report to the Trust Board.

- A recommendation that the different discussion on agency spend in the Quality & Safety, Workforce and Finance & Performance Committees are brought together at Board for a triangulated discussion.

129/23 Meeting review

Already discussed.

130/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 23rd May 2023
Time: 1.30pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 4 pm

Annual Attendance Details:

Name	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023
Michael Proctor	✓	✓	✓	✓	✓	✓								
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	✓	✓	x	✓							
Dr Kate Wood	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	✓
Ellie Monkhouse	✓	✓	✓	✓	x	✓	x	✓	x	✓	✓	✓	x	✓
Dr Peter Reading	✓	x	✓	✓	✓	x	x	x	x	✓	✓	x	x	x
Shaun Stacey	x	✓	x	x	x	x	✓	✓	x	x	x	✓	x	x
Susan Liburd								✓	✓	✓	x	x	✓	✓
Kate Truscott								✓	✓	✓	✓	✓	✓	✓

NLG(23)117

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6 June 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Nursing & Midwifery Assurance Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Board is asked to note the content of the report. The overall Care Hours Per Patient Day (CHPPD) was 8.4 in March, however it has been identified that the CHPPD data for escalation ward B4 has been incorrectly submitted. This is being rectified and will be resubmitted. There is a total of 189.94 Whole Time Equivalent (WTE) (10.19%) Registered and 99.93 WTE (10.25%) unregistered vacancies across the Trust in February. For Community the vacancy rate for both Registered and Unregistered is decreasing with Registered Nurse (RN) vacancies being the lowest since March 2022. The midwife to birth ratio for Diana Princess of Wales (DPOW) is 1:23.9 and Scunthorpe General Hospital (SGH) 1:20 which is below the acceptable ratio of 1:28. A total of 55 staffing red flags were reported compared to 54 the previous month. These continue to be monitored and reviewed daily. The total number of falls reported has decreased for the fifth consecutive month. The number of acute pressure ulcer incidents has increased slightly. The incidence of community pressure ulcers acquired on caseload has seen a further decrease. New formal complaint numbers were 24 for this month which was a reduction of 5 from the previous month. 26 complaints were closed, with an achieved Key Performance Indicator (KPI) of 86% of those closed being within timescale. Trust wide the number of new Patient Advice and Liaison Service (PALS) concerns received was 187 (191 in February). Open PALS continued to maintain a low number of 50. 199 PALs were closed with the KPI of 63% of closed in timescale - this was achieved for a third month. The trust declared one mix sex breach which involved two patients who were not fit for the ward.

	Eight 15 Steps Challenge visits were completed all within the acute schedule. The Trust had a C.difficile infection (CDI) target of no more than 21 cases and ended the year on 24. There were no significant lapses in practice/care detected from the post infection reviews undertaken The Trust reported a Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia case in March 2023 after having no case for over 26 months. A post infection review is being completed. No surgical site infections detected in 2022 – 2023. No surgical site infections detected in 2022 – 2023. The Trust continues to support staff internally (11) and externally (1 Integrated Care Board- ICB) to complete the Leading & Coaching Quality Improvement (QI) course.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: QSC
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	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

Northern Lincolnshire and Goole NHS Foundation Trust

Nursing & Midwifery Assurance Report May 2023

(March 2023 data)

Contents

Assurance Report May 2023 (March 2023 data)

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018).

Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical oversight. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels on a shift-by-shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Oversight continues to be provided to the Quality and Safety Committee on nursing and safe staffing. The changes to ward configurations throughout the pandemic has made it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons. As we continue to reset ward configurations and utilise escalation beds across the Trust, any data should be viewed with caution and for this reason we continue to review individual metrics and apply professional judgement.

In line with the document published in February 2021, Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency, Quality impact assessments are undertaken with final sign-off by the Chief Nurse prior to additional wards being opened.

The Nursing Metrics Review Panel is chaired by the Chief Nurse, meets monthly and is attended by the senior nursing team for the organisation. The panel review the information provided by the nursing dashboard and commission any work required to investigate and support any areas of concern.

2.0 Safe Staffing

2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

The information presented shows data on inpatient wards only.

Shift Fill Rates Summary Mar 2023

Overall

96.1% ▲ 2.6%

Registered Nurses and ...

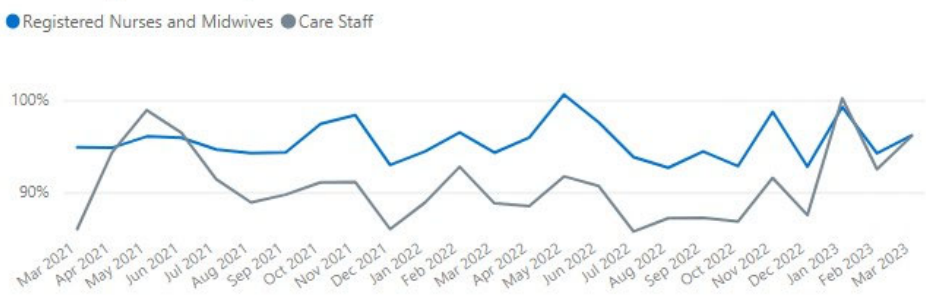
96.2% ▲ 2.0%

Care Staff

96.1% ▲ 3.6%

Overall Fill Rate

Fill Rate by Staff Group



Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPoW	97.3%	3.5%	93.8%	
Mar 2023	GDH	100.9%	4.9%	96.0%	
Mar 2023	SGH	94.1%	1.2%	92.9%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Medicine	97.2%	1.3%	95.9%	
Mar 2023	Surgery & Critical Care	99.4%	7.0%	92.4%	
Mar 2023	Women & Children's	89.4%	0.6%	88.8%	

Actual shift fill rates are reported against ward establishments. Staffing reviews take place at intervals throughout the day, including a Trust wide review of SafeCare Live information at 9am.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard. The combined fill rate shows some variance from month to month, March being 96.1% and an increase from the 94.3% in February. However, the overall fill rate for each ward varies from 73.6% to 500% (see chart below). Some of this high fill rate can be attributed to those wards that have unestablished escalation beds with Ward B4 showing a fill rate 501.9%. This is due to 24 escalation beds opening on a ward that has no planned establishment for inpatients. B4 is usually a day-case ward which has been relocated to another area with their established staffing. The ward has been opened with 24 beds for most of March.

With ward B4 excluded, the overall shift fill rate on inpatient wards is 94.9%.

As part of the Chief Nurse establishment review in 2022, the Safer Nursing Care Tool (SNCT) data was collected during May/June 2022 and was collected again over 20 days during October/ November to account for seasonal variation. Meetings were held with ward and department managers to review the SNCT data and nurse sensitive indicators, and the Annual Safer Nursing Staffing Establishment Review report was presented to Trust Management Board in May 2023. The report suggested that recommendations outlined in the paper were considered and costed as part of the Chief Operating Officer's new bed base review. Most of the requests relate to the current bed model in which we are operating, which includes multi- placement of High Observation Bays (HOBs) beds and ongoing use of unfunded beds providing extra capacity. This review was therefore not seeking financial funds at this time, however recommended that the increase in supervisory provision for our clinical leaders should be discussed by the Senior Management Team.

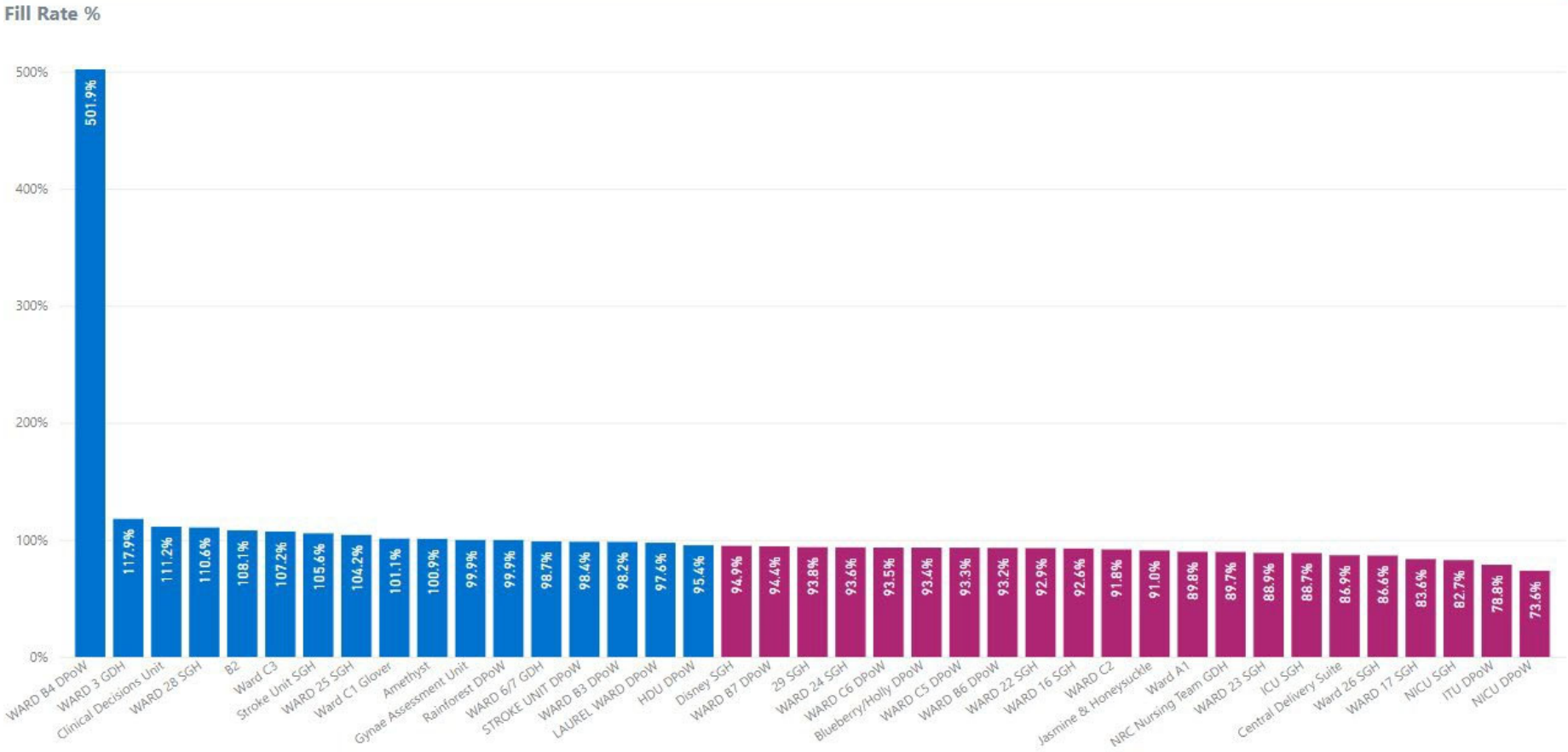
Fill Rate Wards Chart

Mar 2023

Site: All

Division: All

Northern Lincolnshire and Goole NHS Foundation Trust



RNMW Ratio Summary Mar 2023

RNMW Ratio

60.6% ▼ -0.5%

RNMW Ratio

RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPoW	58.5%	-1.2%	59.8%	
Mar 2023	GDH	53.8%	-0.9%	54.7%	
Mar 2023	SGH	64.2%	0.5%	63.7%	

RNMW Ratio by Division

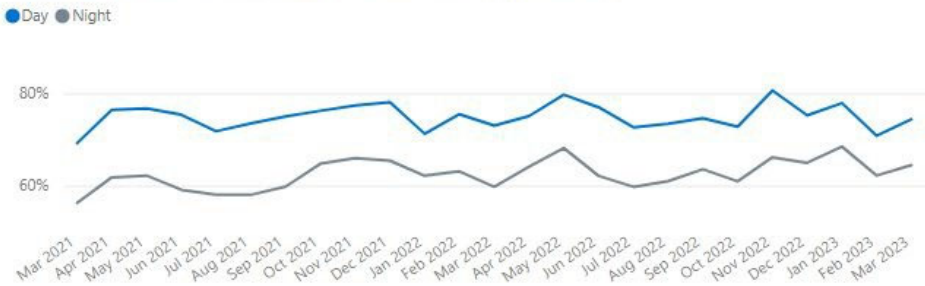
Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Medicine	54.3%	-0.4%	54.7%	
Mar 2023	Surgery & Critical Care	66.9%	-2.8%	69.7%	
Mar 2023	Women & Children's	70.0%	1.5%	68.5%	

A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse and Midwife to Health Care Support Worker (HCSW) ratio for the Trust has been above 60% for the last year. Medicine remains the lowest Registered Nurse (RN) ratio in February at 54.3%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

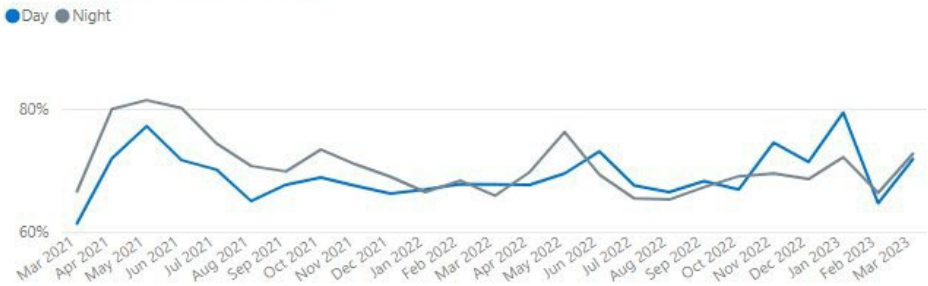
Substantive Fill Rates Summary Mar 2023

RNMW - Day		RNMW - Night		Care Staff - Day		Care Staff - Night	
74.4%	▲ 3.6%	64.5%	▲ 2.3%	71.8%	▲ 7.2%	72.7%	▲ 6.4%

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
Mar 2023	DPoW	75.9%	✓ 3.7%	72.2%	
Mar 2023	GDH	76.0%	✓ 10.8%	65.3%	
Mar 2023	SGH	72.4%	✓ 2.5%	69.8%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Medicine	72.2%	✓ 0.3%	72.0%	
Mar 2023	Surgery & Critical Care	77.0%	✓ 8.1%	69.0%	
Mar 2023	Women & Children's	75.8%	✓ 5.1%	70.6%	

Wards with Substantive Fill Rate Below 50% **Mar 2023**

Staff	
Day or Night	
Ward name	

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD C5 DPoW	44.1%	▼ -9.4%
Ward C3	43.1%	▼ -2.2%
WARD C2	40.9%	▼ -2.1%
WARD 3 GDH	38.7%	▼ -4.1%
Ward A1	37.6%	▼ -6.1%
WARD 17 SGH	32.3%	▲ 7.3%
WARD 6/7 GDH	32.3%	▼ -7.0%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
NICU SGH	28.0%	▼ -59.5%
Ward 26 SGH	25.8%	▲ 7.9%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD 25 SGH	45.2%	▼ -6.6%
WARD C2	43.2%	▼ -17.5%
WARD 23 SGH	40.9%	▲ 18.2%
NICU DPoW	40.5%	▼ -19.4%
NRC Nursing Team GDH	29.0%	▼ -4.9%

Substantive versus temporary staff fill rate is monitored and an increase in substantive staff fill rate is seen for days and nights in March for all staff.

No wards had a substantive fill rate less than 50% on days.

On night shifts there were 7 wards with a fill rate less than 50% for RNs which is a decrease from the 9 wards in February.

Of the 7 wards that had RN substantive fill rate less 50%, 5 of these feature in last month's report and data is contained in the table below to triangulate with sickness and vacancy rates.

The information below demonstrates the level of sickness and vacancies in the areas with the lowest substantive fill rate.

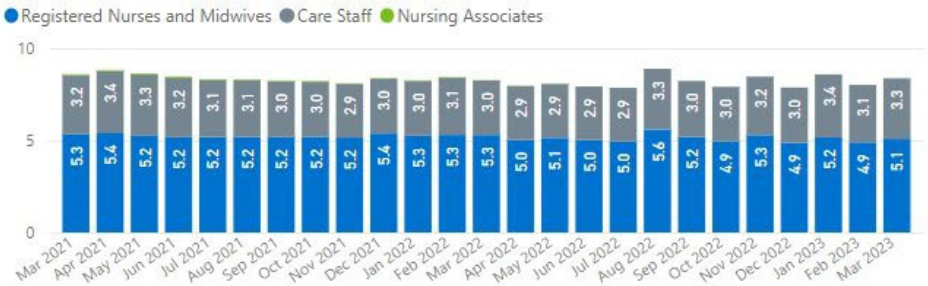
Ward	Sickness	RN vacancy wte	HCA vacancy wte
Ward 17 SGH	6.98%	7.29	4.73
Ward 3 GDH	9.87%	2.10	0.25
Ward 6/7GDH	8.15%	5.41	-2.69
Ward A1 DPoW	9.15%	5.88	4.25
Ward C2 DPoW	10.02%	2.48	1.48
Ward C3 DPOW	5.72%	6.71	1.17

CHPPD Summary Mar 2023

Overall	Registered Nurse...	Care Staff
8.4 ▲ 0.36	5.1 ▲ 0.18	3.3 ▲ 0.18

Overall CHPPD

CHPPD by Staff Group



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPoW	8.4	0.4	8.0	
Mar 2023	GDH	9.3	1.7	7.6	
Mar 2023	SGH	8.3	0.2	8.1	

CHPPD by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Medicine	7.2	0.1	7.1	
Mar 2023	Surgery & Critical Care	9.2	1.3	7.9	
Mar 2023	Women & Children's	12.3	-0.3	12.5	

Wards with CHPPD Below 6.0 **Mar 2023**

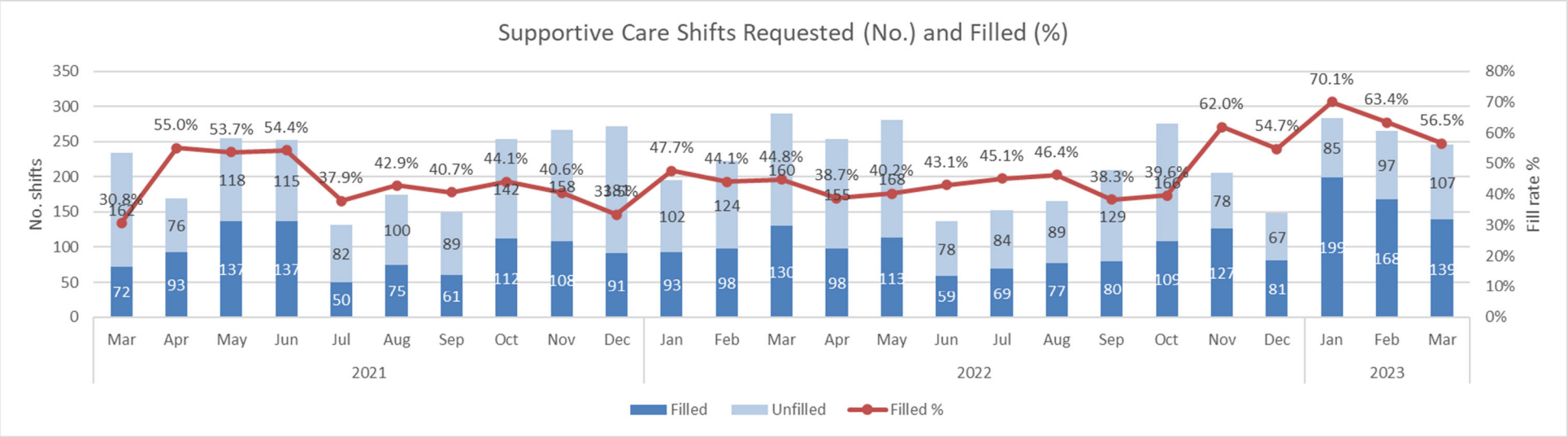
Staff	Registered Nurses and Midwives		Care Staff		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
WARD C2	3.1	▲ 0.08	2.9	▲ 0.02	**6.0**	**▲ 0.10**
Clinical Decisions Unit	2.8	▼ -0.52	2.3	▼ -0.73	**5.2**	**▼ -1.25**
WARD B4 DPoW	1.4	▲ 1.36	3.3	▲ 3.29	**4.7**	**▲ 4.65**
Ward 19	0.0		0.0		**0.0**	

The Care Hours per Patient Day (CHPPD) data is reported monthly and is included in the Trust's NHS Digital return. CHPPD is the total hours per day of Registered Nurses (RN), Midwives (MW) and care staff divided by the number of patients in the ward/department at 23.59 hours each night. This provides a score of the average care hours per patient per day. There are many factors that can affect the care hours required, for example, the proportion of single rooms.

The overall CHPPD was 8.4 in March.The latest model hospital data for January 2023 indicates a provider value of 8.9 (quartile 4 highest 25%) against a peer median of 8.2 and provider median of 8.1. However, it has been identified that the January dataset was submitted incorrectly and has been rectified and re-submitted. The correct CHPPD for January 2023 is 8.6.

It has been identified that the CHPPD data for escalation ward B4 has been incorrectly submitted for March 2023. This is being rectified and will be resubmitted.

2.2 Supportive Care



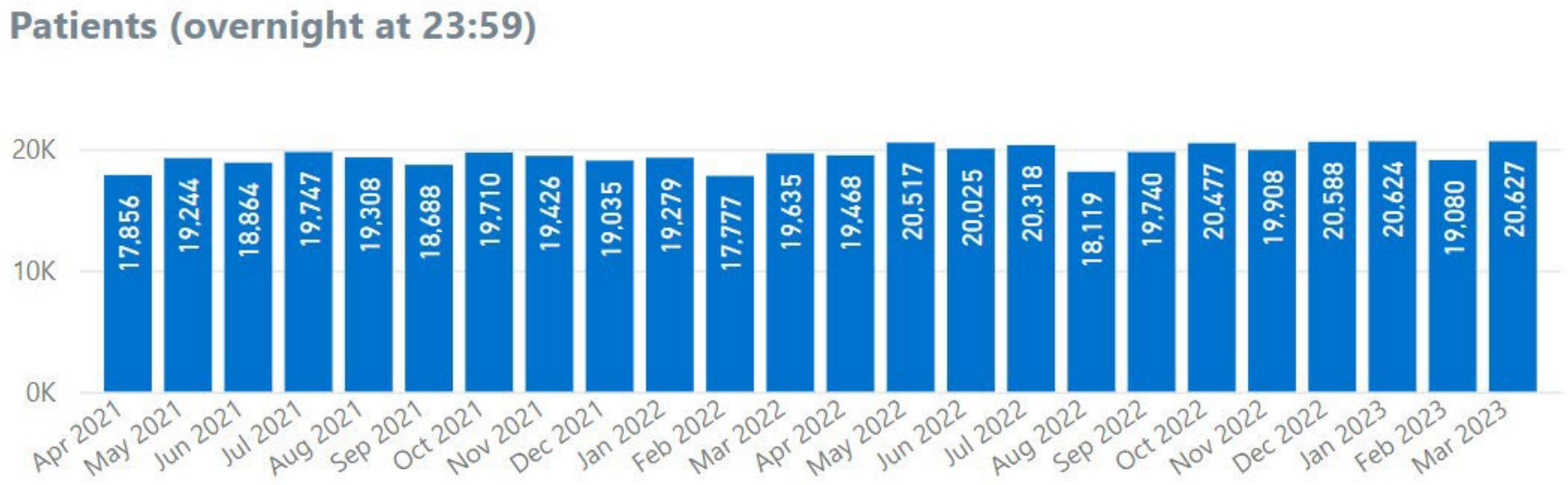
The wards are seeing an increase in number dependent patients, several which require 1:1 supportive care. These shifts are not part of the ward establishment. Shifts are sent to the temporary staffing team to source unregistered cover via the Bank. Additional processes have been put in place for risk assessing our patients with tools such as AFLOAT to support prioritisation and decision-making regarding options available. All areas where 1:1 care need is identified have permission to access additional duties to try and cover this need. Additional allocate on arrival shifts are also booked centrally to help with providing a staff resource outside of the ward establishments to support 1:1 supportive care need. Matrons have a daily presence on the wards and 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 an increase in the percentage of filled shifts for the last five months and is reflective of the active recruitment to substantive and bank healthcare assistant posts (HCA). Recruitment onto the Bank continues, and it is hoped that improvements seen can be sustained. Opportunities to support and develop bank staff are being progressed.

2.3 Escalation Beds

It is still not possible to obtain accurate escalation bed data against established beds from WebV or the Sitrep reports. Escalation beds which are not established are open on C3 (n2), B2 (n5), ward 24 (n5), ward 27 (n4), SGH gynae (n2 D2A) and B4 (n24) - total 42 beds. This has an impact on staffing across all areas. In addition, Ward 19 day case surgery unit has had 10 escalation beds open periodically over December, January February and March.

The graph below shows the monthly bed occupancy at midnight i.e., the total number of patients occupying a bed at midnight. This was the highest it has been in March 2023 and is reflective of the increased use of escalation beds.



2.4 Staffing Indicators

2.4.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies Summary Mar 2023

Vacancies - Total

164.8 ▼ -6.5

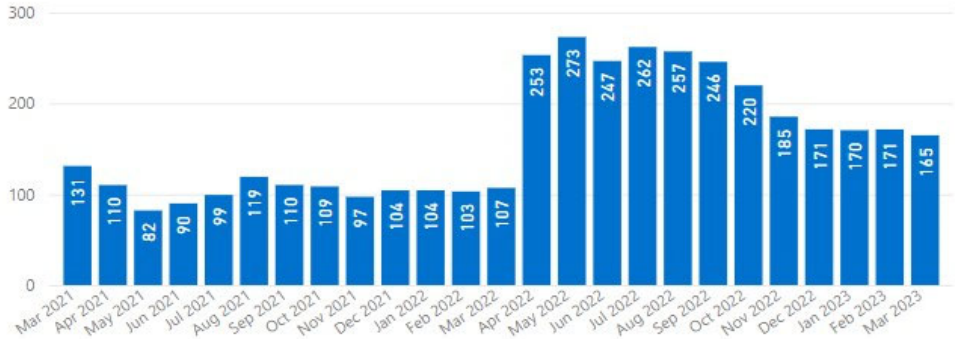
Vacancies - Qualified

99.8 ▼ -9.8

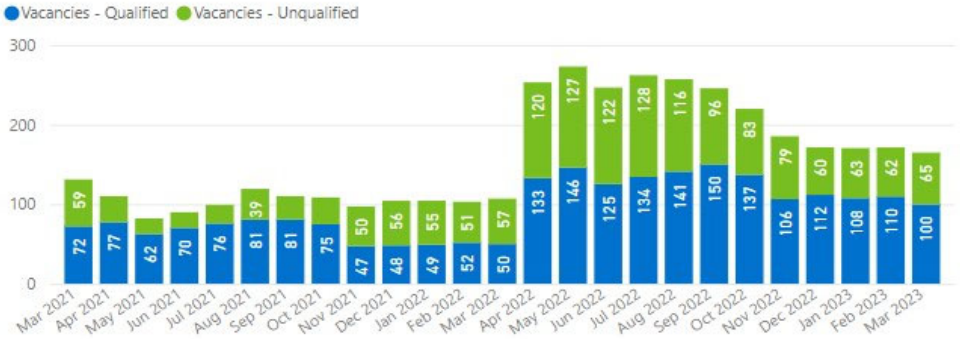
Vacancies - Unqualified

65.1 ▲ 3.3

Vacancies



Vacancies by Staff Group



Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPOW	55.0	-1.4	56.4	
Mar 2023	GDH	11.2	-0.9	12.1	
Mar 2023	SGH	33.6	-7.4	41.0	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Community & Therapies	11.2	-0.9	12.1	
Mar 2023	Family Services	20.9	-4.8	25.8	
Mar 2023	Medicine	45.3	-3.7	49.1	
Mar 2023	Surgery	22.3	-0.3	22.6	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPOW	26.7	3.8	22.9	
Mar 2023	GDH	1.6	-1.0	2.6	
Mar 2023	SGH	36.7	0.4	36.3	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Community & Therapies	1.6	-1.0	2.6	
Mar 2023	Family Services	7.3	0.1	7.2	
Mar 2023	Medicine	44.7	3.4	41.3	
Mar 2023	Surgery	11.4	0.8	10.6	

Vacancies on the inpatient wards in March for Registered Nurses shows a small decrease and Healthcare Assistant vacancies show a slight increase.

There is a total of 189.94 WTE (10.19%) Registered and 99.93 WTE (10.25%) unregistered vacancies across the Trust in March. A total of 87 newly qualified nurses and midwives commenced in post over the autumn/winter, with a further 20 joining the Trust in Q4. Ten international nurses (INs) commenced in post over Q4 with recruitment of an additional 90 by November planned.

The overseas Pre-registration nurses who have joined the Trust continue to progress through their Objective Structured Clinical Examination (OSCE) preparation and induction programme with a 100% OSCE pass rate. Following funding of a business case, substantive posts in the Practice Development team to support OSCE prep and induction have been filled. Availability of suitable training rooms for OSCE prep is a risk and is resulting in additional costs associated with transporting IENs across sites. Alternative external training rooms are being explored.

Recruitment continues for the nursing apprenticeship programmes which have proved to be popular:

- Five started on the RNA – RN Top-up programme at the University of Hull in January 2023
- Nine started on the TNA programme at the University of Lincoln in January 2023
- RNDA programme to commence September at the University of Hull

A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

Recruitment work includes:

- Targeted recruitment campaigns with workforce colleagues – community nursing, Emergency Department (ED), RN & HCA Bank staff for Goole Hospital
- Working with workforce colleagues to diversify the Internationally Educated Nurses (IEN) pipeline and ensure adequate support for ambitions. This includes participating in an ICB led project to recruit IENs from Kerala
- International Midwife recruitment
- Increased engagement with Higher Education Institutions (HEIs) and introduction of newly qualified nurse rotational posts from Sept 2023 – Newly Qualified Nurses (NQN) Open Days and interviews ongoing
- Preceptorship programme reviewed and aligned with Health Education England (HEE) national benchmark and is now a multi-professional policy and induction
- Widening Access Project (National Health Service England- NHSE funding for 12 months) – nurse has been appointed into the Chief Nurse team and work has commenced with the aim of widening the recruitment pipeline by engaging in alternative methods of attracting people from more diverse backgrounds. This includes working with organisations who support people back into work, charities, and local colleges
- Student placement capacity increased from 265,867 hours to 399,090 hours

Retention work includes:

- Ongoing delivery of career clinics, continued development of the nursing career framework and nursing apprenticeships
- Flexible working team rostering pilot with the Resource Centre team (PIU and Stroke Unit DPoW)
- HCA Buddy and Preceptorship programme developed by the Continued Practice Development (CPD) team and is attracting praise from NHSE as an innovative and unique development
- Development of HCA council across sites. Plans in place to develop this into Shared Decision-Making Council
- Legacy mentor project (NHSEI funding) 2023/24 – Legacy Mentor post advertised
- Delivery of the Professional Nurse Advocate (PNA) programme with 35 qualified PNAs
- Targeted work to improve understanding of the benefits of restorative clinical supervision by PNA Lead – compliance has increased from 20-50% over recent months
- International recruitment stay and thrive work
    - Development of a Stay & Thrive Task & Finish Group with IEN membership
    - Development of Team Channel for IENs for the purpose of accessing local social activities, establishing a Buddy system, promoting access to Continued Practice Development (CPD) and religious groups

    - Updated Ward Manager and Staff Guide
    - Preceptorship Workbook pilot
    - IEN experience survey live
    - Welcome/celebration events
    - Preparation of application for NHS Pastoral Care Quality Award for submission in June 2023
- HCA survey developed and distributed to staff on the Bank by the Recruitment Nurse Specialist – 166 responses which has led to the formation of the Bank Staff Forum

2.4.2 Staffing Incidents

The information presented below shows data on inpatient wards only.

Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - C2	2	▲ 1	10	▲ 1
DPOW - C3 Short Stay	0	0	11	▲ 1
SGH - ICU	0	0	6	▲ 1
SGH - Ward 23 Short Stay	2	▲ 2	4	▲ 4
DPOW - Maternity	5	▼ -6	0	0
DPOW - A1	0	▼ -1	3	0
DPOW - Amethyst	0	▼ -1	3	▲ 2
DPOW - C6	2	0	1	▼ -2
DPOW - Laurel	0	0	3	▲ 2
SGH - CDS	3	▲ 3	0	0
SGH - Disney	2	▼ -1	1	0
SGH - Ward 25	2	▲ 2	1	▲ 1
DPOW - B4	1	▲ 1	1	▲ 1
DPOW - Rainforest	2	0	0	0
GDH - GNRC	0	0	2	▲ 1
SGH - NICU SGH	2	▲ 2	0	0
SGH - Ward 24 Assessment Unit	2	▲ 2	0	0
SGH - Ward 27	0	▼ -1	2	0
DPOW - B3	0	0	1	▲ 1
DPOW - B7	0	0	1	0
DPOW - C1 Glover	0	0	1	▼ -1
DPOW - Stroke DPW	0	0	1	▼ -1
SGH - Stroke SGH	0	▼ -6	1	▼ -3
SGH - Ward 16	0	0	1	0
SGH - Ward 17	1	▲ 1	0	0
SGH - Ward 22	0	▼ -1	1	▲ 1
SGH - Ward 26	1	▲ 1	0	0
SGH - Ward 29	1	▲ 1	0	0

28 nurse staffing incidents were reported in March 2023 on the Ulysses system compared to 31 in February 2023.

2.4.3 Red Flags

A total of 55 staffing red flags were reported in March (47 on SafeCare Live and 8 on Ulysses). This is comparable to the 54 reported in February. Some fluctuation is seen month by month.

Red Flags on SafeCare Live

Red Flag type, Ward	No.
Below Safe Staffing Levels	26
C2	5
ICU	4
Ward 23 Short Stay	3
A1	3
C3 Short Stay	3
C1 Glover	1
Ward 16	1
Stroke SGH	1
B3	1
Ward 22	1
B7	1
Amethyst	1
Stroke DPW	1

Red Flag type, Ward	No.
Less than 50% substantive staff on shift	13
C3 Short Stay	5
C2	4
Amethyst	2
Ward 27	1
GNRC	1
Trained Nurse less than 12mths qual left in Charge	3
Laurel	3
Patient Transfer 2200-0600 due to bed pressures	2
Ward 27	1
C3 Short Stay	1
Co-ordinators Non Supernumerary	2
ICU	2
Less than two trained nurses on a Clinical Area	1
GNRC	1
Delay in Medicine Rounds by 1 Hour	1
C3 Short Stay	1
Delay of IV Medication by 1hr x3 Patients	1
C3 Short Stay	1

Red Flags on Ulysses

Red Flag type, Ward	No.
Trained nurse less than 12 months qualified, or still i	2
Ward 23 Short Stay	1
C6	1
Less than 2 trained nurses on a clinical area	2
Discharge Lounge DPW	1
Disney	1
Unplanned Services - 10 or more amber transfers fro	1
Other (SGH)	1
Delay of more than 30 minutes to provide acute pain	1
C2	1
Delay in medicines rounds by 1 hour	1
Ward 25	1
Less than 50% substantive staff on a shift	1
B4	1

Wards C2 and C3 continue to report higher numbers of red flags for safe staffing levels and less than 50% substantive staff on shift. This correlates with high sickness absence and vacancies in these areas and is monitored through the staffing meetings throughout the day and support provided.

3.0 Community Nursing

Activity data not currently available.

Community Nursing Assurance Dashboard — Mar 2023

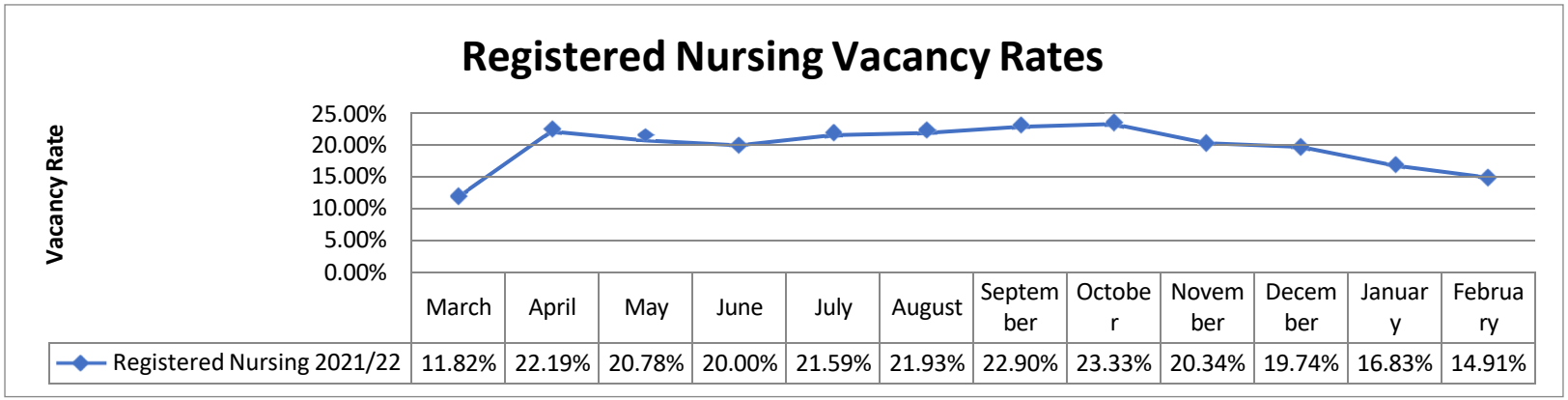
NHS Northern Lincolnshire and Goole NHS Foundation Trust

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	0.0		6.7 ↗			
East Network				1.0 ↗	0.0	9.0 ↗	0.0	0.0	0.0		8.1 ↗			
South Network				1.0 ↗	0.0	12.0 ↘	0.0	0.0	0.0		1.4 ↗			
Unscheduled Care Team (UCT) (incl rapid response)				0.0	0.0	0.0	0.0	0.0			0.6			
Macmillan Health Care Team				0.0	0.0	0.0	0.0	0.0			5.8 ↗			
Specialist Palliative Care Nurses (SPC)				0.0	0.0	0.0	0.0	0.0			2.0			
Palliative Care				0.0	0.0	0.0	0.0	0.0			-1.0 ↘			
Single Point of Access (SPA)				5.0	0.0	0.0	0.0	0.0			3.6			
Continence Team				0.0	1.0 ↗	0.0	0.0	0.0			0.2			
Tissue Viability Team				0.0	0.0	0.0 ↘	0.0	0.0			0.6			
Long Term Conditions / Complex Care Matrons (Comm Matrons)				0.0	0.0	0.0	0.0	0.0			-0.3			
Intermediate Care Services (ICS) + Core Therapy				0.0	0.0	7.0 ↗	0.0	0.0			0.9			
Discharge Liaison Team				0.0	0.0	0.0	0.0	0.0			-1.0			
Locality Co-ordinators				0.0	0.0	0.0	0.0	0.0			-0.3			
Evening / Night Service				0.0	0.0	0.0	0.0	0.0			0.0			
Chronic Wound Team				0.0	0.0	0.0 ↘	0.0	0.0			-0.7			
DN Students				0.0	0.0	0.0	0.0				0.0			
Community Nursing													100.0	40.0 ↗

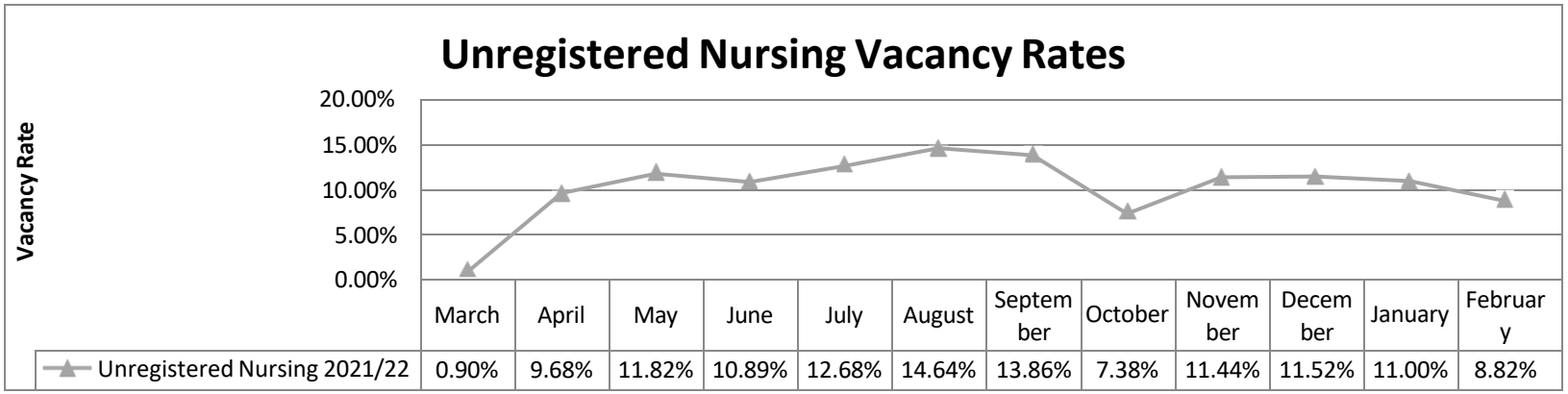
3.1 Safe Staffing

3.1.1 Vacancies

The vacancy rate for both Registered and Unregistered as shown in the graphs below is decreasing with the vacancies for Registered Nurses being the lowest since March 2022.



	March	April	May	June	July	August	September	October	November	December	January	February
Registered Nursing 2021/22	11.82%	22.19%	20.78%	20.00%	21.59%	21.93%	22.90%	23.33%	20.34%	19.74%	16.83%	14.91%



	March	April	May	June	July	August	September	October	November	December	January	February
Unregistered Nursing 2021/22	0.90%	9.68%	11.82%	10.89%	12.68%	14.64%	13.86%	7.38%	11.44%	11.52%	11.00%	8.82%

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.

In the community nursing networks the vacancies are split as below, there have been some changes due to realignment of caseloads. Ongoing recruitment continues for band 5 nurses and discussions with staff about career progression.

STAFF GRADE	OVERALL NETWORK VACANCY
B7	27.5%
B6	13.6%
B5	11.2%
B4	4.8%
B3	0%

EAST NETWORK

	Est WTE	In post	Shortfa	acancy	Due In	Leaver	orecas	acancy %
B7	1	0	1	100%	0	0	1	100%
B6	5	4	1	20%	0	0	1	20%
B5	21.71	11.93	9.78	45%	0.8	1	2.73	13%
B4	6.78	5.8	0.98	14%	0	0	0.98	14%
B3	2.73	4	-1.27	-47%	0	0	0	0%

SOUTH NETWORK

	Est WTE	In post	Shortfa	acancy	Due In	Leaver	orecas	acancy %
B7	2	2	0	0%	0	0	0	0%
B6	4.8	3.8	1	21%	0	0	1	21%
B5	23.71	23.11	6	25%	0	0	0.93	4%
B4	6.78	6.6	0.18	3%	0	0	0	0%
B3	2.73	2.28	0.45	16%	0	0	0.45	16%

WEST NETWORK

	Est WTE	In post	Shortfa	acancy	Due In	Leaver	orecas	acancy %
B7	1	1	0	0%	0	0	0	0%
B6	3.8	3.6	0	0%	0	0	0	0%
B5	22.75	18.8	3.95	17%	0	0	0	0%
B4	6.78	6.73	0.05	1%	0	0	0	0%
B3	2.73	2.73	0	0%	0	0	0	0%

3.1.1 Community Red Flag incidents

The total nursing red flag incidents for March 2023 is eight, three of these relate to shortages in staffing reported by Single Point of Access.

3.2 Activity

There is limited activity information for March 2023 due to the ongoing issues with the data warehousing.

Activity delivered/ not delivered - Community Nursing Networks

Information from the electronic allocation tool shows a slight deterioration in the position of visits deferred from planned date in March 2023. Further work is being undertaken to understand the increase in demand

Visits Allocated March23 (Completed + Deferred)	Visits Completed March 23 (Visits Activity Report)	Visits Deferred/ Cancelled / moved to March 23 (Moved Visits Report)
14352 1423 more visits than Feb 23	12802 Av. 412 daily	1550

3.3 Community Nursing Capacity/demand

What have we done?

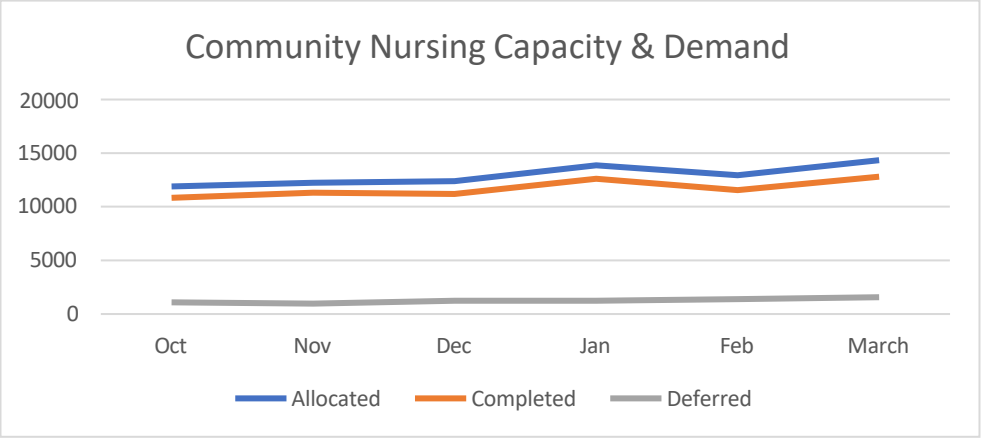
- Demand being more consistently managed within limits of daily capacity to proactively reprioritise visits over 7 days
- Minimum rostered and actual staffing levels being monitored weekly with monthly Associate Chief Nurse (ACN) oversight
- Community Nursing Safer Staffing Tool (CNSST) census week completed w/c 20/03/23, to be completed again in May 2023 due to incomplete datasets

So what?

- Red flags remain static
- Staff feel that workload is being more appropriately allocated
- Reduction in PALs Concern associated with missed visits
- Good patient feedback through 15 steps and leadership engagement

What next?

- Roster approval processes / confirm and challenge & monthly Capacity & Demand performance reviews
- Moving the District Nurses out of the nursing hub to enable oversight and management of caseloads
- QI project to combine District Nursing Hub & Single Point Access into a True SPA with dedicated resource underway
- QI projects to embed virtual consultation and delegation of insulin in dedicated care homes



4.0 Maternity Dashboard and Red Flag Incidents

4.1 Maternity Staffing

The Chief Nurse undertook a desktop review with ward managers at the end of May 2022 and an establishment review using the Birthrate Plus workforce planning tool was undertaken in 2022 and the final report presented to Trust Management Board (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 — **Mar 2023**

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**93.4%**	**▼ -0.1%**	**86.1%**	**▲ 7.2%**	**14.0**	**▲ 1.55**
Registered Nurses and Midwives	89.7%	▼ -2.1%	82.5%	▲ 4.1%	8.6	▲ 0.77
Care Staff	99.9%	▲ 3.5%	92.5%	▲ 12.6%	5.4	▲ 0.77
Central Delivery Suite	**86.9%**	**▼ -8.3%**	**57.1%**	**▼ -5.7%**	**37.2**	**▲ 9.25**
Registered Nurses and Midwives	85.8%	▼ -11.0%	53.2%	▼ -6.4%	30.8	▲ 7.89
Care Staff	92.3%	▲ 3.8%	77.4%	▲ 1.1%	6.5	▲ 1.36
Jasmine & Honeysuckle	**91.0%**	**▲ 1.7%**	**78.1%**	**▲ 6.2%**	**10.5**	**▼ -2.06**
Registered Nurses and Midwives	87.0%	▲ 1.6%	72.1%	▲ 4.5%	6.8	▼ -1.33
Care Staff	99.1%	▲ 2.0%	90.6%	▲ 9.6%	3.7	▼ -0.73
Ward 26 SGH	**86.6%**	**▲ 2.4%**	**62.9%**	**▼ -0.4%**	**7.4**	**▲ 0.59**
Registered Nurses and Midwives	84.1%	▲ 0.6%	65.6%	▼ -0.8%	5.3	▲ 0.31
Care Staff	93.5%	▲ 7.3%	55.4%	▲ 0.6%	2.2	▲ 0.27
Total	**89.7%**	**▼ -1.0%**	**71.7%**	**▲ 1.7%**	**12.6**	**▲ 0.56**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	61.2%	▼ -1.4%
Central Delivery Suite	82.7%	▲ 0.9%
Jasmine & Honeysuckle	64.4%	▼ -0.1%
Ward 26 SGH	70.9%	▼ -1.5%
Total	**69.4%**	**▼ -0.2%**

The fill rate in maternity remains <95% except on Central Delivery Suite. Staffing shortfalls have been experienced across both sites and in the community due to sickness absence and vacancies. Operational staffing meetings are held three times per day with review of issues and escalation of any risks that can't be mitigated, with senior oversight in the 10.00hour safe staffing meeting. Proactive requests for bank staff / agency staff are made as required. Escalation processes and plans are in place with daily oversight from the senior midwifery team.

Recruitment is ongoing and vacancies are reviewed regularly and taken to the weekly establishment review meeting. There is a rolling advert for rotational midwifery posts and international recruitment of midwives has commenced with the support of the regional NHS

England workforce team. The first four international midwives joined the Trust in March 2023.

4.3 Midwife: Birth ratio

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In March 2023 the data for both units is DPOW 1:23.9 and SGH 1:20 which is below the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios. The Midwife to Birth Ratio has throughout the year been below the expected 1:28 for both sites. Neither unit had to close to maintain safety during the month of March 2023. There is a robust escalation policy that is utilised in times of high acuity and there are close links to the Operations team throughout both sites. Maternity services have commenced using the maternity Operational Pressures Escalation Levels (OPEL) status to provide an oversight of their current position. This is provided to the Trust Operational meetings and reported regionally. An increase in fill rates for both sites is seen in March 2023 which is a result of the recruitment of Newly qualified midwifes.

4.4 Maternity Dashboards

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Midwife to Birth Ratio	23.9 ↘	24.9 ↗	24.8 ↘	26.5 ↗	26.5	25.6 ↘	25.5 ↘	23.3 ↘	24.8 ↗	25.4 ↗	24.3 ↘	23.9 ↘
Red Flags	11.0 ↗	2.0 ↘	2.0	7.0 ↗	9.0 ↗	5.0 ↘	3.0 ↘	3.0	2.0 ↘	2.0	1.0 ↘	1.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0 ↘	0.0	1.0 ↗	2.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘	0.0	0.0	0.0	1.0 ↗
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	2.0 ↗	2.0	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	1.0 ↗	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	2.0	0.0 ↘	1.0 ↗	2.0 ↗	4.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	9.0 ↗	1.0 ↘	0.0 ↘	0.0	2.0 ↗	2.0	2.0	1.0 ↘	1.0	1.0	0.0 ↘	0.0
Continuity of Carer %	20.0 ↗	21.0 ↗	21.0	23.0 ↗	24.0 ↗	24.0	25.0 ↗					
In Receipt of %	14.0 ↗	10.0 ↘	15.0 ↗	13.0 ↘	14.0 ↗	15.0 ↗	15.0					
CoC In Receipt of %	82.0 ↗	79.0 ↘	72.0 ↘	89.0 ↗	72.0 ↘	68.0 ↘	66.0 ↘					
Continuity Team Caseload	347.0 ↗	314.0 ↘	314.0	305.0 ↘	305.0	295.0 ↘	311.0 ↗					
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	94.0 ↘	91.5 ↘	92.2 ↗	86.0 ↘	86.0	89.0 ↗	89.5 ↗	97.9 ↗	91.9 ↘	89.9 ↘	91.6 ↗	93.3 ↗
Labour Co-ordinator Supernumerary Status %	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	19.3 ↗	19.4 ↗	19.1 ↘	20.2 ↗	20.3 ↗	26.3 ↗	20.7 ↘	20.5 ↘	20.1 ↘	22.4 ↗	21.3 ↘	19.4 ↘
Vacancies - Registered	16.4 ↗	17.4 ↗	17.5 ↗	17.7 ↗	17.8 ↗	19.5 ↗	19.1 ↘	16.1 ↘	16.2 ↗	17.9 ↗	18.0 ↗	16.5 ↘
Vacancies - Unregistered	2.9 ↗	2.1 ↘	1.5 ↘	2.5 ↗	2.5	6.8 ↗	1.5 ↘	4.4 ↗	3.9 ↘	4.5 ↗	3.3 ↘	2.8 ↘
Serious Incidents	0.0 ↘	0.0	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	0.0
Complaints	2.0 ↗	1.0 ↘	1.0	2.0 ↗	1.0 ↘	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	1.0 ↗	1.0
PALS	3.0 ↗	4.0 ↗	3.0 ↘	1.0 ↘	5.0 ↗	2.0 ↘	2.0	3.0 ↗	2.0 ↘	2.0	2.0	2.0

SGH Maternity Dashboard

Indicator	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Midwife to Birth Ratio	26.4	25.3	25.5	25.8	25.8	26.0	23.8	22.4	23.4	21.6	22.1	20.2
Red Flags	19.0	22.0	15.0	27.0	6.0	4.0	14.0	6.0	14.0			2.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	2.0	0.0	1.0	5.0	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	2.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	1.0	11.0	5.0	11.0	1.0	2.0	5.0	2.0	9.0	0.0	0.0	1.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	15.0	9.0	7.0	10.0	4.0	1.0	9.0	2.0	4.0	0.0	0.0	0.0
Continuity of Carer %	18.0	20.0	13.0									
In Receipt of %	6.0	6.0	5.0	3.0								
CoC In Receipt of %	44.0	50.0	30.0	33.0								
Continuity Team Caseload	177.0	174.0	174.0	0.0	0.0	0.0	0.0					
Divert / Unit Closures	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	80.2	83.3	82.7	81.4	81.4	80.9	88.3	94.0	89.8	97.5	93.2	102.4
Labour Co-ordinator Supernumerary Status %	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	98.9	100.0
Vacancies	27.9	28.5	25.1	24.9	25.5	26.1	21.5	21.2	21.0	20.6	20.4	15.0
Vacancies - Registered	22.3	23.5	21.9	22.7	23.4	23.2	21.3	18.9	19.0	19.0	19.3	13.9
Vacancies - Unregistered	5.6	5.0	3.2	2.2	2.0	2.8	0.3	2.3	2.1	1.6	1.1	1.1
Serious Incidents	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
Complaints	0.0	0.0	2.0	0.0	2.0	1.0	3.0	1.0	0.0	1.0	1.0	0.0
PALS	2.0	2.0	1.0	0.0	1.0	3.0	3.0	1.0	1.0	1.0	1.0	0.0

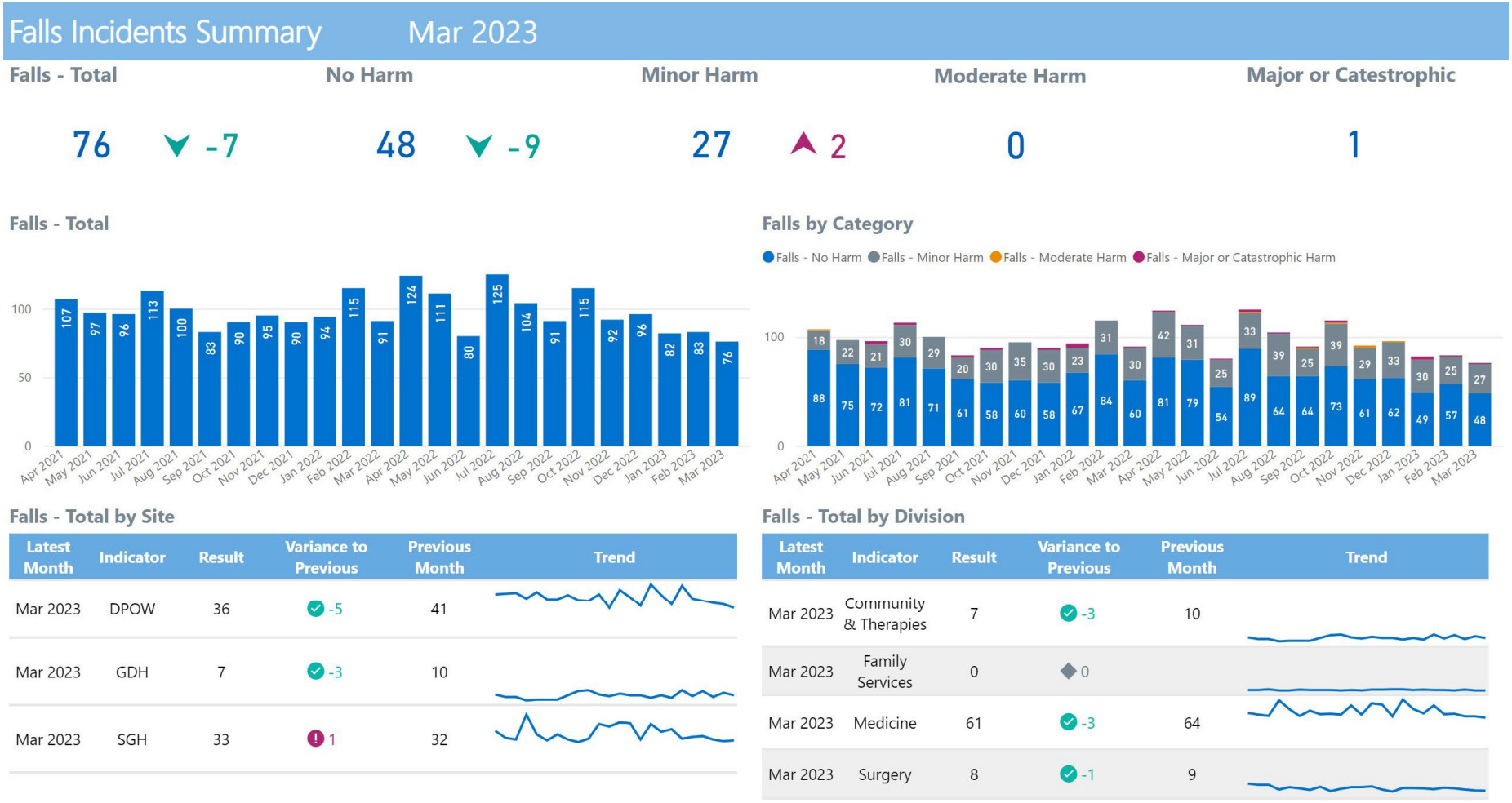
Trustwide Maternity Dashboard

Indicator	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Midwife to Birth Ratio	24.9	25.1	25.0	26.2	26.2	25.8	24.8	22.9	24.2	23.7	23.4	22.2
Red Flags	30.0	24.0	18.0	34.0	16.0	9.0	17.0	9.0	19.0	3.0	1.0	3.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	2.0	1.0	1.0	5.0	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	2.0	3.0	2.0	2.0	1.0	1.0	0.0	3.0	1.0	0.0	2.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	2.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	2.0	2.0	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	1.0	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	11.0	6.0	13.0	5.0	4.0	5.0	3.0	9.0	1.0	1.0	1.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	24.0	10.0	8.0	10.0	6.0	3.0	11.0	3.0	5.0	1.0	0.0	0.0
Continuity of Carer %	19.0	20.0	18.0	12.0	12.0	12.0	14.0					
In Receipt of %	11.0	8.0	11.0	9.0	8.0	9.0	8.0					
CoC In Receipt of %	69.0	68.0	58.0	70.0	72.0	68.0	66.0					
Continuity Team Caseload	524.0	488.0	488.0	305.0	305.0	295.0	311.0					
Divert / Unit Closures	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	88.1	88.0	88.1	84.1	84.1	85.5	89.0	96.2	91.0	93.1	92.3	97.2
Labour Co-ordinator Supernumerary Status %	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	99.5	100.0
Vacancies	46.6	47.3	43.5	44.5	45.2	51.7	41.6	41.1	40.4	42.2	41.7	34.4
Vacancies - Registered	38.1	40.3	38.8	39.8	40.6	42.2	39.8	34.4	34.4	36.0	37.3	30.5
Vacancies - Unregistered	8.5	7.0	4.7	4.7	4.6	9.6	1.8	6.7	6.0	6.1	4.4	3.9
Serious Incidents	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0
Complaints	2.0	1.0	3.0	2.0	3.0	1.0	3.0	2.0	0.0	1.0	2.0	1.0
PALS	5.0	6.0	5.0	1.0	6.0	5.0	6.0	4.0	3.0	3.0	3.0	3.0
Sickness Absence (Division) %	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.



Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPOW	36	-5	41	
Mar 2023	GDH	7	-3	10	
Mar 2023	SGH	33	1	32	

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Community & Therapies	7	-3	10	
Mar 2023	Family Services	0	0		
Mar 2023	Medicine	61	-3	64	
Mar 2023	Surgery	8	-1	9	

The total number of falls reported in March 2023 has decreased for the fifth consecutive month.

There was one fall reported with severe harm in March 2023. The fall occurred on the Neuro Rehabilitation Ward at GOOLE. The huddle identified no lapses in care and a de-log of the serious incident was supported by the ICB. The huddle was completed within one working day of the incident.

5.2 Falls per 1,000 Bed Days

The falls per 1000 bed days across the Trust has decreased in March 2023.

Falls per 1,000 Bed Days Summary Mar 2023

Falls per 1,000 bed days

3.6 ▼ -0.7

Falls per 1,000 Bed Days

Falls per 1,000 Bed Days by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPOW	3.3	-0.8	4.2	
Mar 2023	GDH	6.7	-2.4	9.0	
Mar 2023	SGH	3.6	-0.2	3.9	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Community & Therapies	6.7	-2.4	9.0	
Mar 2023	Family Services	0.0	0.0		
Mar 2023	Medicine	5.0	-0.8	5.8	
Mar 2023	Surgery	1.5	-0.3	1.8	

5.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents **Mar 2023**

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
SGH - Ward 16	5	▲ 2	3	▲ 1	0	0	0	0	8	▲ 3
DPOW - A1	5	▲ 4	2	▲ 2	0	0	0	0	7	▲ 6
SGH - Stroke SGH	2	▲ 1	4	▲ 3	0	0	0	0	6	▲ 4
DPOW - Amethyst	4	0	1	▲ 1	0	0	0	0	5	▲ 1
DPOW - Stroke DPW	4	▲ 2	1	▼ -1	0	0	0	0	5	▲ 1
GDH - Ward 3	2	▼ -1	3	▲ 2	0	0	0	0	5	▲ 1

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
DPOW - A1	12.5	▲ 10.5
SGH - Ward 16	11.3	▲ 3.4
SGH - Stroke SGH	10.5	▲ 6.9
GDH - Ward 3	9.9	▲ 1.4
GDH - Ward 6	8.9	▼ -2.3

Ward 16 at Scunthorpe and the Stroke Unit at Grimsby have triggered as higher reporting wards for the second consecutive month.

None of the higher reporting wards are demonstrating any trends at present.

The areas detailed above will be reviewed alongside other metrics at the Nursing Metrics Panel.

6.0 Quality – Pressure Ulcers

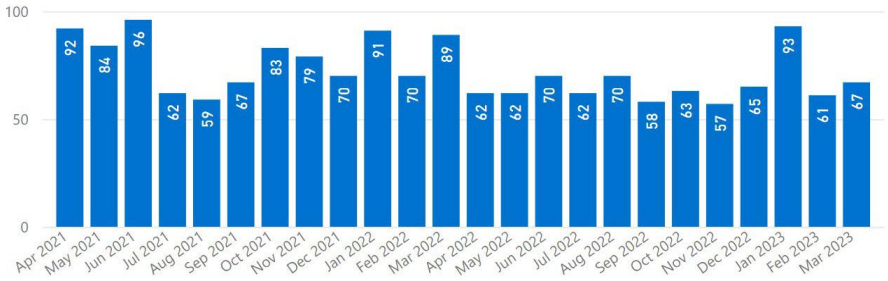
6.1 Hospital Acquired Pressure Ulcer Incidents

The data includes hospital acquired category 2,3,4 and unstageable pressure ulcers and is the standard throughout the report. Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

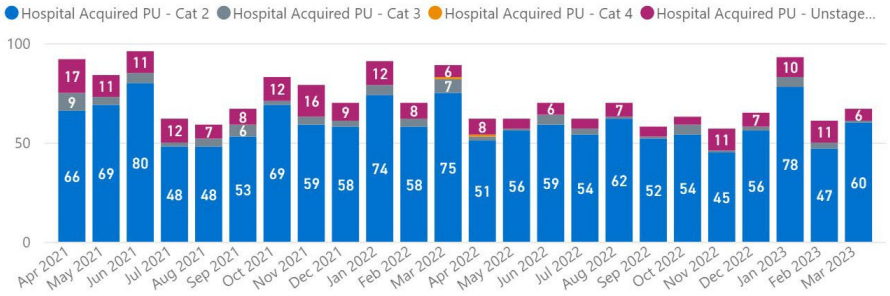
Hospital Acquired PU Incidents Summary — Mar 2023

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
67 ▲ 6	60 ▲ 13	1 ▼ -2	0	6 ▼ -5

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
Mar 2023	DPOW	39	◆ 0	39	
Mar 2023	GDH	2	▼ -3	5	
Mar 2023	SGH	26	▲ 9	17	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Community & Therapies	2	▼ -3	5	
Mar 2023	Family Services	1	▲ 1		
Mar 2023	Medicine	41	▲ 3	38	
Mar 2023	Surgery	23	▲ 5	18	

The number of pressure ulcer incidents reported in March 2023 has increased slightly. There is an increase in the number of reported Category 2 pressure ulcers and a decrease in the numbers of reported Category 3 and unstageable pressure ulcers. This would indicate that appropriate measures have been implemented to prevent deterioration.

Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers.

There has been an increase in the number of reported pressure ulcers at the Scunthorpe site.

In February 2023, there was one hospital acquired category 4 pressure ulcer reported which occurred on the Stroke Unit at Scunthorpe and was identified on discharge. The investigation identified that the Category 4 pressure ulcer was incorrectly validated, and the pressure ulcer was unstageable and not Category 4. The incident report and dashboard have been updated.

6.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

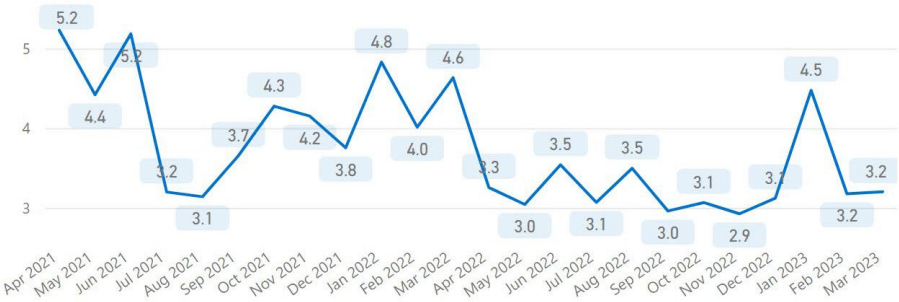
The incidence of reported pressure ulcers per 1000 occupied bed days has remained static in March 2023 and remains higher at the Grimsby site.

Hospital Acquired PU per 1,000 Bed Days Summary — Mar 2023

PU per 1,000 bed days

3.2 ▲ 0.0

PU per 1,000 Bed Days



PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2023	DPOW	3.6	▼ -0.4	4.0	
Mar 2023	GDH	1.9	▼ -2.6	4.5	
Mar 2023	SGH	2.9	▲ 0.8	2.0	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2023	Community & Therapies	1.9	▼ -2.6	4.5	
Mar 2023	Family Services	0.4	▲ 0.4		
Mar 2023	Medicine	3.4	▼ -0.1	3.5	
Mar 2023	Surgery	4.3	▲ 0.8	3.6	

6.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents **Mar 2023**

Indicator	Hospital Acquired PU - Cat 2		Hospital Acquired PU - Cat 3		Hospital Acquired PU - Cat 4		Hospital Acquired PU - Unstageable		Hospital Acquired PU - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
SGH - Ward 22	7	▲ 6	1	▲ 1	0	0	1	▲ 1	9	▲ 8
DPOW - B3	7	▲ 6	0	0	0	0	1	0	8	▲ 6
DPOW - B7	4	▲ 3	0	0	0	0	0	0	4	▲ 3
DPOW - C1 Glover	4	▼ -2	0	0	0	0	0	0	4	▼ -2
DPOW - C5	4	▲ 3	0	0	0	0	0	0	4	▲ 3
DPOW - C6	2	▲ 2	0	0	0	0	2	▲ 2	4	▲ 4

Highest Reporting Wards - PU per 1,000 Bed Days

Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
DPOW - ITU	12.7	▼ -14.3
SGH - Ward 22	11.1	▲ 9.8
DPOW - HDU	10.9	▲ 10.9
DPOW - B3	10.2	▲ 7.3
SGH - ICU	9.0	▲ 4.0

Ward C1Glover has triggered as higher reporting wards for the third consecutive month, however the number of reported pressure ulcers has decreased in March 2023.

None of the other higher reporting wards are currently demonstrating any concerning trends. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

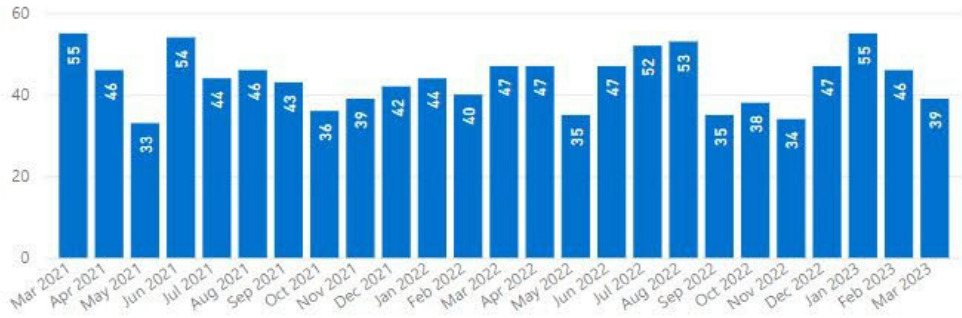
6.5 Community (Acquired on Caseload) Pressure Ulcer Incidents

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.

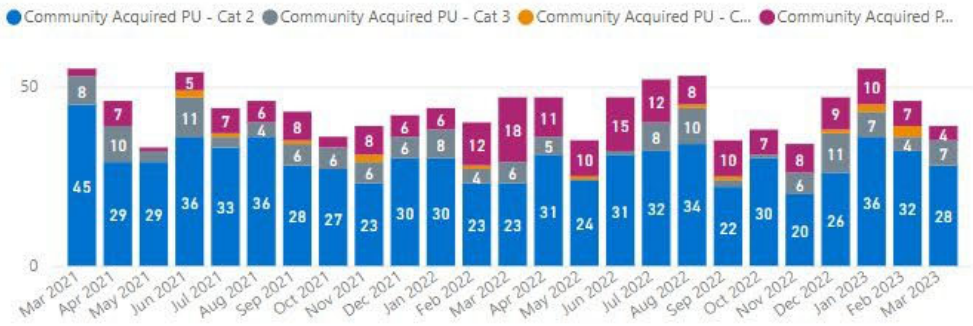
Community (Acquired on Caseload) PU Incidents Summary Mar 2023

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
39 ▼ -7	28 ▼ -4	7 ▲ 3	0 ▼ -3	4 ▼ -3

PU Acquired on Caseload - Total



PU Acquired on Caseload by Category



PU Acquired on Caseload by Team Mar 2023

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
South Network	8	2	0	2	**12**
West Network	8	2	0	1	**11**
East Network	7	1	0	1	**9**
Intermediate Care Services (ICS) + Core Therapy	5	2	0	0	**7**
Total	**28**	**7**	**0**	**4**	**39**

The incidence of pressure ulcers acquired on caseload has seen a further decrease in March 2023.

There have been a higher number of pressure ulcers reported in South and West Networks which is reflective of the size of the caseloads, as below:

Network	Caseload size- March 2023	Average daily visits March 2023	Percentage of pressure ulcers developed on caseload
South	596	175	30%
West	541	139	28%
East	431	110	23%

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.

All moderate harm pressure ulcers for March 2023 have been reviewed at the Community and Therapy Weekly Pressure Ulcer Meeting with one case escalated as a Serious Incident (SI). This case was a category 3 pressure ulcer developed on caseload in West Network. The lapse in care was a delay in timely assessment leading to a delay in the upgrading of specialist pressure relieving equipment. We continue to work on the allocation of timely visits with daily oversight from the electronic tool coordinators and a weekly review of staffing and visit allocation by the Head of Nursing, Matrons, Team Leaders and District Nurses. As part of further quality improvement work the District Nurses have been moved away from the nursing hub to having oversight of their caseloads.

There have been no category 4 pressure ulcers.

A review of the networks and place of residence for patients who developed a moderate harm pressure ulcer for March is as below with no evidence of themes in relation to care homes.

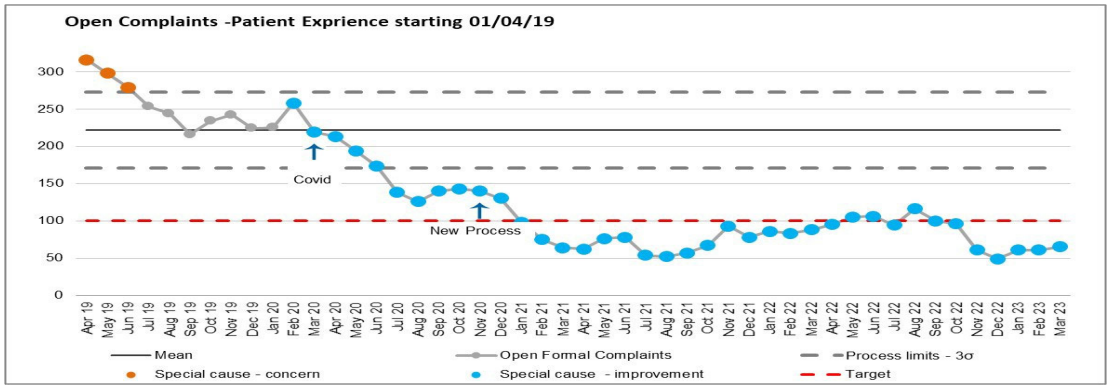
Pressure Ulcer	Developed in patients own home/network	Developed in residential/care home setting (name if known)
Category 3	**2 South Network** **1 West Network**	**1 East Network** Abbey Village Care Home **1 West Network (escalated as SI)** Ascot House **2 Intermediate Care Services** 1 Sir John Mason House 1 The Grange
Category 4	**0**	**0**
Unstageable	**1 West Network**	**1 East Network** 1 Clarence House Nursing Home **2 South Network** 1 at Sycamore 1 at Randolph House

What are we doing?

- Weekly review of all moderate harm pressure ulcers leading to immediate actions being undertaken
- Improvement opportunity identified in relation to risk assessment for pressure damage and BRADEN has been implemented with training having been completed.
- Increased education and training with dates scheduled for 2023 to ensure staff have received an update on pressure area management.
- Weekly safe staffing review using a template based on the National CNSST. The weekly review focuses on the number of visits planned for the following week, a review of staffing and whether the capacity can meet the demand with actions taken to review staffing or move visits to where there is capacity.
- District Nurses released from the nursing hub back to caseload management and oversight.

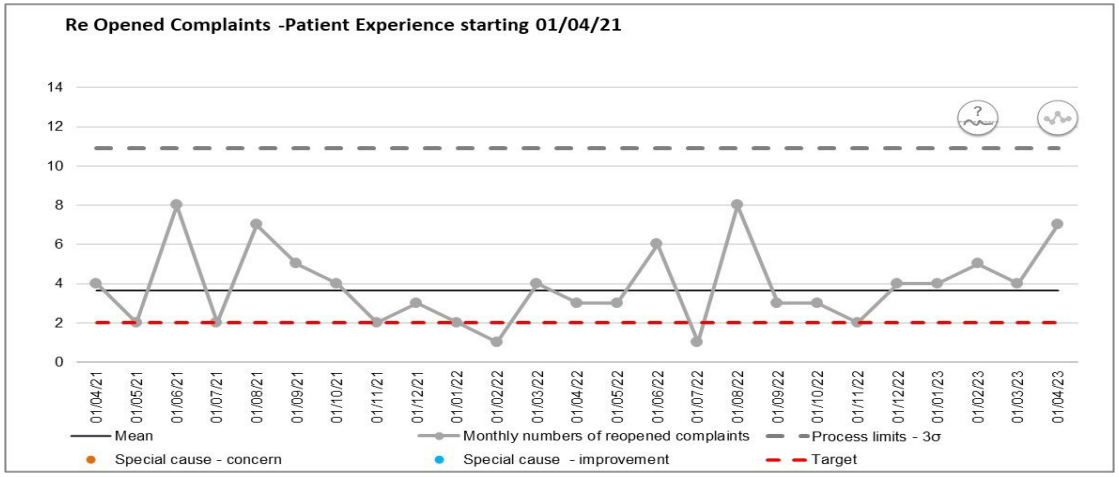
7.0 Patient Experience

New formal complaint numbers were 24 for the month of March. At the end of March, the number of open complaints remains low at 65 and this can be seen in graph A below. Numbers remain below the internally set target of 100.



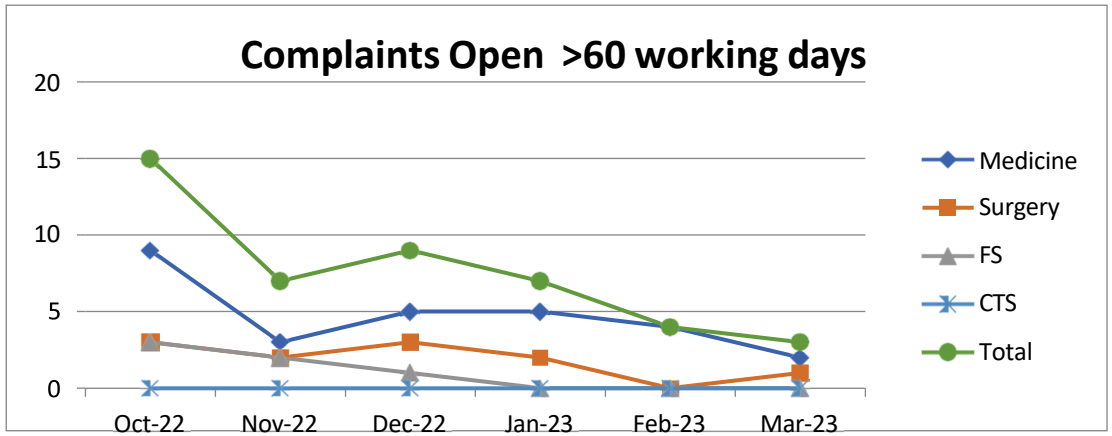
Graph A

There were 7 reopened complaints in March, as seen in graph B. Monthly review continues and the majority of these were classed as unavoidable as their initial response generated new questions which were not raised in their original narrative.



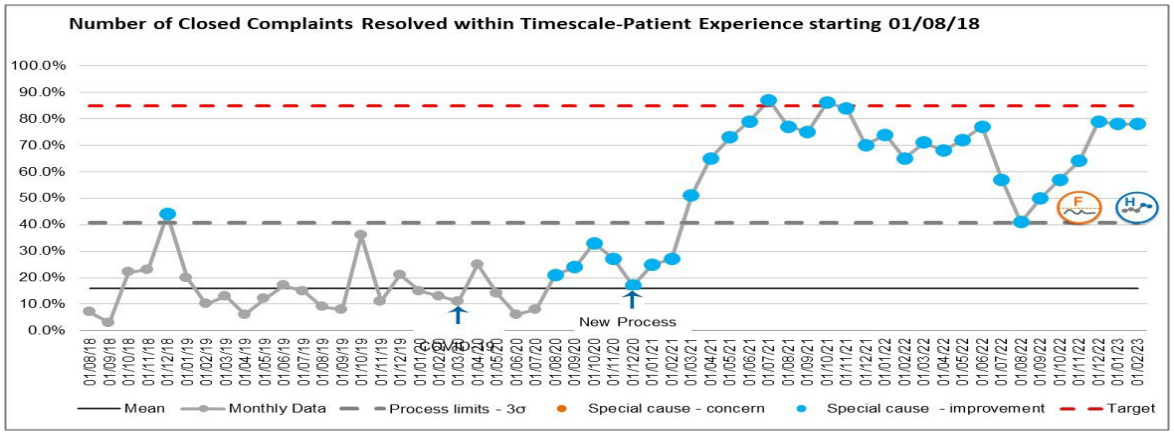
Graph B

Open complaints over 60 working days continued to be low at the time of reporting in March, with only 3 being over timescale, as seen in graph C:



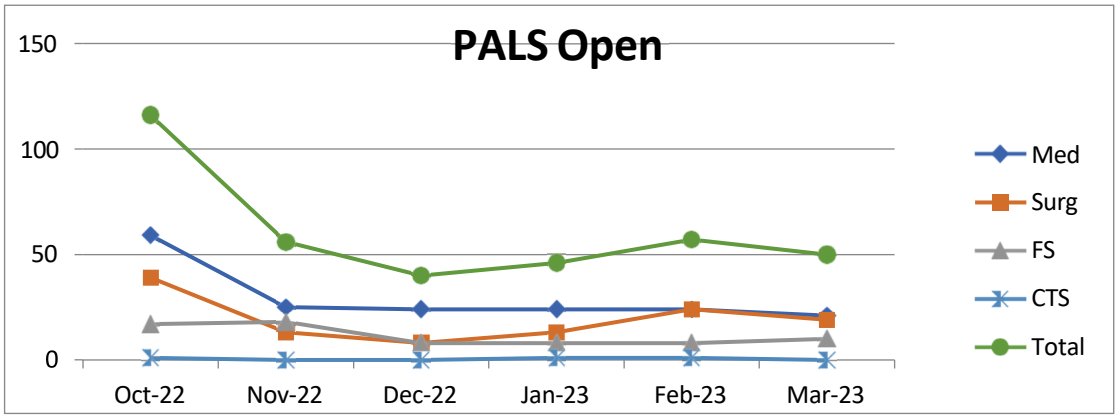
Graph C

In March 26 complaints were closed, with an achieved KPI of 86% of those closed being within timescale, as seen in graph D. Monitoring of delays continues for learning and improvement.



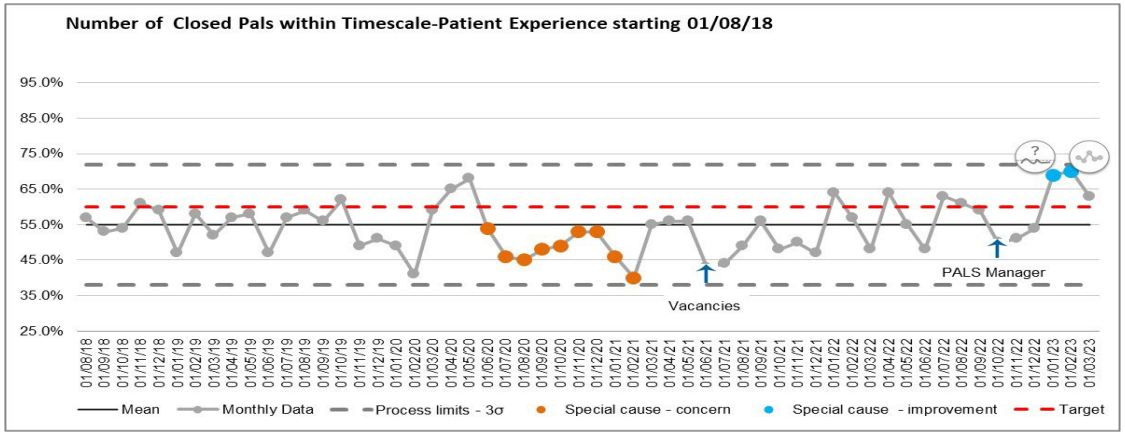
Graph D

Trust wide the number of new PALS concerns received remained in line with February at 187. Open PALS continued to maintain a low number of 50, as seen below in Graph E. The role of the temporary PALS Manager finished at the end of March and there is concern that the loss of this oversight will have an impact on the positive position. This has been mitigated by daily oversight being taken by the temporary Patient Experience Manager. All implemented improvements will be continued; however, the Patient Experience Manager role remains temporary pending business case outcome.



Graph E

A total of 199 PALs concerns were closed in March. The KPI of 63% of PALs closed in timescale was achieved for a third month, although a slight decrease on the previous two months, and this can be seen in graph F below.



Graph F

March saw a total of 87 compliments logged, 83 were logged via the new system on Ulysses. The national platform, Care Opinion, also recorded 4 compliments which are shared with teams when it is possible, and our Communication Team share this positivity via varying platforms.

I can't praise the staff on PIU at Scunthorpe enough. Such a lovely group of staff. They can't do enough for you & have plenty of time for you too. Thank you for making me feel so at ease.

March saw Friends Family Test (FFT) numbers increase for a second month, this is directly linked to the staff engagement being undertaken by the temporary Patient Experience Manager. A divisional report has been circulated and has had positive feedback, giving enhanced monthly oversight. Provider procurement has commenced, and divisional feedback has been included in this process.

Performance Over Filtered Date Range	
% Positive	85.51%
% Negative	8.24%
Average 5 Star Score (all questions)	4.61
Review Count	1,360

A Good Experience, the Integrated Care System (ICS) patient experience project to develop an encompassing patient experience charter continues to make progress. Governors and patient representatives from the 4 provider trusts are now actively participating in the project as understanding of what is already know about what matters to patients is explored. The work undertaken to date will be shared nationally during Experience of Care Week in April.

8.0 Mixed Sex Breaches

In March the Trust declared one mix sex breach on Intensive Therapy Unit (ITU) which involved two patients who were not fit for the ward. One action plan was commenced which contained the actions for all patients affected.

Site	Speciality	Date	Sex	No. that occurred	Reason
DPOW	ITU	19/03/23	F	1	Patient flow- unable to support step down- escalated at the time- Gold aware
DPOW	ITU	19/03/23	M	**0**	Patient flow- unable to support step down- escalated at the time- Gold aware
DPOW	ITU	19/03/23	M	**0**	Patient flow- unable to support step down- escalated at the time- Gold aware

9.0 15 steps Challenge

Eight acute 15 Steps Challenge visits were completed throughout March 2023. The rating for Ward 27 is not comparable to previous visits due to the change in environment, also important to note escalation beds utilised within this area. Main Outpatients Department at Goole District Hospital (GDH) achieved their 3rd consecutive Outstanding rating.

Acute 15 Steps Challenge Visits				
Date	**Area**	**Rating**	**Rating**	**Most Recent Rating**
02/03/2023	Ward 24	23/06/2021	15/02/2022	02/03/2023
08/03/2023	Ward 27	12/08/2021	09/02/2022	08/03/2023
09/03/2023	Therapies DPOW	N/A	N/A	09/03/2023
22/03/2023	Ward B3	21/09/2021	22/03/2022	22/03/2023
28/03/2023	Theatres DPOW	23/11/2021	24/05/2022	28/03/2023
29/03/2023	Ophthalmology GDH	N/A	25/01/2022	29/03/2023
29/03/2023	Maternity Services, GDH	N/A	25/01/2022	29/03/2023
29/03/2023	Main OPD GDH	2019/2020	16/03/2022	29/03/2023

Themes for areas of consideration/ action within the acute schedule

Standards	Themes	Actions
Standard 1: Observation	• Medications left in unlocked rooms, storage areas	• Storage areas repurposed • Safe and Secure principles revisited with staff • Ward Assurance Tool (WAT) compliance and themes monitored
	• Overuse of Gloves	• Infection Control & Prevention (IPC) support requested • Education re: correct use of gloves and handwashing delivered to staff
	• Non - compliance with Uniform (wearing necklaces, hooped earrings, nail polish) in clinical areas while providing direct patient care	• Staff reminded of the uniform policy and guidance with regards to jewellery and nail polish • Spot checks completed by Manager and Deputy
	• Expected Date of Discharge (EDD) not complete on Web V	• QI project starting to look at how this can be improved on first clinical consultation
	• Poor Meal Service	• Re-visit protected mealtimes on ward areas and the importance of a quality mealtime service for patients • Shared theme in Quality Times and Senior Leadership Slides
Standard 2: Documentation	• Malnutrition Universal Screening Tool (MUST) outstanding • Weight not present on Electronic Prescribing Medicine Administration (EPMA)	• Daily review of MUST required by shift lead • Weight to be updated on EPMA when Malnutrition Universal Screening Tool (MUST) recorded on admission/ weekly
	• Movement charts not reflective of patients care plan and risk	• WebV icon to be used to identify patient's risk • WAT to be consistently completed by Ward Managers and themes fed back to the staff • Stop & Check to identify patients from WebV as RED RISK
	• Falls Care plans not consistently completed for patients at risk of falls	• Falls documentation audit completed • All patients at risk of falls to have care plan completed and checked on transfer – staff made aware and education on falls documentation revisited.

Standard 3:	• Patient not aware of EDD or plan for going home	• QI project starting to look at how this can be improved on first clinical consultation (IAAU) and ensuring early communication to patient re: length of stay
Patient Feedback		
Standard 4: Staff Feedback	• Staff unaware of Chief Nurse Future 5	• Relevant posters displayed across wards and departments • Managers and team leads talking to staff about how the future 5 affect them and their individual priorities

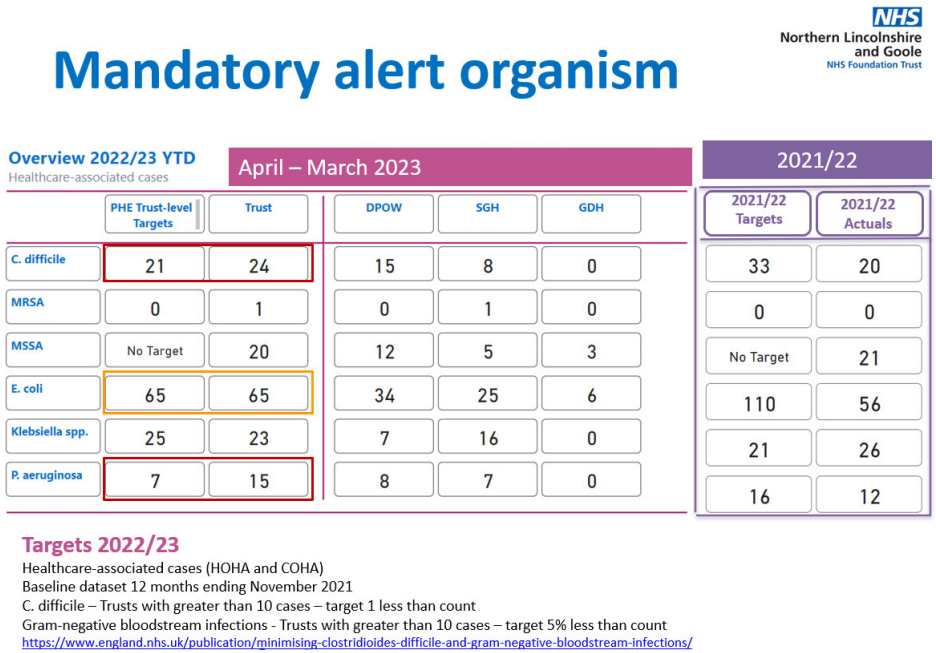
Themes for areas of consideration/ action within the community and therapy schedule will be reported quarterly due to number of visits

Standard	Themes	Actions
Standard 1: Observation	• SMT leadership structure and photos not displayed	• SMT leadership structure and photo's post to be displayed in Main Dept
Standard 2: Documentation	Minimal themes of concern raised	
Standard 3: Patient Feedback	• Appointment letters do not give clear information for patients on where to attend at the ironstone building	• Check all letters contain clear information on where to go at Ironstone
Standard 4: Staff Feedback	Minimal themes of concern raised	

10.0 Infection, Prevention & Control

The 2022 – 2023 Infection Prevention and Control (IPC) focus was to continue close working with colleagues such as hotel services, procurement, estates, operational teams, laboratory, and divisions to ensure robust systems for managing and monitoring the prevention and control of infections. Priority was given to safely manage the continuous Severe Acute Respiratory Syndrome (SARS) CoV-2 variants, a predicted challenging early and long winter of high numbers of patients with other respiratory illnesses mainly flu and bronchiolitis, complicated by numerous patients with dual viruses. Norovirus (diarrhoea and vomiting bug) also presented with high community prevalence and effected several wards in our hospitals (it being the largest outbreak nationally for over a decade). Screening and monitoring of patients along with additional mitigating actions in line with the Hierarchy of Controls, including maximising isolation facilities using Redirooms (portable pods) and High Efficiency Particulate Absorbing (HEPA) filters – mobile air purification units, ensured as safe as possible management of patients and low bed closures.

The IPC Team managed 'business as usual' with achievement of the delivery of the annual education programme to all staff, mandatory national and locally agreed surveillance programme, and audit programme – focusing on the environment, transmission-based precautions, Personal Protective Equipment (PPE) and Hand Hygiene practice, invasive devices, and antimicrobial stewardship.



Mandatory alert organism

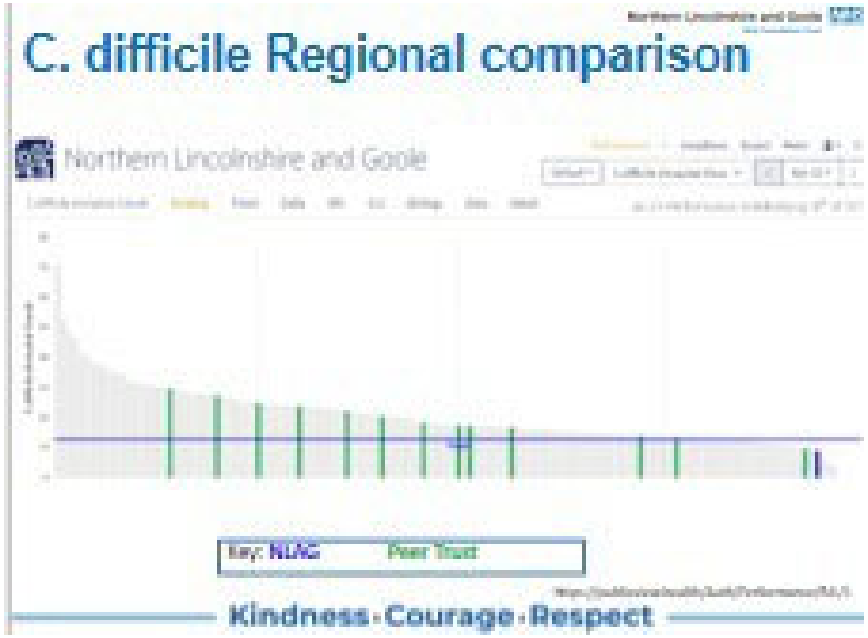
NHS Northern Lincolnshire and Goole NHS Foundation Trust

Overview 2022/23 YTD Healthcare-associated cases	April – March 2023					2021/22	
	PHE Trust-level Targets	Trust	DPOW	SGH	GDH	2021/22 Targets	2021/22 Actuals
C. difficile	21	24	15	8	0	33	20
MRSA	0	1	0	1	0	0	0
MSSA	No Target	20	12	5	3	No Target	21
E. coli	65	65	34	25	6	110	56
Klebsiella spp.	25	23	7	16	0	21	26
P. aeruginosa	7	15	8	7	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/

Mandatory alert organisms - Due to success of considerable reduction of cases in previous years, the trajectory for the year 2022 - 2023 of 21 cases was extremely challenging. The Trust had a Clostridioides difficile infection (CDI) objective of no more than 21 cases and ended the year on 24 reported cases combining Hospital-onset healthcare associated and Community-onset healthcare associated cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. Despite exceeding the threshold, The Trust performed very well for CDI rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.



The Trust reported a MRSA Bacteraemia case in March 2023 after having no case for over 26 months, A post infection review of the case is in progress, 20 MSSA bacteraemia cases – a reduction by one case from the previous year. The Trust has performed well with the other reportable bacteraemia cases although exceeded the objective with Pseudomonas aeruginosa with no identified trend, stayed within the threshold for Klebsiella and E Coli, with a reduction of 3 cases of Klebsiella from the previous year.

Surgical Site Infections - It is a requirement that each trust should conduct surveillance for at least one orthopaedic category for one period (3 months) in the financial year. The categories are: Primary Total Hip Replacement and Primary Total Knee Replacement. The Infection Prevention and Control team undertake continuous surveillance and report on the full year. Good performance by the Trust showed there has been no surgical site infections detected in 2022 – 2023. The Trust is awaiting the details of the 2023-24 Mandatory Alert Organisms Case Thresholds. The Infection Prevention Control Committee (IPCC) 2 Year Strategy Plan is being formulated.

DRAFT Infec?on Preven?on and Control Strategy 2023 - 2025

The IPC plan has been based on The WHO recommenda?ons for affec?ve IPC programme. It also covers the CQC key lines of enquiry Regula?on 12 (safe care and treatment) and Regula?on 15 (premises and equipment).

Infec?on Preven?on and Control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. It is acknowledged there is an element of mul?modal coopera?on, adequate environment and resources to make this a success.

The 5 Priori?es are:-

1. **We will support clinical staff in the best prac?ce management of alert organisms.**
2. **We will con?nue to support clinical leads and link staff to proac?vely manage their areas.**
3. **We will ensure the clinical environment is fit for purpose.**
4. **We will con?nue to work with clinical colleagues to provide them with evidence to support their areas.**
5. **We will share and improve our understanding on reducing risks of infec?on.**

Infec?on Preven?on and Control 5 Priori?es 202-32025

1. Surveillance of alert organisms
Surveillance systems in place to detect trends and ac?on devia?ons
Outbreak monitoring and share lessons across the Trust
Informa?on is available for divisions to inform prac?ce and interven?ons
Systems in place (Power BI) to produce IPC reports
IPC data reviewed and challenged at Nursing Metric Board
Benchmark informa?on with colleagues/partners

2. IPC best prac?ce
Appropriately manage pa?ents with suspected/confirmed or risk infec?ons in line with IPC Manual for England
U?lise Point Prevalence Surveillance and feedback to improve prac?ce
Assist with an?microbial stewardship monitoring to improve lower risk agents usage
Monitor orthopaedic implant standards using high impact interven?ons
Review appropriate interven?ons as part of Gram Nega?ve plan

3. Na?onal standards including built environment
Ensure comply with relevant standards e.g. CQC hygiene code
Monitor standards in collabora?on with clinical colleagues e.g. cleanliness
Ensure mi?ga?ons ac?ons in place to maximise isola?on facili?es and reduce ?transmission of infec?ons e.g. Redirooms, HEPA filters

4. Knowledge workforce
Develop and update training packages in line with NHS England Skills for Health, Infec?on Preven?on and Control 2023.
Further develop Link Network and review educa?onal resources
Support IPCN's to undertake QSIR course and development opportuni?es

5. Surgical site infec?on
Surveillance systems in place to meet Public Health England requirement
Explore feasibility of audi?ng another surgical procedure

Kindness · Courage · Respect

11.0 Quality Improvement

March/April 2023 saw 11 staff from within the Trust and 1 ICB member of staff completing the Leading & Coaching QI course offered within the Trust. The 5-day offering follows the 6 Stages of Project Management for a more detailed and in-depth approach, with QI tools and methodologies interchangeably linked throughout. Candidates bring a problem or idea from their area which is then developed into a Quality Improvement Project (QIP) with a Learning into Action approach using those gained skills. A selection of the project focus areas are listed below, these are in the process of further development into Specific, Measurable, Achievable, Realistic and Timely (SMART) aim's once baseline data has been gathered.

- Reduction in the Length of Stay coming through ED into B2 at DPOW
- Reduce number of inappropriate calls to Information Technology (IT) Out of Hours On Call
- Improve the referral pathways to Gynaecology Assessment Unit
- Improve patient safety in Pink Rose Suite.

12.0 Conclusion

The overall CHPPD was 8.4 in March however it has been identified that the CHPPD data for escalation ward B4 has been incorrectly submitted. This is being rectified and will be resubmitted. With escalation ward B4 excluded, the overall shift fill rate on inpatient wards was 94.9%. The total number of patients occupying a bed at midnight was the highest it has been in March 2023 and is reflective of operational pressures and the increased use of escalation beds.

There is a total of 189.94 WTE (10.19%) Registered and 99.93 WTE (10.25%) unregistered vacancies across the Trust in March. A total of 87 newly qualified nurses and midwives commenced in post over the autumn/winter, with a further 20 joining the Trust in Q4. Ten international nurses (INs) commenced in post over Q4 with recruitment of an additional 90 by November planned. The overseas Pre-registration nurses who have joined the Trust continue to progress through their OSCE preparation and induction programme with a 100% OSCE pass rate.

Recruitment and retention work remains a priority. A HCA Buddy and Preceptorship programme has been developed and is attracting praise from NHSE as an innovative and unique development. A survey has been developed and distributed to HCA staff on the Bank by the Recruitment Nurse Specialist. 166 responses have been received and has led to the formation of a Bank Staff Forum and will inform future work priorities.

The falls huddles process continues and are held promptly following a fall with moderate harm or more. Neuro Rehabilitation Centre reported a fall with severe harm. The huddle identified no lapses in care and a de-log of the serious incident was supported by the ICB. Ward 16 at Scunthorpe and the Stroke Unit at Grimsby have triggered as higher reporting wards in March for the second consecutive month. The Stroke Unit have seen a reduced number of falls in April which is positive. Ward 16 will be monitored, and additional support has been offered.

In February 2023, there was one hospital acquired category 4 pressure ulcer reported which occurred on the Stroke Unit at Scunthorpe and was identified on discharge. The investigation identified that the Category 4 pressure ulcer was incorrectly validated, and the pressure ulcer was unstageable and not Category 4. The incident report and dashboard have been updated.

At the end of March, the number of open complaints remains low at 65. There were 7 reopened complaints, and these were reviewed with the majority classed as unavoidable as their initial response generated new questions which were not raised in their original narrative. The number open PALS continued to be a low number of 50. The role of the temporary PALS Manager finished at the end of March and there is concern that the loss of this oversight will have an impact on the positive position. This has been mitigated by daily oversight being taken by the temporary Patient Experience Manager whose role will end in 3 months' time due to the business case not being approved.

The C.Difficile trajectory for the year 2022 - 2023 year of 21 cases was extremely challenging and ended the year on 24 reported cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. The Trust performed very well for CDI rates for all England acute trusts based on 100,000 bed days and is the best performing trust in the region and in the lowest quartile nationally.

The Trust reported a MRSA Bacteraemia case in March 2023 and a post infection review of the case is in progress.

It is a requirement that each trust should conduct surveillance for at least one orthopaedic category for one period (3 months) in the financial year. The categories are: Primary Total Hip Replacement and Primary Total Knee Replacement. The IPC team undertake continuous surveillance and report on the full year. Good performance by the Trust showed there has been no surgical site infection detected in 2022 – 2023.

QI candidates continue to focus on their selected projects to improve outcomes for our patients, staff, and visitors. Staff are being encouraged to apply for future QI courses.

Agenda Item: NLG(23)118

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	06 June 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 - March 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday 21 March 2023, and approved at its meeting on Monday 22 May 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, 21 March 2023 at 14:00 hours via Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Susan Liburd	Non-Executive Director (Chair)
Linda Jackson	Vice Chair and Non-Executive Director
Kate Truscott	Non-Executive Director

In Attendance:

Paul Bunyan	Interim Deputy Director of People
Jenny Hinchliffe	Deputy Chief Nurse
Simon Nearney	Interim Director of People
Robert Pickersgill	Governor Observer
Ashy Shanker	Deputy Director of Planning & Performance
Liz Houchin	Freedom to Speak Up (FTSU) Guardian (agenda item 5)
Annabelle Baron-Medlam	Inspection Compliance and Assurance Manager (agenda item 6)
Valerie Almira Smith	Head of Organisational Development, Wellbeing, and Inclusion (agenda item 7)
Wendy Stokes	Executive Personal Assistant to Director of People (taking minutes)
Lauren Wilkinson	Head of Workforce Intelligence (observing the meeting)

1 Welcome and apologies for absence

The Chair welcomed Lauren Wilkinson, Head of Workforce Intelligence as an observer at today's meeting. Lauren helps collate information for the IPR report.

Apologies received from Abolfazl Abdi, Sean Lyons, Peter Reading, 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, 31 January 2023

Page one, under present: remove 'Robert Pickersgill' he is already listed as Governor Observer under 'in attendance'.

Page 2, item 5, paragraph 3, sentence 4 should read: Implementation of ESR Manager Self-service has also had an impact on the demands on ward managers.

Page 3, paragraph 2, sentence 2 should read: Linda Jackson asked how we are capturing the need for new roles as part of the interim clinical plan discussions as part of our commitment to closer working together with HUTH going forward.

Page 4, paragraph 2, should read: Linda Jackson stated that the trust has 23 leavers each month in nursing, meaning 35% of staff are absent at any point in time, due to vacancies, sickness, and maternity leave.

With the amendments above, the minutes from the previous meeting held on Tuesday, 31 January 2023 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

4.1 Review of Action Log

Action 102 - Mandatory and Core Skills Training Review
Simon Nearney reported that Jenny Hinchliffe chairs the Portfolio Governance Board (PGB) and that looks at core and mandatory training. Any issues would be escalated through Jenny to Simon. As a mechanism is already in place for escalation it was agreed to remove this item from the action log.

Action 01 - Nursing Recruitment - Prepare a response to the Quality and Safety Committee
The Chair reported she had provided a written response to Fiona Osborne, Chair of Quality and Safety Committee after the deep dive into nursing recruitment at the Workforce Committee meeting in January. Quality and Safety actions is a standing item on the Workforce Committee agenda therefore, it was agreed to remove this item from the action log.

New action: Chair to update the Quality and Safety Committee after today's meeting.
Action: Sue Liburd

Action 02 - Quality and Safety Actions - Pharmacy, and Occupational health update to be given
This is item 8 on the agenda for discussion at today's meeting. It was agreed to remove this item from the action log.

Action 03 - Industrial Action - circulate a virtual response to the Committee.
This action had been completed and is item 16.1 on the agenda for discussion at today's meeting. It was agreed to remove this item from the action log.

5 Freedom to Speak Up (FTSU) Guardian - Quarter 3 Report 2022-23

Liz Houchin reported the highlights from the FTSU Guardian Quarter 3 Report for 2022-23 available on SharePoint. For reassurance, Liz stated that two concerns had been raised in total by twenty people. Main concerns were worker safety, behaviours, and process. The National Guardian's Office had seen a 15% increase nationally compared to Quarter 2, and a 17% increase compared to last year. A total of 29% of concerns in Quarter 2 were for inappropriate behaviours and in Quarter 3 that had risen to 33%.

Linda Jackson queried the second bullet point on page 3: '11 concerns involved an element of patient safety. This puts the trust in the mid-quartile nationally (12 month rolling average), the peer figure being 22 and the national median 23'. Liz Houchin highlighted that information had been taken from the Model Hospital Website and she probably needed to query that.
Action: Liz Houchin

Linda Jackson queried patient and worker safety on page 5 because both numbers had increased from quarter 2. She asked if there was anything that Liz Houchin felt should be raised in terms of themes. Liz Houchin highlighted six patient safety concerns were around staffing levels and the perception that staff are not providing the care they would want to provide. There have been some reasonable adjustments around neurodiversity conditions and how that impacts on safety and worker wellbeing. Colleagues start talking to each other which leads to an increase in concerns being raised. Linda Jackson suggested putting reasonable adjustments into the highlight report to Trust Board.

Simon Nearney stated that Liz Houchin works with line managers, the OD team and the HR team and he asked if there are any blockages in the system preventing Liz from getting the answers she needs. Liz Houchin stated that in some areas staff feel that if the FTSU Guardian contacts their line manager they are going to be in trouble. Liz explains to staff that she has heard one person's perspective and wants to hear others to be able to work towards a solution and to get all parties working with each other. The organisation needs to work on culture, manager behaviours and role models which will be picked up as part of the leadership programme, as well as creating the right environment for staff to feel they can speak up and this also links into the OD Team.

The Chair asked Liz Houchin if there is a mechanism for her to feedback into the leadership development agenda and management programmes. Liz Houchin confirmed she already has a slot on the new leadership development programme and softer skills of leadership. Liz gives a presentation and asks managers to undertake the listen up training for the FTSU module. It is good for managers to try and understand what signals they might be sending to their staff without even realizing it.

Kate Truscott asked, regarding reasonable adjustments, is that in relation to staff who are neurodiverse or NLaG staff caring for people who are neurodiverse. Liz Houchin confirmed it was staff who are neurodiverse themselves and she gave an example of that.

Ashy Shanker felt that was the interface between the brilliant work being undertaken and how that relates to actions in leadership and other work to improve the culture of the organisation is also about the effectiveness of that leadership activity and how that is measured. Ashy asked how the trust focuses on and better measures the outcomes rather than the process. Liz Houchin explained that she is also trying to close that loop and get an outcome for the person with the concern. Liz also shares positive stories of people speaking up because that does have an influence. On the FTSU page on the Hub there is 'you said, we listened, we did' which is part of the culture work and Liz is always open to further suggestions on how she can spread the word.

6 CQC Update

Annabelle Baron-Medlam reported several changes in the report available on SharePoint. There are major pieces of work taking place following publication of the CQC report. Actions from 2022 report have been reviewed and decisions made on how to move forward with them.

Action plans for 2023 have been set up for each division and a trust wide action plan including a total of 116 actions. Some actions around workforce are being split up into four actions including

nursing, training, and medics because one area might be doing better than the other. The new report is being used to gain assurance against the closed actions. The language has changed, and the trust is no longer using red, amber green and blue ratings. The trust is now using full, significant, moderate, limited and no assurance ratings. The front sheet will also include a track of the last three months ratings.

Linda Jackson commented that a lot of effort has gone into the report, and she finds it easy to read. Kate Truscott agreed it is a very comprehensive report that gives a good overall picture. It may well be possible to funnel down into the blue areas at a future date and highlight those, although it is important to see all the other ratings. Regarding leadership visibility in terms of what is in place and what is in plans, Kate asked where that is being picked up.
Annabelle Baron-Medlam stated that for Finance & Performance Committee there is a separate appendix, and she can look at doing that for the next Workforce Committee. Regarding leadership visibility there are only two divisions with actions, and it was just one member of staff that was spoken to. However, they are still taking this very seriously, more work can be done, and a programme can be put in place. Annabelle Baron-Medlam agreed to give a full response at the next meeting.

The Chair also liked the report and front sheet and was supportive of colleague's comments and questions. Bank staff induction is to be completed by 31 March and the Chair asked, is the trust on track with that and questioned whether Annabelle will be able to report back on that at the next meeting. Annabelle replied that she had picked this up last month and has discussed how to maintain that. It is around the date of achievement, what is the more realistic date, and asking divisions why they have changed the date to make sure this is being done properly. Annabelle needs to understand the divisions issues to be able to articulate them to this committee and hopefully she can pick this up at the next meeting. Annabelle's only concern would be if divisions stop giving her the updates.

7 National Staff Survey Results Presentation

Valerie Almira-Smith presented the national staff survey results available on SharePoint.

Kate Truscott stated that the race equality data is set against all the effort being put into recruiting international staff. If the trust brings in even more international staff Kate's concern would be how the trust can move that on to have better outcomes for people.

Linda Jackson stated that over the years, whatever the trust has done, the survey results have not moved that much and with the trust being in double special measures, she felt that does affect staff morale. Linda felt there needs to be a different approach, focusing on four or five things that will make a difference and then having an active campaign to improve scores. Linda asked how the trust makes an impact moving forward, particularly when it is very close to coming out of financial and quality special measures.

Ashy Shanker felt that the trust needs to manage expectations through communication and lead by example, teams look up to their managers around what is acceptable and what the repercussions will be. The trust also needs to consider the amount of work and stress involved in relation to what is being expected to be achieved in small teams. Transformational programmes, values and beliefs are important and Ashy asked is the trust ready for more international recruitment.
Jenny Hinchliffe noted that the Trust had not made improvements in staff perception that service users are the Trust's top priority and is one of the worst performing organisations. Jenny questioned whether that is because the trust has been in financial special measures. If the trust could get that right, and if all priorities were the same, that may help with some of the other

measures. Retention of international colleagues is a risk with the amount of recruitment that is planned.

Kate Truscott stated the trust is ranked sixty-two out of sixty-five and she questioned what trusts in the middle and top are doing, and what can NLaG aspire to in terms of top performers. Money is tight everywhere; all trusts have dealt with Covid and have retention issues.

The Chair thanked Valerie for presenting the information in a way that can be easily digested. The Chair stated that the trust has an incredibly unique culture in a unique part of the world and there are many complexities and nuances that exist. At the heart of all of that is leadership, the trust cannot focus on everything, it needs to focus on a few key areas. The leadership programme needs to be right in the first place and should have already been piloted. The trust will need to be innovative and engaging and not come from a place where it beats people with a stick.

Robert Pickersgill endorsed what the Chair said, the leadership programme continues to be delayed, and that is really important to drive improvement. Governors want more impetuous around that and have suggested a working group where governors can join in and share their commercial experience.

Simon Nearney stated that the trust needs to focus on things such as equality, disability and inclusion, wellbeing, career development, flexible working, making sure staff take their breaks, leadership, and compassionate leadership. The trust needs to unlock staff potential and create positivity through the Exec Team and Board, who must role model that. They need to provide a people first culture. Managers make decisions all the time but on occasions do not engage or involve their teams. It is not what managers do, it is the way they do it i.e., their style or approach to people. This has to change managers must regularly consult their staff, gain their feedback, and actively listen to what they have to say. Leadership development should include:

1) Has this organisation got a Staff Charter on how managers and staff work together, if so, that really does need to be reviewed and recirculated to staff and used.
2) Having the top 200/300 managers getting together off site for a half-day session to discuss trust priorities, challenges, finances and our vision and values. However the session would focus in the main on our staff survey results and actions we need to take; all our managers to create a better working environment for our people. We need to hold up a mirror.
3) The trust needs to create a people first culture.
4) The leadership development programme has started, but is the trust resourced to get the numbers of staff through it.
5) Staff need to take a break and finish on time. We need to ensure we do the basics right. We also need to continue our recruitment drive; the trust has got a 14% vacancy gap and that needs to be down to between 3% and 4%.
6) Regarding appraisal, the trust does well on numbers of staff having appraisals, but do managers put a career porgramme together and does the trust have the training infrastructure and resources to sustain that.

The Chair asked, given the six items above, what might stop them from happening and the trust being able to move forward. Simon Nearney stated that the ICB has taken another £10m from the trust budget. That will have an impact upon our people if not directly then indirectly. Whenever a decision is made the manager making it must understand the impact upon our people. Managers need to actively listen and involve their staff. Valerie Almira-Smith felt that the Exec Team needs to ask themselves what the trusts ambition is, how far it wants to travel, and whether it wants to be average or the best.

The Chair went on to ask, what this committee can do to support the change. Simon Nearney, Valerie Almira-Smith, and HR colleagues are drafting up an action plan and working with management colleagues to implement that into directorates. Investment may be required for international recruitment, pastoral care, wellbeing, or EDI. Simon Nearney asked the committee to understand and champion that managers must be better people managers and encourage a 'people first' culture.

8 Quality and Safety Actions

Recruitment plans:
Paul Bunyan reported the people directorate is signing off business planning, submitting plans for delivery in 2023/2024 and moving to Q1. The draft workforce plan is with the ICB for final review. The plan maps out activity month on month and what the position should be in all areas including nursing and medical. The plan also looks at what that should look like in the next five years, and this will be discussed at a future Workforce Committee meeting.

Nursing workforce:
Nationally there is a problem recruiting registered sick children's nurses. Jenny Hinchcliffe reported a bid has been submitted to support international recruitment. Paediatric services have indicated they require eight children's nurses. Newly qualified nurses come into the trust in autumn and some work is being done around adult nurses already qualified which is looking more positive than in other areas.

Kate Truscott asked what is being done with paediatric nurses in the emergency departments. Jenny Hinchliffe reported the plan is to strengthen the model and extend the hours up to 11 pm. That is challenging and would be for all trusts across the country. Kate Truscott went on to ask if extending the current model would meet the CQC requirement for safe staffing levels in the emergency departments. Jenny Hinchliffe agreed to find out and bring that information back to the committee.
Action: Jenny Hinchliffe

Jenny Hinchliffe reported that lots of work is taking place around international recruitment to try and diversify that pipeline. More work is needed locally in the UK to recruit more nurses into community, emergency departments and midwifery. Recruitment events have taken place to recruit healthcare support workers and widening the access locally through working with colleges. In September, the trust will be offering rotational posts to newly qualified nurses and face-to-face open days are taking place.

Workforce engagement across the ICB is taking place to work more collaboratively with York, Harrogate, ICB, HUTH and NLaG. From May this year an initiative with Kerala in India is taking place to build relationships with them to find out what is needed for their final year students to make them more ready to come and work in the UK.

Pharmacy recruitment:
It is difficult to recruit from the UK and even more difficult to recruit from overseas and keep within the regulatory guidance. The trust is working with education providers from Sunderland University to try and shorten the time required from arriving internationally to being able to hit the ground running. It is currently at least eighteen months before being able to work in the UK and the ICB and HUTH are driving to shorten that time. They have tried to recruit five pharmacists from India and received thousands of applicants. Locum agency staff are covering pharmacy vacancies. SGH has most vacancies and finding it difficult to recruit to three pharmacy posts. The trust is

exploring additional development within current posts for staff to be able to progress to bands 5, 6, 7 and 8. Kate Truscott asked if it is appropriate to have a pharmacy apprenticeship. Paul Bunyan reported that the national apprenticeship framework is in the trailblazer phase, there are apprenticeships for band 3 to 4, but no senior ones for use at present. Paul Bunyan added this can be explored with Heath Education England trailblazer scheme going through normal channels.

Occupational health recruitment:
Paul Bunyan reported that a temporary band 5 nurse is in post and trained and if all goes well the department should be back to business as usual from May. It has invested £11k in temporary staffing. Peter O'Sullivan has been appointed as Head of Occupational Health, he has previous experience and commences in post on 24 April 2023. The ICB are exploring whether NLaG, HUTH and York can appoint our own Occupational Health Physician with a view to improving clinical services and being a lead for wellbeing particularly around mental health. Also to develop a programme to build our own internal occupational health nurse capacity.

The Chair asked what level of assurance this committee has that some of the previous hurdles have been reduced. Paul Bunyan replied there are already process in place without an extensive level of inconsistency of application. This has been audited and reviewed by the recruitment team taking a quality improvement (QI) approach to strengthen the process. Paul added that they are also going through the process with the QI team, to remove waste and introduce a new process. Linda Jackson sated that there are some hurdles with internal transfers, and she asked what the delay is now and what needs to be done to get back to business as usual. Paul confirmed the current delay is clearing staff from Mid-January and getting through the sheer volume of clearances required with limited staffing. Peter O'Sullivan has already got some good operational ideas going forward.

The Chair agreed to provide an update to the Quality and Safety Committee.
Action: Susan Liburd

9 DBS Requirement

Simon Nearney informed the committee that a doctor with sexual offences against him was working for an East Kent staffing agency, therefore HR conducted a review of our own DBS process. Simon reported that permanent staff undertake a DBS and risk assessment process if they need to commence work before being DBS cleared. Simon gave assurance that agencies providing staff must come through the framework, and the trust has never had an agency who has not provided the relevant checks.

10 Workforce Integrated Performance Report (IPR) - Trust and Directorate

Paul Bunyan presented the highlights from the Workforce IIPR available on SharePoint.

Kate Truscott referred to some of the narrative about the issues around accommodation and travel, and she asked if assurance can be given that those problems have been resolved.
Paul Bunyan stated no, this applies to internationally recruited nurses, accommodation is scarce, and the biggest issue is finding good suitable accommodation. The trust has extensive networks with private landlords and a recent partnership with Navigo, but accommodation remains a real struggle.

Kate Truscott went on to ask about mandatory training and particularly fire training because that is problematic. Paul Bunyan confirmed this is a space issue, and the trust has had to move to some

off-site training.

11 Recruitment KPIs/Dashboard

Paul Bunyan presented the highlights from the Recruitment KPIs/Dashboard available on SharePoint. Paul highlighted the improving position trust wide from conditional offer to being cleared. One element of concern is surgery and critical care which is significantly higher. Work is starting to see where those delays are and what is needed to bring them back in line.

12 Trust Board Highlight Report

The Chair confirmed highlighting the following in the Trust Board Highlight Report:

- Receipt of the national staff survey results
- Freedom to Speak Up (FTSU) Guardian - Quarter 3 Report 2022-2**3**
- DBS requirement
- Workforce Integrated Performance Report (IPR) showing some positive news on the latest recruitment figures
- Plan for the occupational health department including some investment in temporary and permanent solutions. The improved wait for health clearances is now down to six weeks.
- Peter O'Sullivan has been appointed as permanent head of occupational health and that is a good foundation block for the department to be able to move forward.

13 Annual Workplan

The Chair suggested Simon Nearney and herself taking a deep dive into the annual workplan to confirm if the reports are appropriate for the committee, there is no duplication and whether time frames look correct because there has been a request to present a quarterly report instead of a current annual report. The Chair also suggested Kate Truscott joins them in terms of health and wellbeing reports and minutes from committees. Simon Nearney suggested health and wellbeing updates every six months.
Action: Sue Liburd, Simon Nearney, Kate Truscott

Linda Jackson suggested the committee looking at more deep dives going forward, and the Chair agreed with that.

14 Workforce Committee Terms of Reference, and Self-Assessment - Annual Review of Committee

The Chair reported the Terms of Reference and Self-Assessment Annual Review of Committee blank forms had been sent out to all committee members. All replies must be forwarded to Wendy Stokes by the deadline of 06 April 2023 so that information can be collated.

15 Items for information - refer to Appendix A

The Portfolio Governance Board and talent and leadership development had already been discussed.

16 Any Other Business

No other urgent business discussed.

16.1 Industrial Action

Paul Bunyan reported that the BMA did strike on 13, 14 and 15 of March involving 96% of junior doctors. Consultants and specialty doctors covered rotas although some junior doctors did attend work and were allocated to the emergency departments. There has been a lengthy debate around payment during strike action, and the BMA wanting to get the BMA card introduced. This was discussed at ICB level and accepted by JLNC on both sites. The BMA mandate remains, there is currently no mandate from the Government and further strike dates are yet to be confirmed.

Government, UNISON and RCN (not UNITE) appear to have reached an agreement which is being put forward to their members to ask if they accept the offer, which is being recommended for AfC staff. There is also some discussion around the RCN wanting separate pay scales for nursing and midwifery staff, like what currently exists for medical staff.

17 Date, time, and venue of next meeting:

Monday, 22 May 2023 at 14:30 hours via Microsoft Teams

Post meeting note:
The date of the May meeting has been changed from Tuesday, 16 May to accommodate the Group Chief Executive recruitment process.

The meeting closed at 16:15 hours

Cumulative Record of Workforce Committee Attendance (2022/2023)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Michael Whitworth	3	2	Ellie Monkhouse	6	0
Michael Proctor	2	1	Helen Harris	5	2
Fiona Osborne	3	3	Jenny Hinchliffe	6	3
Sean Lyons	6	1	Diane Hughes	2	2
Linda Jackson	3	3	Shaun Stacey	6	1
Peter Reading	6	1	Robert Pickersgill	6	6
Christine Brereton	4	4	Abolfazl Abdi	2	2
Maneesh Singh	3	1	Aswathi Shanker	2	2
Susan Liburd	4	4	Simon Nearney	2	2
Kate Truscott	3	2			

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 June 2023	
Director Lead	Dr Kate Wood, Chief Medical Officer	
Contact Officer/Author	Dr Elizabeth Evans, Guardian of Safe Working	
Title of the Report	**Guardian of Safe Working Quarterly Report**	
Purpose of the Report and Executive Summary (to include recommendations)	The Guardian of Safe Working is a role that provides assurance to the board that the doctors in training in the trust are working within their contract. This report provides information on the number and type of deviations from the contract and the steps taken to resolve any issues.	
Background Information and/or Supporting Document(s) (if applicable)	n/a	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	n/a	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	n/a	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Dr Liz Evans
Guardian of Safe Working
1st April 2023

Contents

1. Executive Summary

Exception reports for the quarter 1st January 2023 to 31st March 2023 saw a significant decrease from 28 to 28 exception reports. The majority of the exception reports submitted were in connection with working hours, with some also submitted around service support, educational opportunities and work patterns which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant divisions/directorates.

There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce. The first training session was recently undertaken, and this work is ongoing.

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	311
Number of Doctors/Dentists in Training (WTE)	249.9
Number of Less than full time (LTFT) Trainees (Headcount)	20
Number of Training post vacancies (WTE)	61.1
Total number of trainees: SGH	129.5
Total number of trainees: DPOW	120.4
Total number of trainees: GDH	0

Source Finance data

During the period of this quarterly report (1st January 2023 to 31st March 2023) there have been a total of 28 exception reports submitted through the allocate exception report system.

This showed a decrease of 79 exception reports from the last quarter (1st October 2022 to 31st December 2022).

Of the 28 exception reports submitted, 23 were linked to hours. This showed a decrease of 55 reports from the previous quarter.

The exception reports for this quarter relating to hours have been compensated by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL). They have mostly been closed successfully.

The below table is a breakdown of the exception reports over the last quarter (January 2023 – March 2023)

Exception Reports Open (ER) between 1st January 2023 – 31st March 2023	
Total number of exception reports received	28
Number relating to hours of work	23
Number relating to pattern of work	1
Number relating to educational opportunities	0
Number relating to service support available to the Doctor	3
Number initially relating to immediate patient safety concerns	2

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support have the option of specifying whether the report constitutes an immediate safety concerns (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st January 2023 and 31st March 2023	
Total number of exception reports resolved as at 31/03/2023*	26
Total number of exception reports unresolved as at 31/12/2023*	8
Total number of exception reports where TOIL was granted	22
Total number of exception reports where overtime was paid	2
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	2
Total number of exception reports resulting in fines	0

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

2. Immediate Safety Concerns

During this quarter there were 2 exception reports submitted where the Doctors raised an immediate safety concern in addition to either a concern around working hours or clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

This quarter has demonstrated a significant decrease in the number of immediate safety concerns received. This is an improvement on the previous quarter where an action plan was put in place by the medical director in response to a large number of concerns raised in medicine in DPOW.

3. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

4. Trend in Exception Reporting

There has been a significant decrease in exception reports received this quarter. This is despite high operational pressures in the medical departments. The action plan put in place by the medical director in response to concerns raised during the previous quarter appears to have had a good effect at improving both safety and morale on the wards, particularly in relation to staffing in gastro and cardiology in DPOW. Improved engagement with the doctors during induction has embedded the culture of exception reporting well among the doctors in training, particularly at a foundation level, which has meant that this system is being used appropriately to highlight staffing issues.

5. Fines Levied against Departments this quarter

There have been no fines this quarter. There is however a fine from the previous quarter which has been calculated using guidance obtained from NHS England which was not previously available, causing a delay. This fine was owing to staffing in medicine in DPOW and has been calculated as £2241.36. This is £1400.95 for the junior doctors to spend as required, and £840.41 paid in individual fines to the doctors concerned. This is in addition to £432.40 which is to be used in Scunthorpe and has been carried over from the previous quarter. This money will be discussed at the junior doctors forum, to decide how best to use it.

6. Communication and Engagement

Work continues regarding communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for a year, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF has been changed to lunchtime following consultation with some of the juniors at induction, which has had a

positive impact on attendance. This has been re-discussed at a recent JDF, and the junior doctors have confirmed that this time is convenient for them.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. This is usually run by the guardian of safe working, but several times a year is a joint session with PGME or the Freedom to Speak Up Guardian. In addition there is a regular quarterly newsletter which is circulated via e-mail. Information pertaining to the guardian office is available on the HUB, and there is a leaflet which is provided to all doctors in training on joining the trust containing details of the support available. There is also now a regular meeting between the Guardian of Safe Working, the Freedom to Speak up Guardian, and a representative of PGME. This enables the support mechanism for Doctors in Training to establish any common themes and co-ordinate an approach to finding solutions.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, commenced in this role in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated a significant decrease compared with the previous quarter. This is likely to reflect the interventions in place in medicine in response to the increased reporting in the previous quarter. There has been a corresponding decrease in immediate safety concerns which is reassuring.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise. We will ensure that we continue with this work, as it provides real-time information about the situation on the wards, in addition to being a contractual obligation.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one.

Dr Liz Evans - Guardian of Safe Working

Date: 1st April 2023

NLG(23)120

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	6 June 2023	
Director Lead	Simon Parkes, NED / Chair of Audit, Risk & Governance Committee	
Contact Officer/Author	Lee Bond, Chair Financial Officer	
Title of the Report	**Audit, Risk and Governance Committee Minutes of meeting held on 23 February 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 23 February 2023 and approved at its meeting on 20 April 2023.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Oversight of entire BAF process, completion and achievement.
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**23 February 2023** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
	Kate Truscott	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Helen Harris	Director of Corporate Governance
	Sally Stevenson	Assistant DoF – Compliance & Counter Fraud
	Ian Reekie	Governor
	Chris Boyne	Deputy Director, Internal Audit (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	Nicki Foley	Local Counter Fraud Specialist
	Nicola Parker	Assistant DoF – Planning & Control (For item 9.1)
	Liz Houchin	Freedom to Speak Up Guardian (For item 10.1)
	Mick Chomyn	Director of Pathology (For item 10.2)
	Ashley Leggott	Emergency Planning Manager (For item 10.3)
	Sue Meakin	Data Protection Officer (For item 10.4)
	Ivan Pannell	Head of Procurement (For item 10.5)
	Lauren Short	Directorate Admin / PA to CFO (Minutes)

Item 1 02/23 **Apologies for Absence:**

There were no apologies for absence.

Item 2 02/23 **Declarations of Interests**

Simon Parkes asked if there were any additional declarations of interest not otherwise disclosed on the Trust Declaration system. None were advised.

Item 3 02/23 **Minutes of Previous Meetings**

3.1 The minutes from the public meeting held on 24 November 2022 were agreed as an accurate record.

3.2 The minutes from the private meeting held on 24 November 2022 were agreed as an accurate record.

3.3 The Public Highlight Report from 24 November 2022 had been provided and noted.

3.4 The Private Highlight Report from 24 November 2022 had been provided and noted.

Item 4 02/23 **Matters Arising/Review of Action Log**

There were no matters arising that were not included on the agenda or covered in the action log. Due to technical difficulties experienced by Simon Parkes, he asked Sally Stevenson to read through the action log.

Minute No. 7.1 (21.4.22) Assurance Map – Simon Parkes confirmed that he had reviewed this document with Helen Harris and that he was content with the assurance being obtained with the correct committees. The Assurance Map would be brought to the next meeting.

Minute No. 11.5 (27.7.22) RATS Highlight Report & Action Log – After further discussion and acknowledgement of the sensitivities around RATS business, it was agreed assurance was required to ensure that the RATS Committee is working as per their Terms of Reference and be able to provide this independent assurance to the Trust Board, and that a yearly paper covering the key points throughout the year would suffice instead of the confidential highlight reports/action logs. Closed.

Minute No. 5.1 (24.11.22) External Audit VFM Opinion – Sally Stevenson confirmed that this was discussed at the External Audit tender evaluation meeting. Closed.

Sally Stevenson confirmed that all the other actions were either on the agenda or closed with the evidence provided on the action log.

Item 5 02/23 **External Audit**

5.1 Update on Position with External Audit Service Tender

Lee Bond advised that he had been in discussion with NHSE regarding the difficulties encountered to secure an External Auditor, and NHSE had requested answers to a list of questions on what the Trust had done to secure an Auditor, the answers to which had been duly provided and he was awaiting a further response from NHSE. Lee Bond added that conversations are happening at a national level about similar issues other Trusts are facing, and that although NHSE have no power to appoint an Auditor they do want to assist Trusts finding themselves in this position. He advised the Committee he would chase NHSE for a response in two weeks' time if he had not heard anything by then.

Gill Ponder queried what would happen if the annual accounts could not be audited. Lee Bond confirmed that it can potentially impact on the Whole of Government Accounts if the values become material, but this was not completely new territory and referred to one Trust having a similar issue for the last two years, however it is understandably not something the Trust would want to have to go through. Simon Parkes thanked Lee Bond for the update and noted that all possible steps had been taken so far to secure an Auditor and advised that he would continue to feedback to the Governors on this issue.

Item 6 02/23 **Internal Audit (Audit Yorkshire)**

6.1 Internal Audit Progress Report

Danielle Hodson presented the Internal Audit Progress Report on the 2022/23 plan and highlighted that six reports had been finalised since the last report with two at draft stage. The majority of other audits are at fieldwork stage. Finalised audits were:

- Junior Doctors - Rotas (Limited assurance)
- Compliance with NICE Guidance (Significant assurance)
- Declarations of Interests, Gifts and Hospitality Registers (Significant assurance)
- Health & Wellbeing of Staff (Significant assurance)
- Core Financial Systems (Significant assurance)
- Board Assurance Framework (Significant assurance)

Two changes to the plan were requested and approved by the Committee:

- CQC Compliance – scope changed slightly (as detailed in the progress report) due to the timeliness of CQC monitoring of should/must do actions and how the Trust monitors these.
- Activity Planning – requested to move to Q4 due to lack of capacity for data and information to be provided in the current month as people will be working on the plan.

Danielle Hodson highlighted one performance indicator which had not been met due to a late response, but this should improve as the audits are completed, and reported that 140 days had been undertaken to date which was in line with the plan, with the overall plan being 205 days.

Danielle Hodson referred to the Junior Doctors Rotas audit which has been rated with 'Limited Assurance' due to a significant amount of manual intervention required regarding the current processes, and asked members if they had any questions. Kate Truscott was concerned to hear that the Trust was still using manual systems when it has the electronic tools available and suggested this needed picking up at the Workforce Committee. Lee Bond expressed his frustration due to the Trust having invested in the e-roster system, with what seems to be no clear plan to roll it out to the rest of the Trust now that both ED's have implemented it. Lee Bond added that by implementing e-roster across the Trust, it would help with a whole host of problems in the fullness of time e.g., gaps in rota's, etc. and that operating spreadsheets with manual intervention was labour intensive and not entirely rewarding for those using it. Gill Ponder queried what experience the Junior Doctors were having as a result of this and agreed with Kate Truscott to have this feature on the Workforce Committee's agenda. Simon Parkes shared the Committee's views and agreed for this audit to be highlighted to the Trust Board and to the Workforce Committee as the committee to take on this challenge. It was also discussed and agreed that the management response to the roll out of Health Roster was inadequate and required to be more ambitious. Chris Boyne offered to go back to management and challenge the response, and this was agreed by the Committee.

Action: Chris Boyne

Gill Ponder added that the issue of workforce features highly in Finance and Performance Committee meetings and had recently been escalated to the Trust Board, so the e-roster solution may be a key enabler to solving a lot of problems and challenges the Trust is currently facing.

Significant Assurance ratings were noted on the other reviews contained within the progress report.

6.2 IA Recommendations Follow-up – Status Report

Danielle Hodson presented the report and advised that it was overall another positive update, highlighting two moderate overdue recommendations which would be closed as soon as they had been approved at sub-committee level. There were a total of eight recommendations with revised target dates with reasonable rationale for the delay.

Kate Truscott queried job planning and asked whether 2021 job plans were done, commenting that they are meant to be prospective, not retrospective; and added that this links to the Junior Doctors Rota audit in the previous item. Danielle Hodson confirmed that 2021 job plans were complete and the follow-up of the job planning audit would be brought to the next Committee meeting. Simon Parkes acknowledged that job planning had not been in a good place but he had been advised through discussions with the Medical Director, Dr Kate Wood, that it had been substantially improved and that progress is being made, with the follow-up audit hopefully being able to test this and show how solid the progress has been. It was agreed to include the better progress with Internal Audit recommendations in the Highlight Report to the Board.

6.3 Insight Technical Updates Report

The Insight Technical Updates Report had been provided for information with Danielle Hodson highlighting four key items:

- NHS Audit Committee Handbook (supplement issued);
- NHSE guidance on developing the joint forward plan and NHS priorities and operational planning guidance;
- Delivery plan for recovering urgent and emergency care services;
- NHS financial framework 2023/24 and associated guidance issued.

There were no questions from Committee members.

6.4 Draft Annual Internal Audit Plan 2023/24

Danielle Hodson confirmed that the draft 2023/24 plan had been discussed with the Executives, presented at the Executive Team meetings, and approved by the Chief Executive. The plan had been developed following a review of the Trust's Risk Register and Board Assurance Framework and was presented to the Committee for initial insight into the proposed content of the plan.

Helen Harris queried the Board Self Certification featuring on the plan as it had been agreed with the Chief Executive to remove this from the audit plan due to receiving good assurance over the past couple of years. Sally Stevenson confirmed she had received the email from the Chief Executive and this should have been removed, adding that the 2 days could be put into contingency.

Gill Ponder queried why the Recruitment and Retention audit seemed to be focusing on nursing staff when the Trust has a problem with medical staff. Danielle Hodson confirmed that the nursing staff were highlighted within this audit plan due to it being identified in the CQC report, however the review would include all staff. Lee Bond shared further explanation (volume of doctors versus

nurses) around the need to focus on nursing staff as it is the single biggest issue the Trust faces at the moment, adding that the bigger issue for Doctors was retention rather than recruitment.

Liz Houchin joined the meeting.

Simon Parkes noted a broad set of challenges when it comes to the recruitment and retention agenda, therefore an in-depth audit is required to give clear insight into one of the Trust's highest risk areas.

The final version of the Annual Internal Audit Plan for 2023/24 to be brought back to the April 2023 meeting.

Action: Danielle Hodson

The next item was taken out of sequence on the agenda.

10.1 Annual Review of Trust's FTSU Arrangements

Liz Houchin spoke briefly to the paper, which provided an update from the previous report which detailed the background on the creation of the Guardian role and provided information about the Freedom to Speak Up process, how the process works in practice and how the information received is used to improve organisational learning. Liz Houchin advised she was happy to take any questions, but there were none and Simon Parkes thanked Liz Houchin for a well detailed report.

Liz Houchin left the meeting. The Committee returned to the sequence of the agenda.

Item 7 11/22 Counter Fraud

7.1 LCFS Progress Report

Nicki Foley presented the progress report and highlighted the following key points to note:

- National eLearning Fraud Awareness Training – Following approval from Trust Management Board, this training had been made mandatory for all staff within the Trust and is to be renewed every 3 years. It went live on 18 January 2023 and at 17 February 2023 the Trust was already 53% compliant.
- Fraud Risk Assessment – This document had been completely refreshed and now has 28 risk areas with each of these having a risk owner within the Trust and would be subject to regular review. This will be presented within the annual work plan for 2023/24 which will be presented at April's Committee meeting.
- Newsletter – the latest edition included some interesting national cases and a section on the Trust's Standard of Business Conduct policy to further raise awareness of this policy to staff.
- Investigation Referrals – Five new referrals received since the last report with six updates covered within the report. The current status is 4 referrals closed and 7 remaining open for further development.

Simon Parkes welcomed the move to make fraud awareness training mandatory for the Trust, acknowledging training pressures, with the percentage of staff having completed the training already looking very positive. Lee Bond also noted this being a step in the right direction with an impressive percentage of completion in a short period of time. Nicki Foley was thanked for her continued work and a good report.

Item 8 02/23 **Board Assurance Framework and Strategic Risk Register – Q3**

Helen Harris presented the report and noted the following points:

- The Trust Board reviewed the BAF on 7 February 2023. The risk relating to the Chief Information Officer had not been reviewed at that time but had since been finalised within the report provided to the Committee.
- Assurance progress ratings had been added to each of the planned actions to make it easier for committees to challenge those actions which had not made much progress.
- Visual graphs had been added.
- The Strategic Development Committee would be reviewing their risks on 2 March 2023, noting a delay due to previous meeting cancellations.
- The high scoring risks contained within the report were noted.

Lee Bond posed the question of how much of the Board's agenda was focused around issues in the BAF and the Trust's objectives, noting the BAF only being valuable if the Trust Board is working with it and queried whether it was currently enough. Simon Parkes agreed that there should be a stronger connection between the BAF and the Trust Board and commented whether there was enough time spent looking at finances and workforce issues as a Board.

Simon Parkes asked whether the Committee would feel content to add this to the Highlight Report to the Trust Board as well as putting it forward to be discussed at the upcoming Board Development Day looking at the BAF. Helen Harris informed the Committee of further discussions which had taken place with Sean Lyons, Linda Jackson and Peter Reading to postpone the BAF discussion on this occasion and for it the feature at the Joint Board Development Day due to working towards the Group structure. It was agreed to still highlight this to the Trust Board.

Nicola Parker joined the meeting.

The Committee were content with the reviewed BAF report.

Item 9 02/23 **Management Reports for Assurance – Items for Approval**

9.1 Accounting Policies including IFRS16 details

Nicola Parker spoke to the report advising the Committee of the draft accounting policies which would be included within the Trust's year end accounts, although she stated that the final guidance from NHSE is still awaited and would update the accounting policies as necessary once received. Nicola Parker referred to the items of interest noted on pages 1 and 2 of the report and confirmed that the accounts would be prepared on a going concern basis and the Trust is still

forecasting to break even at the year end with an adjusted financial position for the ICB. Also forecasting year end cash balance to be around £21m. Nicola Parker also updated the Committee on IFRS16 requirements.

Lee Bond reflected on the position with cash balances and stated that it did not detract from the Trust's ability to say the Trust is a going concern basis, relating to the Trust's forecasted year end cash balance of £20m which is significantly lower than in previous years, and possibly with the best part of £10m being capital due to invoices not yet being received. Cash is projected to be a big issue for 2023/24 if the plan is signed off at £44m with the cash balance forecasted to run out in June 2023 and PDC needing to be drawn down, if the Trust does not improve its financial position.

Simon Parkes thanked Nicola Parker and Lee Bond for a clear update on the significant changes coming through this year.

Nicola Parker left the meeting.

9.2 Annual Review of Policy for Engagement of External Auditors for Non-Audit Work

Sally Stevenson provided a brief update as to the need for the policy which is designed to ensure the Trust has no threats to the independence of the Trust's External Auditor and noted limited amendments to the policy which were shown as tracked changes in the document for ease of reference. Helen Harris highlighted the wording around the reference to Code of Governance needed to be updated to 'NHSE Code of Governance for NHS Provider Trusts'. The Committee were content with the proposed changes, subject to this minor wording adjustment, and approved it to be uploaded to the Trust's Hub site.

Action: Sally Stevenson

Lee Bond left the meeting, and the Committee took a short break and reconvened at 10:50am, whereby Mick Chomyn joined the meeting.

Item 10 02/23 Management Reports for Assurance

10.2 Mortuary and Body Store Assurance

Mick Chomyn was pleased to update the Committee that all of the Trust's mortuaries and body stores are now fully compliant with the NHSE requirements for controlled access to these areas. With regards to the Goole mortuary a full review had taken place with Ant Rosevear and Community & Therapies have now taken full control of the Goole site, with the outcome being to keep the Goole body store running, therefore all the relevant reviews of audits and access requirements have been completed and are fully compliant. Mick Chomyn stated that the Committee could be totally assured that there was full compliance with NHSE and the Human Tissue Authority requirements.

Gill Ponder asked for an update in relation to Bariatrics storage. Mick Chomyn clarified that this was a separate issue and a programme of capital works was nearing completion at both DPoWH and SGH mortuaries and was due to be

completed by the second week of March 2023. Long term freezer storage would then be in place at both sites.

Simon Parkes thanked Mick Chomyn for the positive update, confirming that this assurance would be highlighted to the Board and the matter closed and wished Mick Chomyn a happy retirement.

Mick Chomyn left the meeting.

10.6 Salary Overpayments Report

This item was taken out of sequence on the agenda.

Sally Stevenson was pleased to report a significant reduction in the value of salary overpayments in quarter 3 of 2022/23, with it being the lowest quarterly figure reported since quarter 1 of 2017/18. The Payroll team were praised for this achievement. Also, at the end of month 10 the total value of overpayments totalled £242,000 which if this continued, would be a significant achievement as it would be the lowest annual figure for several years.

Kate Truscott congratulated the Payroll team and wanted to understand what the process was for following up the non-compliance letters as some were not responded to since March 2022. Sally Stevenson explained the formal non-compliance process in place whereby repeat managerial offenders are contacted with a formal letter and discussions can take place. Sally Stevenson explained that not all managers receiving a letter contact her, which could be for a variety of reasons, but if they re-offend then it triggers a further letter, etc.

Ashley Leggott joined the meeting.

Gill Ponder confirmed that the Committee had had some fairly robust discussions regarding this issue previously and thanked Sally Stevenson and the Payroll team for their efforts in this area. Simon Parkes agreed to include the positive quarter 3 report findings within the Highlight Report to the Trust Board and thanked the Payroll team and managers for their work in reducing the amount of salary overpayments. Simon Parkes stated that this was an area that the organisation must continue to pay attention to.

The Committee returned to the sequence of the agenda.

10.3 EPRR Steering Group Highlight Report Inc. Medical Gas Oversight and Assurance

Ashley Leggott spoke to the paper and explained the background to the issue. Due to an oxygen system major incident at the Trust in November 2020 a thorough investigation had taken place and a letter sent by the Chief Executive to highlight an assurance process which was required. Operationally the Trust now has an extremely well-established process in relation to the oxygen system and flow rates which is carried out via the daily operational meetings with access to a flow dashboard highlighting areas which are experiencing high demands of oxygen flow in real time. The operational plans are in the process of being updated to ensure they include the oxygen flow rate procedures, etc.

Ashley Leggott referred to the assurance process flowing from the Medical Gas Committee. The ARG Committee were asked to approve the Highlight report coming to the Committee on an annual basis but noting if there were any incidents to report, the Committee would receive these when necessary.

Sue Meakin joined the meeting.

Gill Ponder was confused with the alignment of EPRR due to it also being part of the Finance and Performance Committee workplan and raised concerns of duplication across committees, pointing out that Shaun Stacey, as Executive Lead for EPRR attends the Finance and Performance Committee but doesn't attend the ARG Committee. Gill Ponder agreed with Ashley Leggott's proposal of just the annual report coming to the ARG Committee due to the Finance and Performance Committee having oversight of EPRR through their workplan twice a year.

Sally Stevenson referred to the Chief Executive's letter nominating this Committee to receive the EPRR annual report and the quarterly EPRR Steering Group report, although considering this to be on an exception basis. After further discussions took place, it was agreed for the Chairs of both Committee's to review where the EPRR needs to sit when undertaking their review of the Terms of Reference and Workplans for each committee. Simon Parkes stated that he was happy to go back to the Chief Executive and say where assurance is being received to ensure no duplication if necessary.

Action: Simon Parkes / Gill Ponder

Ivan Pannell and Ant Rosevear joined the meeting.

Simon Parkes raised whether the scrutiny of the underpinning assumptions and data relating to the design of operational and surge plans may be a challenge for the Committee to undertake as it is not an area the Committee have the knowledge and skills to necessarily to give assurance on. Simon Parkes suggested that this may be an area to review as one of the Data Quality audits in order to obtain independent assurance and asked Danielle Hodson to consider it for the audit plan.

Action: Danielle Hodson

Ashley Leggott left the meeting. Simon Parkes acknowledged Ant Rosevear arriving in the meeting and explained that Mick Chomyn had already dealt with the Mortuary and Body Store paper as the meeting had been running early. Ant Rosevear therefore left the meeting.

10.4 IG Steering Group Highlight Report

Simon Parkes advised the report would be taken as read and asked whether there was anything in particular to highlight. Sue Meakin noted the progress in work regarding the improvement plan from last year with only 2 actions remaining to be completed. One of which is how to encourage more staff to undertake IG training and working with the Learning and Development team on this, as well as now partnering with HUTH on a package to jointly push out more

eLearning via MS Teams. The second item is working with Procurement around how to put due diligence in regarding procurement of information and IT systems. Final submission of the DSPT is in June 2023.

Simon Parkes noted that the Trust was still below the 95% target for IG training which had previously been highlighted to the Trust Board, but on this occasion, it was agreed not to be highlighted to the Board due to other matters needing to be noted. Sue Meakin reassured the Committee that work is still on going to meet the compliance target. Simon Parkes thanked Sue Meakin for the on-going efforts to achieve compliance in this hugely important area.

Kate Truscott noted that the Medicine division had a high rate of documentation incidents and asked what plans were in place to improve this. Sue Meakin confirmed that all issues are reported to the Clinical Record Keeping Committee and are fed back to the SAT Teams. They are currently focusing on record keeping issues and pulling incidents reports off Ulysees and putting in support and training for staff. Both agreed that a digital solution would mitigate a lot of these manually generated (e.g., misfiling of notes) incidents. Danielle Hodson highlighted that a Record Keeping audit featured in the Annual Internal Audit Plan for 2023/24 so would be able to provide assurance on this in due course.

Sue Meakin left the meeting.

10.5 Waiving of Standard Orders Report

Ivan Pannell took the report as read, highlighting that it had been a relatively quiet quarter with just 19 waivers, and invited questions from the Committee. Gill Ponder raised the number of waivers completed for the extension of maintenance contracts and queried whether action is taken in a timely manner to tender these types of contracts, or whether it was due to lack of action that a waiver was necessary to extend the contract. Ivan Pannell stated no and reassured Gill Ponder that the Medical Engineering team hold a data base of medical equipment maintenance contracts for the Trust, with vast majority of such maintenance having to be undertaken by the original supplier of the equipment.

Simon Parkes stated that Gill Ponder raised an important point, and that the Committee needed to be made aware of non-compliance with Procurement procedures and that such incidents should be clearly highlighted in the report. Ivan Pannell confirmed that there is always narrative in the report detailing why a waiver has been completed and being categorised accordingly but added that he took on board the Committees' comments to ensure the reasoning for each waiver is clear.

Discussions took place regarding the rejection of waivers whereby Ivan Pannell explained that often advice is given as to whether a waiver should be completed or not. Therefore, there are no waivers to report as rejected due to stopping these from happening before any unnecessary work is completed. Gill Ponder stated that she felt the Committee should know the number of such interventions by the Procurement team. Ivan Pannell stated it was about terminology, they don't 'reject' waivers but take action to make sure they don't get to that point, however any breaches would be reported as necessary.

Simon Parkes asked Ivan Pannell to discuss with Lee Bond ways of reporting this number in the context of overall activity once a year.

Action: Ivan Pannell

Ivan Pannell left the meeting. Shauna McMahon joined the meeting.

11.7 HFMA Financial Governance Self-Assessment Checklist Status Report

Sally Stevenson highlighted that it set out where the Trust is with regard to the recommendations resulting from completing the checklist, and the results of discussions with HUTH which identified that differences in scoring on some questions was due to interpretation. Sally Stevenson confirmed that the Trust was well on the way with implementing the recommendations but highlighted the deadline given for 31 January 2023 by NHSE was never going to be achieved for a number of the actions due to some of the work not being able to take place at that time, e.g., budget sign off not happening by that time of year. Sally Stevenson confirmed that the action plan would continue to be worked through until all actions were complete and a paper brought back to the Committee in due course. Gill Ponder stated it was a really helpful paper and referred to the action plan being made available to the Committee for completeness, whereby Sally Stevenson agreed to circulate the document via email to the members of the Committee.

Action: Sally Stevenson

10.8 Declarations of Interests Report

The report was taken as read and Helen Harris highlighted the low levels of compliance as shown on the report and reassured the Committee of ongoing work to increase the percentage of declaration forms completed in order to make the Trust complaint. Simon Parkes asked the Committee if this matter should feature on the Highlight Report to the Trust Board. Gill Ponder considered that it should be included on this occasion due to having to declare some of these in our year end accounts, although noting that the Trust Board declarations were fully compliant.

The Committee agreed to highlight this to the Trust Board.

Item 11 02/23 Committee Governance Items

11.1 Results of ARG Committee Annual Self-Assessment Exercise 2023 – Draft for Approval

Simon Parkes thanked Sally Stevenson for preparing this paper and for the helpful comments received on email from Gill Ponder. The Committee agreed to approve the self-assessment exercise for 2023 for submission to the Trust Board for assurance, with no questions or queries raised.

Action: Sally Stevenson

It was noted that Shauna McMahon had joined the meeting and confirmed that it was to support Sue Meakin with her IG paper. Simon Parkes advised that the paper had been dealt with due to the meeting running ahead of schedule and therefore Shauna McMahon left the meeting.

11.2 HFMA NHS Audit Committee Handbook Supplement 2022

Simon Parkes asked if anyone had any comments regarding the Supplement. Kate Truscott queried point 5.6.1 (actually in item 11.3) as to how and by what mechanism the Committee would determine assurance on developing partnerships (in relation to the ICB). Sally Stevenson acknowledged that the document is quite general with no specific guidance on this. Simon Parkes felt it was about members of the Committee using their broader experience and expertise to contribute towards such discussions at the Board. Danielle Hodson confirmed that an audit would be undertaken in Q4 of 2023/24 regarding the partnerships between the ICB which will support the Trust on this. Helen Harris also mentioned work with regards to ICS Boards updating their strategies and refers to the BAF (page 5).

Sally Stevenson advised that a new NHS Audit Committee Handbook would be published by the HFMA this year which may give more information on emerging ICB issues. Simon Parkes asked that the new Handbook be circulated once published.

Action: Sally Stevenson

11.3 Annual Review of ARG Committee Terms of Reference – Draft for Approval

Gill Ponder commented that in light of the earlier discussion in relation to the EPRR issue, the Terms of Reference may need to be adjusted slightly in the near future. Sally Stevenson referred to the earlier agreement of an annual paper to be submitted by the RATS Committee and posed the question of when in the Committee's business cycle this should be. It was agreed for this to come to the Committee before the financial statements were signed off, therefore at the latest June 2023. The Committee approved the ARG Terms of Reference for submission to the Trust Board for final ratification, noting the above points.

Action: Sally Stevenson

11.4 Annual Review of ARG Annual Rolling Work Plan 2023/24

Discussions took place around the workplan and the following points noted:

- The EPRR element will be updated once discussions have taken place outside of the Committee to agree this.
- Salary Overpayments report to reduce to twice a year, with items of exception brought to the Committee in the intervening period if necessary.
- Procurement KPI Data confirmed to be an annual report.

A brief discussion took place around whether or not the Committee required sight of the Clinical Audit Annual report, with Sally Stevenson noting that it features on the HUTH Audit Committee workplan. Members of the Committee did not feel this was necessary and trusted that the Quality and Safety Committee have this under control, adding that it did not need to go to two sub-committees.

Item 12 02/23 **Action Logs and Highlight Reports from other Sub-committees.**

The following action logs and Highlight reports were provided and noted:

12.1 Finance & Performance Committee
12.2 Quality & Safety Committee
12.3 Workforce Committee
12.4 Health Tree Foundation Committee
12.5 Strategic Development Committee

Item 13 02/23 **Private Agenda Items**

13.1 Policy on Handling Interventions and Intellectual Property and Standards of Business Conduct Policy

This item was discussed and minuted under a private agenda item.

Item 14 02/23 **Any Other Business**

There was no other business raised.

Item 15 02/23 **Matters for Escalation to the Trust Board**

All issues for escalation were agreed throughout the meeting. Sally Stevenson would draft the Highlight Report for the Chair to review and approve.

Action: Sally Stevenson

Item 16 02/23 **Matters to Highlight to other Trust Board Assurance Committees**

The issue of the Junior Doctors Rotas audit report to be flagged to the Workforce Committee.

Item 17 02/23 **Review of the Meeting.**

Members of the Committee were happy with how the meeting was undertaken, commenting that there had been lots of debate and praised those who had written the reports to a high and thorough standard which meant there were limited questions necessary. Simon Parkes asked Sally Stevenson to pass on the Committee's thanks to those involved and inform them that the Committee appreciated the work going into papers which was helpful to the Committee.

Action: Sally Stevenson

Item 18 02/23 **Date and Time of the next meeting**

Thursday 20 April 2023 – 9.30am – 12.30pm via Microsoft Teams.

NLG(23)121

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6/6/2023	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights some of the key projects the Communications team are working on to improve staff morale and engagement and reputation through external communications. It covers March and April 2023 and includes an overview of team plans and progress. The Trust Board is recommended to note the report.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

June 2023

Kindness • Courage • Respect

Report period: March and April 2023

Contents

Headlines

3772+ Members of the staff Facebook group

188 Ask Peter questions asked

169 General enquiries dealt with

116 Staff attended Team Brief Live

96% Of media enquiries dealt with on deadline

Progress and plans

Improve Trust reputation through external communications and patient experience	Improve staff morale and engagement
What we've already done • Launched a new website in line with accessibility requirements • Consistently achieved goals around responsiveness to media enquiries • Responded to 95%+ FOIs within statutory time limits. • Taken over the remit of 'Membership communications' and started a new quarterly newsletter • Reviewed the content on our website, and that on the NHS website for our Trust • Introduced regular infographics on maternity stats, A&E stats and more recently patient feedback	**What we've already done** • Created a regular drumbeat for internal communications – Monday Message, Weekly Wednesday News, Building our Future on Thursdays and #ThumbsUpFriday • Put in place a new Thank You System for staff to easily share compliments boosting morale • Created a safe space for staff to raise concerns via the Ask Peter forum • Set up a staff Facebook group (c3.8k members) and have recently carried out a review of this to make improvements • Introduced Team Brief Live • Re-invigorated the way we share compliments on social media – swapping #ThankYouTuesday for #ThankYouNHS • Added the Trust Twitter feed to the home page of the Hub so staff not on social media can see our celebrating success content • Introduced a new managers email so we can target manager specific messages
What we're working on • How we can work more closely with our local media, providing positive news stories • Introduce more video content where relevant • Reviewing our social media channels	**What we're working on** • Working with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work. • Bringing back the annual staff awards ceremony, Our Stars 2023 • Reviewing Ask Peter

Supporting the Trust's priorities

Trust Priority 1 – Our People: We continued to support our FTSUG with Liz Houchin's appearance at April's Team Brief Live, we also conducted site visits across the Trust and designed some promotional materials. We videoed the Leading with Kindness, Courage and Respect leadership programme to create promotional materials for future cohorts. We also welcomed our first internationally recruited midwives with a press release and social media and supported the launch of the Trust's Dyslexia Guidance.

Trust Priority 2 – Quality and Safety: We supported the QI team with promoting the second conference and provided on-the-day support.

Trust Priority 3 – Restoring Services: We supported the next phase of the digital letters which was the rollout of admission letters to the remaining inpatient specialties

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Supporting the Trust's priorities

Trust Priority 8 – Capital Investment
March saw the opening of the new Scunthorpe Emergency Department. We held a media day which led to extensive regional print and broadcast coverage. We also created a whole suite of videos explaining about the different elements of the department. The tour of our new ED was the top video on our You Tube channel in this period with just under 5,000 views. In total, across all our channels, all of the videos we produced on this topic have bee viewed 17,094 times and are also featured on the P&HS Architects website which we can't get stats from.

While we did receive positive comments about how the unit looks, many members of the public raised concerns about staffing levels and waiting times. To address this, as part of our ongoing communications strategy, we will be highlighting good news stories around recruitment/ waiting times.

Trust Priority 10 – The NHS Green agenda - We continue to promote our sustainability work including a number of green initiatives. We encouraged staff to get involved with litter picking at Scunthorpe hospital and promoted Global Recycling Day.

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Campaigns and awareness weeks

Campaigns and awareness weeks

New security infographic
We created a new infographic to highlight the many incidents our security teams deal with and the efforts they go to keep staff, patients and visitors safe. It generated many compliments for the team which was a big boost for staff morale.

Neonatal, Children and Young People's strategy launch
We supported the launch of our first ever Neonatal, Children and Young people's strategy with a week of comms materials including a Monday Message, Hot Topic and screensaver.

Campaigns and awareness weeks

Campaigns and awareness weeks

Health Tree Foundation

Scunny Bikers paid a visit to Disney Ward for their annual Easter egg run. We sent out a news release. The organiser was interviewed on BBC Radio Humberside before the event and ITV Calendar attended on the day and spoke to people there on the day.

International Womens' Day

We celebrated IWD by sharing the inspiring stories of 21 of our female colleagues from a range of professions.

Improving staff morale and engagement

Keeping staff informed

All staff emails
Each week we send to all staff the Monday Message (a blog from a senior leader on a key topic), Wednesday Weekly News (an e-news round-up of news and updated) and on Thursdays we have a dedicated ‘Building Our Future’ update covering updates on the capital programmes in both estates and digital.

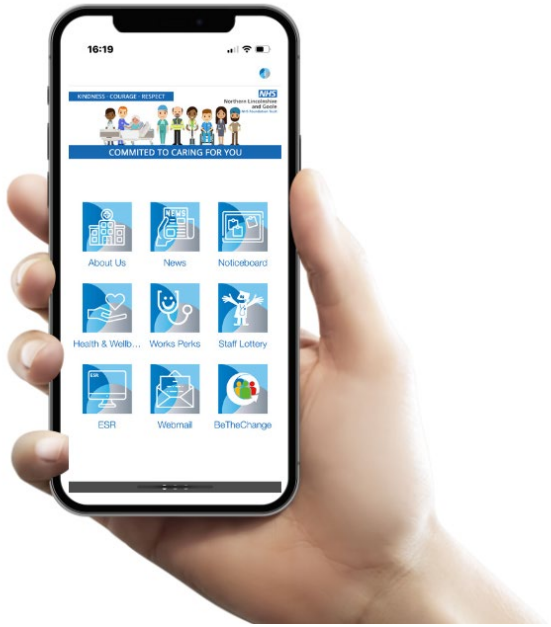
Each week we see between 5,700 and 7,200 opens of the Wednesday Weekly News.

The most popular edition of the Monday Message, with 6,423 opens, was the one covering Our Stars coming back from 2023

Building Our Future was opened 59,087 times over March and April and generated 3,357 click throughs.

There were 1243 opens of the March manager update and 1213 in April.

Staff App
There were 460 downloads of the staff app in this period.



Improving staff morale and engagement

Team Brief Live

Team Brief Live is a relatively new format held on Teams. For those who can't make it we share a recording of the session. Feedback has been positive so far.

56 joined the March session, with Director of People, Simon Nearney, which focused on our culture work including the staff survey results. In April the Trust Priorities and a focus on Freedom to Speak Up in April attracted 60 staff.

"No questions but valuable information thank you
Really interesting interactive session - thank you everyone!

Team Brief Live

NHS Northern Lincolnshire and Goole NHS Foundation Trust

We each have a voice that counts

Senior Leadership Briefing

64 senior leaders attended the SLC briefing in March. 68 joined in April

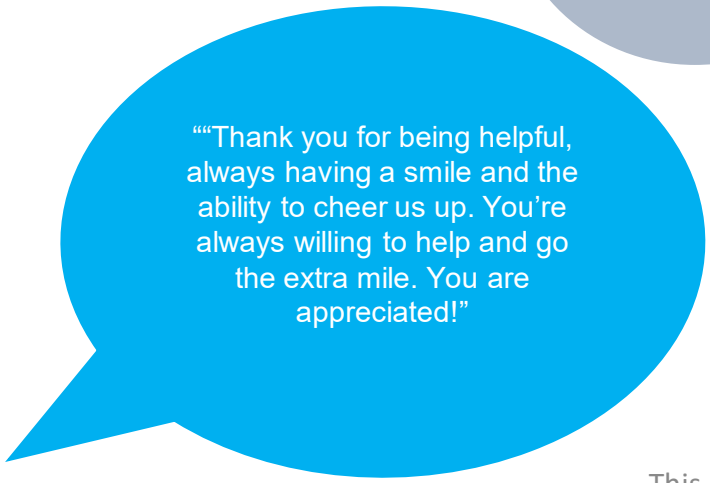
68 Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Giving staff a voice

Ask Peter
Ask Peter received a total of 188 questions in March and April 2023, despite the board being closed between 23 March to 5 April. However, this was a reduction of 22 from the previous two months in 2022. The directorates with the most questions continue to be Estates and Facilities, People, and the Chief Nurse. The main topics included: pay, incentives, uniform; pigeons; electric charging points for staff; face masks and HCAs training and roles. In total we redacted seven questions – to remove the names of wards/teams and disrespectful comments, and we removed two. One was a comment which was felt to be inappropriate about COVID-19, and the other was dealt with outside of the forum directly with the member of staff.

Staff Thank You
Since the 'Thank you' system launched in January staff have sent more than 1,176 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.



Improving reputation through external communications

Media coverage

There were 55 stories about the Trust in the media during this period. 100% of media coverage was positive or neutral in tone.
78% of coverage was in print or online media.

We categorise the media coverage into themes – in this period performance data was the top theme.

We issued 10 proactive news releases and the most covered was a story was the Scunthorpe Emergency Department opening.

National coverage of note including one of our Occupational Therapists featured in OT magazine in a positive piece. Digital Health covered our NHS app integration with outpatient letters and appointments

100%
Of media coverage was positive or neutral

Media enquiries

45 media enquiries were handled in this time, 96% were dealt with within the requested timescale. The top theme was pressures

The top theme for media enquiries was pressures and came in on the back of proactive news releases. The main reason journalists got in touch was to put in an interview request. 5 reactive statements were issued in this period.

Staff were interviewed on the recruitment of international midwives, preparations for the junior doctors strikes and Maternal Mental Health Week

96%
Of media enquiries dealt with on deadline

Social media

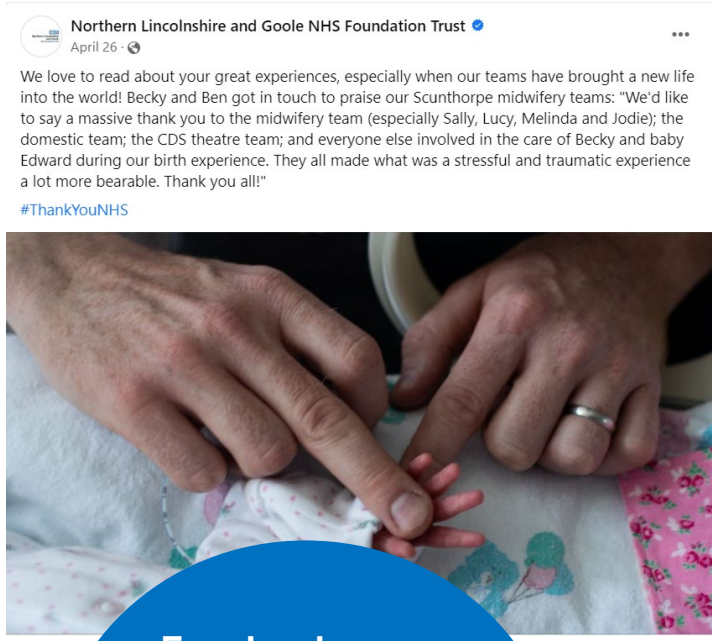
Social media overview
Followers update for the Trust's corporate accounts:

- 14,400 on the Trust's Facebook page
- 5,508 followers on Twitter
- 5351 followers on LinkedIn
- We are rated 4.6 out of 5 stars on reviews on Facebook

We shared 8 #ThankYouNHS posts and 25 #ThumbsUpFriday posts in this period

Staff Facebook group

Our closed staff Facebook group continues to grow and is one of our most used communication channels. It's a useful way of reaching staff who do not work in front of a computer all day so have limited access to the Hub, emails etc. We have more than 3,772 staff members on there and we're increasingly seeing staff use the group as a way to thank often thank each other for times when they've been in as a patient or as the family member of a patient.



Facebook group stats
3772 members
885 posts in this period
4299 comments
17,697 reactions

Improving reputation through external communications

External website – www.nlg.nhs.uk

The big news this period was the Trust's external website jumped up 92 places on the NHS website accessibility index, moving from 113th to 22nd! In April we moved up again and are now ranked 18th out of all NHS websites.

149,000
Page views on our website

Key stats:
37081 users
149,000 page views
5726 forms submitted
363 files downloaded
75% are mobile users
Most visited page: staff page followed by the Consultants A-Z and then the Grimsby hospital home page

The top three news releases viewed on the website were the Scunthorpe Emergency Department opening, preparations for the junior doctors strikes and text message reminders. It's worth noting the text message reminder release was issued in this time period, highlighting the search function on the website is bringing up relevant content for users.

Social media

Twitter
Both our top tweet, (by impressions) and top media tweet were posts about our new ED department at Scunthorpe

MAR 2023 SUMMARY

Tweets 68	Tweet impressions 22.7K
Profile visits 2,383	Mentions 171
New followers 27	

APR 2023 SUMMARY

Tweets 87	Tweet impressions 30.3K
Profile visits 3,030	Mentions 222
New followers 28	

Top tweet March

Top Tweet earned 2,863 impressions

Today we will be welcoming our first patients to our new £17.3m Scunthorpe Emergency Department (A&E) – just five months after the opening of its sister facility in Grimsby. Find out more: buff.ly/3Ln2eYJ

1 4 23

Top tweet April

Apr 2023 · 30 days

TWEET HIGHLIGHTS

Top Tweet earned 1,500 impressions

A big thank you to **@apetitouk** who have today put on a taste test as we look to make changes to our patient menu. We're aiming to reduce our carbon footprint by 60 tCO2e a year, that's the equivalent of driving 200k miles in an average car 🚗
pic.twitter.com/HxFpjPpyTy

2 4 8

View Tweet activity View all Tweet activity

Top media tweet March

Top media Tweet earned 1,073 impressions

Luckily, for most of us, our only experience of coming to an Emergency Department is for relatively minor injuries or illnesses. These are dealt with in our Urgent Care Centre and here, Matron Zoe Powell-Wiffen explains more about what you can expect at our new Scunthorpe A&E
pic.twitter.com/4KR2avau1Y

4 9

View Tweet activity View all Tweet activity

Top media tweet April

Top media Tweet earned 861 impressions

Meet our first internationally educated midwives, who will soon start their new roles at Scunthorpe and Grimsby hospitals 💙

The foursome are qualified and experienced midwives who have relocated to the local area to work with us.

Read more: buff.ly/3KbUXsv
pic.twitter.com/Z9Z5OdWxXO

3 10

View Tweet activity View all Tweet activity

This report covers March and April 2023

Social media

Facebook page
The Facebook post with the highest engagement was a Thumbs Up Friday about a staff member retiring.

Top three posts in March

Showing 5 posts in total

Sorted by Impressions

March 16, 2023 07:00am

Today we will be welcoming our first patients to our new Scunthorpe Emergency Department A&E – just five months after the opening of its sister facility in Grimsby. Once again, the £17.3 million unit has almost doubled the size of our existing department, providing us with modern, well-equipped facilities that are purpose

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,686	100	12,136	11,598	15.02%	–

March 22, 2023 10:33am

Our Community colleagues have been celebrating their 15 Steps certificates for delivering excellent care and services to our patients ✨💙 Congratulations to all of the following areas 👇 • Nutrition and Dietetics, Monarch House – Outstanding • North Lincolnshire Adult Community Therapies, Global House – Out

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
2,142	132	10,522	6,952	21.68%	–

March 29, 2023 06:01pm

This is Gareth, a patient of ours who got in touch to share his story and positive feedback... 💙 My name is Gareth, I am 28-years-old with a learning disability, autism and cerebral palsy. My mum is writing this for me as I don't read and write but I can understand what I want and in my own way let her know what I like and

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
964	179	5,949	5,854	19.65%	–

Top three posts in April

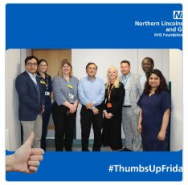
Showing 5 posts in total

Sorted by Impressions

April 7, 2023 08:00am

Virtual Ward Coordinator, Katie, retires next week! Her team got in touch with us to wish her a fond fairwell: "To a very special colleague, heartfelt congratulations on your retirement from the Trust. "It has been a privilege to work with you. Your devotion to your job and your kindness shown to all throughout the years st

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,384	287	6,102	5,990	30.35%	–



April 21, 2023 06:01pm

Today colleagues from the medicine division got together for a fish and chip Friday to celebrate the career of Dr Aamir Butt, Consultant Dermatologist pictured centre . Originally from Lahore, Pakistan, Dr Butt first came to Scunthorpe in 1991 for a job interview - where he recalls the medicine division consisted of

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
622	65	5,136	5,073	13.45%	–

April 12, 2023 04:08pm

A therapy challenge celebration event was held today at Scunthorpe hospital. A total of 76 therapists took part in an activity challenge to boost morale and health and wellbeing last month. Activities included walking alone, in groups and with dogs , running, dancing, climbing, swimming, exercising, cycling, football, horse ri

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
963	92	4,675	4,505	22.80%	–

Social media

LinkedIn

Stats

1,305 page views
554 unique visitors
806 reactions
43 comments
60 reposts

Content

The top post for impressions was a video on our new ED focusing on resus, and the top post for engagement was a recruitment event at a local college

You Tube

Stats

March	April
28	12
NEW SUBSCRIBERS	NEW SUBSCRIBERS
9,436	3,587
TOTAL VIEWS	TOTAL VIEWS
16.6K	5,638
MINUTES WATCHED	MINUTES WATCHED

Content

Our top video was a tour of our new Scunthorpe Emergency Department, which had 4,918 views

Enquiries and information requests

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 169 were received and dealt with. These can be anything from chasing appointments and results to providing feedback on services. For many of these the team act as a conduit for the Trust and filter them to other teams to deal with, but some are more complex and take more time. The top themes were accessing services and appointments.

169
General enquiries dealt with

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 104 submitted in this period – of these 91 are closed, 10 are still in progress and 3 are awaiting a response from the requester.

104
FOIs received

NLG(23)122

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6 June 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 (April 2023 – NLG(23)076).	
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**
275	Licence for Alterations Relating to Ambulance Station, Goole District Hospital (GDH)	17.05.2023

Action Required

The Trust Board is asked to note the report.

NLG(23)123

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6 June 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Trust Board Reporting Framework**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a scheduled of reports due at the Trust Board Meeting.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
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	
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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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4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Trust Board - Business Reporting Framework

REPORTING YEAR					2023 / 24					
Agenda Item	**Committee Oversight**	**Lead**	**Frequency**	**Action**	**April**	**June**	**August**	**October**	**December**	**February**
Business Items										
Declarations of Interest	N/A	Chair	Bi-monthly							
Chair's Opening Remarks	N/A	Chair	Bi-monthly							
Chair's Briefing	N/A	Chair	Bi-monthly	Noting						
Chief Executive's Briefing (to include Trust Priorities)	N/A	Chair	Bi-monthly	Noting						
Minutes of the Previous Meeting	N/A	Chair	Bi-monthly							
Trust Board Action Log	N/A	Chair	Bi-monthly							
Patient Story	N/A	Chief Nurse	Bi-monthly	Noting						
Integrated Performance Report	All Committees	Chief Information Officer	Bi-monthly	Noting						
Trust Board - Business Reporting Framework	N/A	Director of Corporate Goverance	Bi-monthly	Noting						
Register of Directors Interest and Fit & Proper Persons	N/A	Chair	Annual	Approval						
Trust Strategy	N/A	Chief Executive	3 Yearly	Noting						
Strategic Objective 1 - To Give Great Care										
F&PC Highight Report & Board Challenge	F&PC	NED Chair of F&PC	Bi-Monthly	Assurance						
Executive Report Performance - Key Issues	F&PC	Chief Operating Officer	Bi-monthly	Noting						
Q&SC Highlight Report & Board Challenge	Q&SC	NED Chair of Q&SC	Bi-Monthly	Assurance						
Executive Report Quality and Safety - Key Issues	WC	Chief Medical Officer and Chief Nurse	Bi-monthly	Noting						
Annual Establishment Review of Safe Staffing	Q&SC	Chief Nurse	Bi-annual	Approval						
Annual Quality Account	Q&SC	Chief Medical Officer	Annual	Approval						
Annual Review of Mental Health Strategy	Q&SC	Chief Operating Officer	3 yearly	Assurance						
Delivery of Mixed Sex Accommodation - Annual Declaration of Compliance to Trust Board	Q&SC	Chief Nurse	Annual	Approval						
Strategic Objective 2 - To Be a Good Employer & Strategic Objective 5 - To Provide Good Leadership										
WC Highlight Report & Board Challenge	WC	NED Chair of WC	Bi-monthly	Assurance						
Executive Report Workforce - Key Issues	WC	Director of People	Bi-monthly	Noting						
Freedom to Speak Up Guardian Report	WC	Freedom to Speak Up Guardian	Biannual	Assurance						
Freedom to Speak Up Self Assessment	WC	Director of People	Annual	Noting						
Gender Pay Gap Report	WC	Director of People	Annual	Approval						
Modern Slavery Statement	WC	Director of People	Annual	Approval						
Staff Survey	WC	Director of People	Annual	Noting						
Workforce Equality Disability Standards (WDES)	WC	Director of People	Annual	Approval						
Workforce Equality Standards Annual Report (WRES)	WC	Director of People	Annual	Approval						
Freedom to Speak Up Self Assessment	WC	Director of People	Annual	Noting						
Equality & Diversity Strategy	WC	Director of People	3 yearly	Approval						
People Strategy	WC	Director of People	3 yearly	Approval						

Agenda Item	Committee Oversight	Lead	Frequency	Action	April	June	August	October	December	February
Strategic Objective 3 - To Live Within Our Means										
Executive Report - Finance	F&PC	Chief Financial Officer	Bi-monthly	Noting						
F&PC Highight Report & Board Challenge	F&PC	NED Chair F&PC	Bi-monthly	Assurance						
Operational & Financial Plan	F&PC	Chief Operating Officer	Annual	Approval						
Business Planning / CIP Timetable	F&PC	Chief Financial Officer	Annual	Noting						
Major Capital / Overarching Capital	F&PC	Chief Financial Officer	Annual	Noting						
Winter Plan	F&PC	Chief Operating Officer	Annual	Assurance						
Annual Accounts - Delegation of Authority	AR&GC	Chief Financial Officer	Annual	Approval						
Digital Strategy	SDC	Chief Information Officer	3 yearly	Approval						
Estates Strategy	SDC	Director of Estates & Facilities	5 yearly	Approval						
Strategic Objective 4 - To Work More Collaboratively										
Executive Report - Strategic & Transformation	TBC	Director of Strategic Development	Bi-monthly	Assurance						
HTFC Highlight Report & Board Challenge	HTFC	Chair of HTFC	Bi-monthly	Assurance						
SDC Highlight Report & Board Challenge	SDC	Chair of SDC	Monthly	Assurance						
Clinical Strategy	F&PC	Director of Strategic Development	3 yearly	Assurance						
Governance										
AR&GC Highlight Report & Board Challenge	AR&GC	NED Chair of the AR&GC	Quarterly	Assurance						
Annual Accounts / Going Concern / Audit Letter / Annual Report & Annual Governance Statement	AR&GC	Various	Annual	Approval						
Audit Committee Annual Report	AR&GC	NED Chair of AR&GC	Annual	Approval						
Board Assurance Framework (BAF) and High Level Risk Register	All Committees	Director of Corporate Goverance	Quarterly	Assurance						
Emergency Preparedness, Resilience & Response Annual Report	AR&GC	Chief Operating Officer	Annual	Noting						
Fire Annual Report	AR&GC	Director of Estates & Facilities	Annual	Approval						
Health & Safety Policy Statement	AR&GC	Director of Estates & Facilities	Annual	Approval						
LSMS Annual Report and Workplan and Security Annual Report	AR&GC	Director of Estates & Facilities	Annual	Approval						
Protocol for Matters Reserved for Private Meetings	N/A	Director of Corporate Goverance	Annual	Approval						
Risk Appetite Statement	N/A	Director of Corporate Goverance	Annual	Approval						
Risk Management Strategy	AR&GC	Chief Medical Officer	3 Yearly (next 2024)	Approval						
Trust Constitution & Standing Orders	Trust Board & COG	Director of Corporate Goverance	3 yearly	Approval						
Trust Board - NHS Provider Self-Certification	N/A	Chair	Annual	Assurance						

Agenda Item	Committee Oversight	Lead	Frequency	Action	April	June	August	October	December	February
Trust Board, Board Committees & approval of changes to Terms of Reference	All Committees	Committee Chairs	Annual	Approval						
Trust Board & Board Committee Meetings Timetable	All Committees	Director of Corporate Goverance	Annual	Approval						
Trust Board and Board Committees Performance & Effectiveness	N/A	Chair	Annual	Noting						
Trust Board Development Programme	N/A	Chair	Annual	Noting						
Trust Scheme of Delegation and Powers Reserved for the Trust Board / Standing Financial Instructions	AR&GC	Chief Financial Officer	3 yearly	Approval						
Items for Information										
Communications Report	N/A	Associate Director of Communications	Bi-monthly	Noting						
Committee Minutes - Public & Private	All Committees	NED Chairs	Bi-monthly	Noting						
Deviations from NICE guidance	Q&SC	NED Chair	Ad-hoc	Noting						
15 Steps Annual Report	Q&SC	Chief Nurse	Annual	Noting						
Nursing Assurance Report (includes same sex accomodation)	Q&SC	Chief Nurse	Bi-monthly	Assurance						
Guardian of Safe Working Hours	WC	Chief Medical Officer	Quarterly	Assurance	Q3	Q4	Q1		Q2	
Patient Experience Report incorporating Annual inpatient survey result & action	Q&SC	Chief Nurse	Quarterly	Assurance	Q3	Q4	Q1		Q2	
Documents Signed Under Seal	N/A	Director of Corporate Goverance	Quarterly	Noting	Q4			Q2		
Executive & NED Statutory & Other Lead Roles	N/A	Vice Chair / Director of Corporate Governance	Annual	Noting						
Annual Complaints Report	Q&SC	Chief Nurse	Annual	Assurance						
Medical Appraisal & Revalidation Annual Report (AOA)	WC	Chief Medical Officer	Annual	Assurance						
Infection Control Annual Report	Q&SC	Chief Nurse	Annual	Assurance						
Safeguarding & Vulnerabilities Annual Report	Q&SC	Chief Nurse	Annual	Assurance						

Items for Trust Boards - Guidance for Papers

Title	Description	Frequency	Source	Action
Adult & Child Safeguarding Annual Report	The purpose of the report is to provides assurance that Trust is compliant with safeguarding duties. To update the Trust Board on safeguarding activity, issues and risks	Annual	There are multiple sources but the link below is fairly comprehensive. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-	Assurance
Annual Emergency Planning Position & Plan - EPRR Self-Assessment Assurance Report	The purpose of this document is to provide guidance to organisations completing the EPRR annual assurance process by: providing an overview of the Core Standards for EPRR outlining roles and responsibilities of the organisations involved defining the participating organisations setting out the EPRR annual assurance process. The Civil Contingencies Act 2004 and the NHS EPRR Framework requires NHS Acute organisations to plan for, respond to and recover from major incidents. The purpose of this paper is for information purposes detailing the work of the Emergency Planning Team	Annual	Annually, NHS England issues a set of EPRR Core Standards on which the trust has to complete a self assessment. https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-annual-assurance-guidance-v1.pdf	Incorporated within the Annual Report
Annual Plan / Draft Operational & Financial Plan	NHS Operational Planning and Contracting Requirements	Annual	See NHS Operational Planning and Contracting Guidance 2021/22 https://www.england.nhs.uk/operational-planning-and-contracting/	Approval
Annual Quality Account	Improving quality in organisations: All organisations should implement plans to improve quality of care, particularly for organisations in special measures; drawing on the NQB's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services; and participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare. To formally adopt the Quality Account in public session	Annual	See page 7 of https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf	Assurance
Annual Report and Accounts including Annual Governance Statement and Quality Report	The Department of Health and Social Care (DHSC)'s Group Accounting Manual (GAM) requires NHS trusts to include an annual governance statement (AGS) in their annual report	Annual	https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual/ https://improvement.nhs.uk/resources/quality-accounts-requirements/	Assurance
Annual Report from the Director of Infection Prevention and Control	The purpose of this report is to inform and provide assurance to the trust Board, patients, public and staff of the processes in place at NLAG to prevent and control healthcare associated infections (HCAI). To provide an update on the Trust's Infection Prevention & Control activities and information on actions in place	Annual	Health and Social Care Act (2008) : Code of Practice for the NHS on prevention and control of healthcare related guidance. https://www.nice.org.uk/guidance/ph36/chapter/Quality-improvement-statement-1-Board-level-leadership-to-prevent-HCAIs	Assurance
Audit Committee Annual Report	To provide assurance to the Trust Board that the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Annual	In line with the requirements of the NHS Audit Committee Handbook (HFMA) and contributes to the Annual Governance Statement	Approval
Caldicott Guardian Annual Repo	To advise the Board of work undertaken by and in support of the Caldicott Guardian during the preceding year	Annual	The Caldicott Guardian is appointed by the Trust Board and The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust's overall governance framework	Assurance
Delivering a Net Zero Health Service	The Publication of the Delivering a Net Zero Health Service for NHS in October 2020 set a mandatory framework for NHS organisations. This includes sustainability indicators reported nationally through systems, such as the Greener NHS Dashboard and produce a Green Plan to be approved byt the Board along with an annual summary of progress towards net zero	Annual	Carbon Reduction forms part of Annual Report and Accounts. Annual sustainability reporting is now mandated for clinical commissioning groups (CCGs) and trusts by the NHS Standard Contract (Service Condition 18) See Page 45 of this link. https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf	Assurance
Flu Vaccination Information	In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018	Annual		Noting
Freedom to Speak up Guardian Reports including Annual Report	The report provides an update from the Trusts Freedom to Speak Up Guardian in relation to any national or local developments relating to Raising Concerns or Whistleblowing. To provide thematic reporting to the Board on the themes and issues that are being reported to the FTSUG. The Trust Board is responsible for setting the culture and tone of the organization and in line with the Trust's values of openness, compassion and learning	Bi-annual	Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf The requirement for NHS organisations to establish a Freedom to Speak Up Guardian (F2SUG) arose from the recommendations made by Sir Robert Francis in his report into failings at Mid Staffordshire Hospitals NHS Foundation Trust. There is also an expectation that the F2SUG will report directly to the Chief Executive Officer and the Trust Board on the issues that are being reported to them	Approval
Health and Safety Risk Management Annual Report	HSE Gudance sets out an agenda for the effective leadership of health and safety. It is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. Provided primarily for assurance given the overall responsibility of the Trust Board for Health & Safety in the organisation and the potential individual and corporate consequences of health and safety breaches	Annual	Various requirements See link https://www.hse.gov.uk/pubns/indg417.pdf	Assurance
High Level Risk Register	To inform the Board of the Trust's highest rated risks which are currently logged on the Corporate Risk Register	Three times per year	This quarterly report is included as part of the Board reporting framework	Assurance

Title	Description	Frequency	Source	Action
Information Governance/Cyber Security reporting	Data Security and Protection Toolkit. Information Governance is a key component of the Trust's governance framework and has regulatory consequences if requirements are not adhered to	Annual	Some general reference to the Board but does not include specifc board reporting requirements https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit	Assurance
Medical Appraisal and Revalidation Annual Report - Annual Organisational Audit	This Report provides information about the medical appraisal and revalidation system and processes over the year, highlighting key issues and action being taken to respond to them. Revalidation is a statutory obligation with which the Trust must comply. Reports provide assurance that requirements are being met and that governance arrangements are robust	Annual	A Framework of Quality Assurance for Responsible Officers and Revalidation https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/04/fqa.pdf	Assurance
Mortality (SHMI and HSMR) Update	Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals" This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings This first edition of National Guidance on Learning from Deaths aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful. To monitor	Various	National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to 'Learning From Deaths' to quality accounts from 2017/18 onwards. These new regulations and the explanatory memorandum are available at http://www.legislation.gov.uk/uksi/2017/744/introduction/made	Noting
NHS Provider Licence Self-Certification	NHS foundation trusts and trusts must self-certify that they can meet the obligations set out in the NHS provider licence. The licence includes requirements to comply with NHS acts and constitution, and with governance requirements. NHS foundation trusts designated to provide commissioner requested services are also required to complete a self-certification on the availability of resources to deliver those services	Annual	The NHS Provider Licence https://improvement.nhs.uk/resources/self-certification-guidance-nhs-foundation-trusts-and-nhs-trusts/ NHS foundation trusts and trusts must self-certify that they can meet the obligations set out in the NHS provider licence. The licence includes requirements to comply with NHS acts and constitution, and with governance requirements. NHS foundation trusts designated to provide commissioner requested services are also required to complete a self-certification on the availability of resources to deliver those services	Assurance
NHS Resolution Maternity Incentive Scheme	Self Declaration	Annual	https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf	Assurance
NHS Staff Survey Report and Action Plan	Provides an overview of the annual NHS National Staff Survey. The report is to provide assurance regarding engagement, quality and people management matters across the Trust	Annual		Noting
Ockenden	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Quarterly to Q&SC & Trust Board	https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf	Assurance
Patient Experience Report incorporating Annual inpatient survey result and action, and Annual Complaints Report	Quarterly reports collating the various sources of patient feedback are produced by the Patient Experience Team	Three times per year & Annual report	Patient experience information supports the CCG in making decisions about local health services The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 statutory instrument 309 requires NHS bodies to provide an annual report on its complaints handling, which must be available to the public. To provide the Board with oversight around the management of complaints following the report of the Chief Inspector of Hospitals Inspection	Assurance
Quarterly Report from the Guardian of Safe Working Hours – This is a requirement of the Junior Doctors contract T&Cs	The 2016 junior doctors contract (Schedule 6, para 11) requires the Guardian of Safe Working an overview and assurance of the trusts compliance with safe working hours for doctors across the trust and to highlight and detail any areas of concern. The report is to demonstrate the work of the Guardian in championing safe working hours in the trust to ensure the protection of patients and doctors	Quarterly	See Page 35 https://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Terms-and-Conditions-of-Service-for-NHS-Doctors-and-Dentists-in-Training-England-2016-Version-2--30-March-2017.pdf	Assurance
Research and Development Ann	Sets out the strategic objectives, how the strategy is delivered, benchmarking data and provides commentary around income and future developments	Annual	Research, development and innovation are fundamental to excellence in healthcare which is one of the guiding principles of the NHS as set out in the NHS Constitution. The Trust is required to demonstrate adherence to national guidance and current legislation	Noting
Risk Management Strategy	To approve Strategy Updates	Annual	The management of risk underpins all strategies, processes and activities that lead to the achievement of the aims and objectives of the Trust	Approval

Title	Description	Frequency	Source	Action
Safer Staffing and Expectations relating to nursing, midwifery and care staffing capacity and capability	It is an expectation set out in the National Quality Board that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level	Bi-annual	NQB guidance published in November 2013 (http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf) - page 7 It is a national requirement that a staffing assessment is submitted twice a year in order that the Board is aware of the Trust's position against national guidance and can take action where appropriate	Approval
Timetable of Board and Committ	To approve the annual timetable of Board and Committee meetings for the year ahead	Annual	As part of the overall governance structure for the organisation	Noting
Workforce Race Equality Standard (WRES) Action Plan & Workforce Disability Equality Standard (WDES)	To enable organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice.To provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda. To inform the Board of the work of Equality and Diversity throughout the Trust and progress in relation to the actions in the Equality and Diversity System2	Annual	The Trust is required, by the Equality Act 2010, to eliminate discrimination, victimisation and harassment, advance equality of opportunity and foster good relations between different groups and required to publish Equality. To ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the work place - aligned to the strategic objective to be an employer of choice	Assurance

Update Reports shared through Executive and Non-Executive Director Highlight Reports to the Trust Board			
Committee & Report Update	**Frequency**	**Update included within Executive Report**	**Update included within NED Chair Report**
Quality & Safety Committee			
CQC Update (to include costs when required)	Ad-hoc	X	
Mental Health Strategy Progress Update	Annual	X	
Mortality Update	Quarterly	X	
Quality Improvement Update	Bi-annual	X	
Serious Incident Report	Quarterly	X	
CNST & Ockenden (maternity)	Quarterly		X
Complaints Report	Annual		X
Delivery of Mixed Sex Accommodation - Annual Declaration of Compliance to Trust Board	Annual		X
Deviations from NICE guidance	Ad-hoc		X
Medicines Management Report	Annual		X
Infection Control Annual Report	Annual		X
Quality Account	Annual		X
Research and Development Report	Annual		X
Safeguarding & Vulnerabilities Report	Annual		X
Workforce Committee			
Self Assessment Review - Health Education England		X	
People Strategy Progress Update	Annual	X	
Equality & Diversity Progress Update	Annual	X	
Annual Organisational Audit (AOA)			X
Flu Vaccination Self-Assessment			X
Flu Vaccination Update Rates			X
Medical Appraisal and Revalidation Annual Report (AOA)	Annual		X
Freedom to Speak Up Strategy			
Audit, Risk & Governance Committee			
Information Governance/Cyber Security Reporting (IG Toolkit)	Annual	X	
Caldicott Report	Annual		X
Local Counter Fraud Specialist Annual Report (private board - information item)	Annual		X
Risk Management Strategy Progress Update	Annual	X	
Strategic Development Committee			
Digital Strategy Progress Update	Annual	X	
Chief Executive Reporting			
Approval of CQC Statement of Purpose			
Trust Strategy Progress Update	Annual	X	
Finance & Performance Committee			
Estates Strategy Progress Update	Annual	X	
Other			
Clinical Strategy Progress Update	Ad-hoc	X	
High Level Risk Register	3 times per year	X	
Trust Constitution & Standing Orders	Ad-hoc	X	