NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD
Tuesday, 3 October 2023
Main Boardroom, Diana, Princess of Wales Hospital
Time – 9.00 am – 12.30 pm
For the purpose of transacting the business set out below

No	Agenda Item	Lead	Format	Purpose	Time
Standing Items					
1	Welcome and Apologies	Chair	Verbal	Noting	09:00 hrs
2	Declarations of Interest/Conflicts of interest with any agenda items	Chair	Verbal	Noting	
3	Minutes of the meeting held on Tuesday, 1 August 2023	Chair	Attached NLG(23)168	Approval	
4	Action Log - Public	Chair	Attached NLG(23)169	Noting	
5	Matters Arising	Chair	Verbal	Noting	
6	Trust Board Reporting Framework	Director of Corporate Governance	Attached NLG(23)170	Information	
7	Patient Story	Senior Nurse – Patient Experience	Verbal	Assurance	09:10 hrs
8	Report from the Group Chief Executive	Group CEO	Attached NLG(23)171	Assurance	09.30 hrs
9 Board Committees Highlight Reports					
9.1	Escalation from the Quality & Safety Committee	Chair of Committee	Attached NLG(23)172	Assurance	09.50 hrs
9.2	Escalation from the Finance & Performance Committee	Chair of Committee	Attached NLG(23)173	Assurance	10.05 hrs
9.3	Escalation from the Workforce Committee	Chair of Committee	Attached NLG(23)174	Assurance	10.20 hrs
9.4	Escalation from the Group Development Committee-In-Common	Chair of Committee	Attached NLG(23)175	Assurance	10:35 hrs
9.5	Health Tree Foundation Trustees' Committee	Deputy Chair of Committee	Attached NLG(23)176	Assurance	10:45 hrs
BREAK – 10:55 hrs – 11:05 hrs					
10 Quality & Safety					
10.1	Maternity & Neonatal Oversight Report	Chief Nurse	Attached NLG(23)177	Assurance	11:05 hrs

11 Governance and Assurance					
11.1	Board Assurance Framework	Director of Corporate Governance	Attached NLG(23)178	Assurance	11:15 hrs
12 Items for Approval					
12.1	Workforce Disability Equality Standard (WDES)	Interim Director of People	Attached NLG(23)179	Approval	11:35 hrs
12.2	Workforce Equality Standard Annual Report (WRES)	Interim Director of People	Attached NLG(23)180	Approval	11:45 hrs
12.3	Protocol for Matters Reserved for Private Meetings	Director of Corporate Governance	Attached NLG(23)181	Approval	11:55 hrs
12.4	NHS Impact – Baseline & Assessment	Chief Nurse	Attached NLG(23)182	Approval	12:00 hrs
12.5	Fit & Proper Persons Policy and New Framework	Director of Corporate Governance	Attached NLG(23)183	Approval	12:05 hrs
12.6	Council of Governors & Trust Board Engagement Policy	Director of Corporate Governance	Attached NLG(23)184	Approval	12:10 hrs
Any Other Business					
13	Other Business	Chair	Verbal	Noting	12:15 hrs
14	**Date and time of the next meeting:** Tuesday, 5 December 2023 Time: 9am Main Boardroom, DPOWH	Chair	Verbal	Information	
15 Supporting Documents					
15.1	**Quality & Safety**				
	Quality & Safety Committee Minutes – July & August 2023	Chair of Committee	Attached NLG(23)185	Noting	
	Annual Complaints Report	Chief Nurse	Attached NLG(23)186	Assurance	
	Nursing & Midwifery Assurance Report	Chief Nurse	Attached NLG(23)187	Assurance	
15.2	**Workforce**				
	Workforce Committee Minutes – July 2023	Chair of Committee	Attached NLG(23)188	Noting	
15.3	**Finance & Performance**				
	Finance & Performance Committee Minutes – June, July & August 2023	Chair of Committee	Attached NLG(23)189	Noting	
15.4	**Health Tree Foundation Trustees'**				
	Health Tree Foundation Trustees' Committee Minutes – July 2023	Chair of Committee	Attached NLG(23)190	Noting	

15.5	**Other**				
	Trust Board & Board Committee Meetings Timetable	Director of Corporate Governance	Attached NLG(23)191	Noting	
	Communications Report	Associate Director of Communications	Attached NLG(23)192	Noting	
	Documents Signed Under Seal	Director of Corporate Governance	Attached NLG(23)193	Noting	
	Integrated Performance Report	Chief Information Officer	NLG(23)197	Noting	

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.

NLG(23)168

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (MEETING IN PUBLIC)

Minutes of the Public Meeting held on Tuesday, 1 August 2023 at 9.00 am
In the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Diana Barnes	Public Governor
Rachel Farmer	NHS Liaison
Nicky Foster	Associate Chief Nurse – Midwifery, Gynaecology & Breast Services (for item 3.2)
Charlie Grinhaff	Communications Manager (representing Adrian Beddow)
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates & Facilities
Jo Loughborough	Senior Nurse – Patient Experience (for item 1.3)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Ian Reekie	Lead Governor
Kate Truscott	Associate Non-Executive Director
Katrina Vorley	Business Support Officer – Corporate Governance
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.

1.2 Apologies for Absence

Apologies for absence were received from Simon Nearney, Simon Parkes and Adrian Beddow (represented by Charlie Grinhaff).

1.3 Patients' Story

Jo Loughborough shared Vicki's story which related to changes around visiting times. Ellie Monkhouse explained one of the key themes from patient feedback was around passionate care. This would also be shared at the Nursing Conference due to be held in September. A review had been undertaken in respect of visiting which had been tested with patients, carers and visitors, those results were now being compiled. It was noted the Trust had arranged visiting very differently during Covid, particularly for those patients that were vulnerable, other Trusts had sought the Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) policy to review processes.

Sean Lyons commended the Nursing Conference to everyone noting it was an uplifting event and well worth attending.

Fiona Osborne explained visiting arrangements and other aspects were reviewed through the Quality & Safety Committee (Q&SC), it was noted this included the psychological harm of patients in those circumstances. Sean Lyons queried whether this was often a national level story for patients. Jo Loughborough agreed it was the case and was being recognised that having significant others around you whilst in hospital did make a difference. It was noted new Legislation would be released regarding this in the future.

Helen Harris queried whether the video shared could include subtitles as it was difficult to hear at times. Jo Loughborough agreed to investigate this.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

Shaun Stacey apologised for some papers being shared late and thanked everyone for the understanding of this.

2.2 To approve the minutes of the Public Meeting held on Tuesday, 6 June 2023 – NLG(23)131

The minutes of the meeting held on the 6 June 2023 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments were made.

- Fiona Osborne referred to page six, item 3.4. It did not include the recommendation made by the Q&SC to have a Board discussion to better explore Bank and Agency usage, shift fill rates and subsequent impacts to the patient. It was agreed to add the recommendation to the minutes.
- Lee Bond referred to page six, item 3.4. It was noted the phrasing of this would be reworded.
- Dr Kate Wood referred to page four, section 3.1. Wording to be changed to state weighing had not been resolved, however, additional mechanisms were in place to support weighing through the Emergency Department (ED).
- Dr Kate Wood referred to page four, item 3.1. Additional wording to be added to the paragraph to read "the issue was with regard to the timing of a pressure ulcer meeting which had now been rectified".
- Dr Kate Wood referred to page ten, item 5.2. A query was raised regarding the strike costs as they appeared to be high. Lee Bond agreed there had been a decimal point missing and this would be amended.

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)132

Sean Lyons referred to the action log and requested updates. The following updates were noted.

- Item 3.4, 6 June 2023 meeting, Q&SC Highlight Report – Issues around recruitment. Fiona Osborne asked if the wording could be changed to read "bank and agency usage" rather than recruitment as that was the issue raised by the committee.
- Item 3.2, 6 June 2023 meeting, Maternity Oversight Report. Ellie Monkhouse explained the table had not been split by division but had been amended for this meeting.
- Item 3.4, 6 June 2023 meeting, Q&SC Highlight Report – Record on Risk Register. Dr Kate Wood confirmed this item was on the Risk Register.

2.5 Chief Executive's Briefing – NLG(23)133

Shaun Stacey referred to the report and highlighted key points. It was noted that the Amanda Bloor visit had gone well, a further visit at the Grimsby site would be undertaken later in the month. Any impact due to the industrial action was detailed within the report.

Shaun Stacey wanted to note thanks to the staff involved in the two incidents detailed within the report, all staff had worked amazingly.

Shaun Stacey advised of two staff members who had sadly passed away, Sean Lyons noted condolences to the families from the Board.

2.6 Integrated Performance Report (IPR) – NLG(23)134

Sean Lyons advised the IPR was for noting and discussion in the following Executive items on the agenda. Sean Lyons noted new metrics within the report and asked if that could be highlighted during discussions.

3. Strategic Objective 1 – To Give Great Care

3.1 Quality & Safety - Key Issues - NLG(23)134

Dr Kate Wood addressed the additional indictors in the report at the outset, it was pleasing to see they were now included within the IPR. The End of Life indicators were part of the quality priorities for the year and was therefore within the IPR, these were also discussed at length at the Q&SC through deep dives.

Ellie Monkhouse advised there was some data surveillance around maternity services. These were key indicators that were recommended for patient safety within maternity services. These allowed themes and trends to be reviewed and monitored. Regional and National benchmarking would be reviewed to set the NLAG target.

Shauna McMahon explained the IPR should include targets when there was a metric included. The team were in the process of collating this information to be included in the IPR.

Action: Executive Team to provide target information

Linda Jackson queried what the Robson score was. Ellie Monkhouse advised this was dictated by the World Health Organisation (WHO), included within this was 10 classifications. A description of them would be appended to the next report.

Dr Kate Wood explained Venous Thromboembolism (VTE) continued to be maintained. The Summary Hospital Level Mortality Indicator (SHMI) remained stable, however, there was a lack of reporting in respect of mortality benchmarking at the moment. The data was due to be pulled across to align with Hull University Teaching Hospital NHS Trust (HUTHs) reporting mechanisms. There was challenge in respect of mortality due to the structured judgement review data pack. The Trust had been an early adopter through NHS England (NHSE), however, the support provided had now been withdrawn which meant clinicians were struggling to analyse the data. Shauna McMahon was supporting alongside the team to ensure a mortality package was in place, this would be the same across the two Trusts. The reviews looked at themes across mortality which had remained the same around early identification and end of life care. It was noted all deaths were scrutinised by the medical examiner which meant the structured judgement reviews were not being relied on. In respect of weighing patients this was still not

where it should be. The robotic process automation would be in place from October 2023 which would mean the weight of a patient would be transferred from WebV to the Electronic Prescribing and Medicines Administration (EPMA) system to provide a more holistic view of patient weights.

Sean Lyons referred to the data gap in respect of paediatric sepsis. Dr Kate Wood advised that although the team were treating patients, this was not being recorded. The sepsis teams would work through how to manage this more effectively going forward. Nothing had been flagged as an issue through incidents, however, the data did not provide assurance.

Ellie Monkhouse highlighted the yearly targets for infection control, it was noted that as NLAG had met positive targets in terms of Clostridium Difficile (C.Diff) it had been reduced this year to 20. It was noted there were some anomalies within the IPR that had been noted in the Q&SC. Sean Lyons queried whether there was confidence the new C.Diff target would be met. Ellie Monkhouse advised that although this would be a challenge the team were confident due to the processes in place.

3.2 Maternity Oversight Report – NLG(23)135

Nicky Foster shared the paper and referred to highlights within the report. It was noted a visit had been received by the team where the action plan and evidence had been presented, a further visit was expected in September 2023. It was noted training details would be included in future reports.

Dr Kate Wood wanted to highlight the excellent work in respect of training compliance as this had improved compared to previous reports. Stuart Hall referred to the Birmingham Symptom Specific Triage Systems (BSOTS) and queried where NLAG was in terms of the roll out of this. Nicky Foster advised the initial triage had commenced and been in place for a year, the second phase of triage had started. Nicky Foster explained an electronic system had been used previously, however, the Badgernet system would strengthen that. Linda Jackson referred to the staffing figures within the report and queried what plans were in place to address the number of vacancies. Nicky Foster confirmed that despite the number of vacancies the service was still being run in a safe way. A number of newly qualified midwives were due to start in the Autumn, different ways of working were being reviewed to address cover across services. It was noted those newly qualified midwives would need a month to induct into those roles. Ellie Monkhouse explained staffing levels were reviewed daily and were adapted to cover areas that required additional cover.

Fiona Osborne queried whether additional support was required from the board in respect of the Clinical Negligence Scheme for Trusts (CNST). Nicky Foster advised there may be a need for a Diabetes Midwife to be part of the Multi-disciplinary Team (MDT), the funding process had commenced for this. The ten actions were on track, some workforce reviews would also be supported by Ellie Monkhouse. Lee Bond queried whether one of the current vacancies could convert to this role, it was explained converting a Band six to a Band seven post would not be normal process. It was agreed further discussion would take place around this matter outside of the meeting. Shaun Stacey agreed this would be

discussed through the Trust Management Board (TMB) and Nursing and Midwifery (N&M) Board to ensure it was within current financial controls. Ellie Monkhouse advised this would only solve a temporary issue.

Sean Lyons referred to the board assurance tool compliance and queried whether there was anything to be concerned about. Nicky Foster explained this was being addressed as there had been an anomaly with the reporting, this would be reported correctly in the next report. Gill Ponder advised this issue had been discussed at the Q&SC so oversight was in place. Ellie Monkhouse was confident this would be resolved.

3.3 Quality & Safety Committee Highlight Report and Board Challenge – NLG(23)136

Kate Truscott referred to the report and highlighted key points. Dr Kate Wood referred to the National Dementia Audit and Delirium point highlighted within the report, it was noted awareness sessions were being held with medical staff on the importance of delirium screening and pathway follow up had been re-emphasised. Ellie Monkhouse felt confident the Trust would not be in this position when the next results were received as improved processes were already in place.

Sean Lyons referred to the Patient Safety Incident Reporting Framework (PSIRF) and advised the Board would receive a briefing on this in the future. It was a greed Helen Harris would schedule this into the programme.

Action: Helen Harris

Fiona Osborne added that the Q&SC received an update on programme progress on a monthly basis. The committee were assured by the framework in place and that communication would be implemented in a productive way. Kate Truscott noted that although HUTH had been an early adopter of the system NLAG had adopted a different approach, having a briefing would provide more understanding to the Board. Sean Lyons agreed it would be useful to see how this progressed at both Trusts. Stuart Hall agreed this was still working progress at HUTH.

3.4 Performance - Key Issues – NLG(23)134

Ashy Shanker referred to the report and advised that Urgent Emergency Care (UEC) maintained trajectory. The challenge would be to reach the 76% target by the end of the year. Mitigation was in place by ensuring establishments were robust across all EDs. There had been some challenge in reaching performance of patient flow in ED. To improve this, patient length of stay was being reviewed. Weekly meetings were being held to include the review of long waiters. One of the key issues related to North Lincolnshire (NL) patients as they tended to stay in hospital longer. Sean Lyons queried why this was the case. Ashy Shanker advised this was due to the issues with social care capacity. Sean Lyons was aware discussions had taken place with the Integrated Care Board (ICB) Chief Executive around those issues. Shaun Stacey advised the approach to social care was different to North East Lincolnshire (NEL). This issue would be raised at the next follow up meeting. Sean Lyons offered to provide support if required. Ashy Shanker referred to the report and provided an update on the cancer waiting times.

Fiona Osborne referred to the 104-day cancer referrals and queried how many of those patients were believed to have cancer. Ashy Shanker explained there was currently 57 patients which were being worked through, once diagnostic testing was completed those identified with cancer would be prioritised. Lee Bond felt the report described this as an administration issue. Ashy Shanker confirmed this was not the case. Dr Kate Wood advised the administrators only inputted information provided by clinicians, it was felt the wording needed to be more clear to explain this. Lee Bond queried whether the 92% occupancy included the 21 opened escalation beds, Ashy Shanker confirmed this was the case.

Linda Jackson referred to the reduction of the outpatient follow up target and queried whether there was confidence this would be achieved. A further query related to long waiters and whether there was confidence this would be addressed. Ashy Shanker referred to the follow up query and explained these were stretched targets which included transformational targets, review of these would take place on a regular basis and it was believed this would reduce over the next few months. There were a number of follow ups, some patients were not discharged until a review took place which impacted on numbers. These were being reviewed with clinical leads to customise the process. In relation to long waiters, these had been focussed on, however, there had been some validation breaches. The focus was to have zero patients waiting longer than 65 weeks by the end of the year. One of the issues related to theatre availability as those had been reduced, despite those issues it was felt the target would be achieved.

Gill Ponder highlighted the administration issue had been raised at the Finance & Performance Committee (F&PC), however, the committee had been assured patients were being worked through correctly.

Stuart Hall queried how 'wait to be seen' times were monitored, a further query related to an update being provided on mitigating actions in place during the scheduled industrial action. Ashy Shanker explained a triage service was in place for patients that arrived at ED, an assessment was undertaken by a senior nurse or doctor where a plan of care was decided. Waiting times were monitored on a daily basis, if an increase in time was identified this would be addressed. Although industrial action had some impact, this was addressed by putting in place senior cover when required. The most impact related to elective activity being cancelled due to consultant strikes. When this affected cancer patients', additional resource was put in place in respect of Multi-disciplinary (MDT) meetings being held prior to the industrial action to alleviate any issues.

3.5 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(23)137

Gill Ponder referred to the report and noted key highlights. The Committee recommend that the Board accept the Elective Care 2023/24 Priorities submission, this was noted by the Board.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Workforce - Key Issues - NLG(23)134

Lee Bond referred to the report and noted sickness had reduced over the last six months. It was noted the registered nurse position had reduced, however, this remained slightly above target. Appraisal compliance was 84% which was the best position NLAG had been in since December 2021. Linda Jackson referred to page 38 in respect of the medical vacancy rates increase, this had previously been raised at F&PC, it was queried whether there was more understanding of why this was the case. It was agreed this would be addressed as part of the workforce deep dive session that afternoon.

4.2 Workforce Committee Highlight Report & Board Challenge – NLG(23)138

Sue Liburd referred to the highlight report and advised of the request from the Audit, Risk & Governance Committee (AR&GC) regarding the Apprenticeship Levy. The Board were advised action was being taken.

Fiona Osborne referred to the mitigations around the Level 3 Safeguarding training and queried whether robust escalation was in place for non-completion. Sue Liburd confirmed this was in place, individuals were monitored once the non-compliance was highlighted. Ellie Monkhouse explained the National Workforce Plan had detailed some challenging figures of what would be expected to be delivered over the next two years and it was hoped this investment would fulfil this requirement.

Dr Kate Wood referred to item seven within the report, Guardian of Safe Working Hours Annual Report. This was listed as an item for information within the appendix and required Board approval.

The Trust Board approved the Guardian of Safe Working Hours Annual Report.

4.3 Medical Appraisal & Revalidation Annual Report (AOA) – NLG(23)157

Dr Kate Wood shared the report and advised it was an essential requirement for the Board to receive the Annual Report. A deep dive had also been undertaken of the report at the Workforce Committee.

Dr Kate Wood sought Trust Board approval, the Trust Board approved the Medical Appraisal and Revalidation Annual Report.

Linda Jackson recognised the improvements made in respect of appraisals and revalidation. Dr Kate Wood explained an extensive action plan of what would be completed over the next year was in place.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 03 - NLG(23)139

Lee Bond referred to the report and advised the Trust had an in-month deficit of £3.5 million which was a slight improvement against the plan. The year-to-date deficit was £6.9 million at month three which again was an improvement against the plan. A number of forecasts had been completed for the year based on spend as detailed on page eight. There may be ways of mitigating some of the risks as detailed within the report by addressing non-recurrent funds, however, this would have an impact the following year.

There continued to be issues regarding workforce spend in respect of bank and agency spend which had been higher than the target set. There was currently a number of capital pressures that had arisen and being worked through by the Executive Team as it was felt this would not meet the plan by year-end.

Next month, detail of the ICB reporting would be included in the report. Within this would be bank and agency efficiency programmes across the ICS which would be discussed at the F&PC. The cash position had deteriorated due to the deficit and it was felt this would continue to year-end.

Fiona Osborne requested a summary of what the costs would have been for posts that were filled against the premium that was paid for those vacancies. Lee Bond agreed to include this within the next report. It was explained bank costs would be at the normal rate, however, agency was higher. The costs of this were different between clinical and nursing roles. Sean Lyons explained a deep dive into Workforce issues was due to be held in the Trust Board private meeting that afternoon.

Action: Lee Bond

Shaun Stacey reported there was a need to review how emergency care was delivered amongst other services. Lee Bond explained there was some capacity in terms of operating theatres where additional lists could be added, however, this impacted on staffing costs, if staff were not available to work additional shifts. There may be an option to recover financial costs with outpatient appointment modelling to reduce overall financial costs. To support this there would be a need for positive engagement with clinicians and the community.

Linda Jackson queried whether there was a handle on productivity to move the organisation forward. Lee Bond advised the IPR stated theatres were almost at maximum capacity. Shaun Stacey advised this was the case and had been independently audited. There were areas that could be improved, however, the first consequence would not be finances but the quality of service and patient experience.

Dr Kate Wood queried how the organisation would capture the savings made through the quality improvement work. Lee Bond advised the finance and quality improvement team were reviewing all schemes, however, there had unfortunately

been no significant financial savings. Dr Kate Wood noted a saving had recently been made by a Dietician, as shared at the Quality Improvement Conference.

5.2 Finance & Performance Committee Highlight Report and Board Challenge – Finance – NLG(23)140

Gill Ponder referred to the report and highlighted key points. It was felt the Board needed to be more focussed over the coming year on fire regulations, particulary with regard to issues regarding the programme to repair and replace fire doors. Mitigations had been put in place due to the length of time of the programme. It was noted the Trust had recently had two fires due to domestic appliances being used in workplaces. It was recommended that staff are reminded of the dangers of using domestic appliances whilst at work. Shaun Stacey highlighted this would be undertaken through the Senior Leadership Committee (SLC) and through social media along with staff updates. It was noted domestic items were still available to order through the internal supply chain. Sean Lyons queried whether staff had been using domestic appliances due to the internal lengthy processes in place when ordering items. It was agreed this was more than likely the case.

Action: Shaun Stacey

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(23)141

Ivan McConnell referred to the report and drew the Board's attention to key highlights. It was reported a decision was taken by the ICB/NHSE to decouple paediatric and maternity services from the consultation as a result of wider system issues. The ICB approved the Programme progressing to consultation in July subject to the successful completion of an NHSE Gateway Review. Subject to approval by the NHSE Regional Director, the Programme would progress to statutory consultation. A Joint Health Overview and Scrutiny Committee (JHOSC) would be set up consisting of five authorities. The JHOSC would meet after the consultation commenced. The final output from the consultation would be set out in a decision-making business case (DMBC). Senior operational and strategy resource had been allocated to the process for finalisation of the DMBC. The DMBC and Implementation Plan would be approved by the ICB. It was important to note under current legislation the Decision may be subject to challenge and referral to the Independent Reconfiguration Panel, Secretary of State or to Judicial Review. A number of assurance reviews had been undertaken of the process to date and no major concerns raised.

In respect of the Community Diagnostic Centre (CDC) NHSE had confirmed £29.6 million was to be allocated to North and North East Lincolnshire, this would mean £19.6 million for Scunthorpe and £10 million for Grimsby. The implementation of the CDC programme brought a number of challenges, including build timescales, affordability, and resourcing. This was a National Priority Programme and the team were working closely with the NHSE National and Regional teams. Sean Lyons queried whether the Place Directors would lead on any impacts. Ivan McConnell advised the CDCs were run through the ICB Diagnostic Board. The Collaboration of Acute Providers (CAP) were running the Diagnostics programme

overall, this would then feed back into the ICB. It was agreed to further discuss the concerns outside of the meeting.

Lee Bond advised Ivan McConnell had flagged the capital risks, however, a more worrying concern was the revenue risks. Discussions were taking place regarding the projected workflow that would go through those services. As this currently stood there were some significant problems with this. Ellie Monkhouse queried whether the Board felt the loops had been closed in respect of risks that the organisation was not responsible for. After further discussion it was agreed Ivan McConnell would take this forward with Ellie Monkhouse outside of the meeting.

Gill Ponder felt actions to address the issues and mitigations were not clear. It was queried whether those risks would be addressed. Ivan McConnell advised there were conflicting priorities between Providers, Place and the ICB along with regulatory pressures. Although processes were in place it may not be as effective as it could be. From a North and North East Lincolnshire perspective all issues were managed through a Joint Programme Board chaired by Alex Seale, Place Director.

6.2 Executive Report – Digital – NLG(23)142

Shauna McMahon referred to the report and noted focus needed to be around the completion of Information Governance (IG) training. There was a move for staff to be able to reset individual passwords instead of a request being made through the helpdesk. As both NLAG and HUTH moved to the group model some applications would need to be adapted. Gill Ponder queried whether a risk analysis had been undertaken in light of sharing information. Shauna McMahon explained the team continued to improve cyber security at both Trusts. There would be a need to cease the sharing of passwords due to individual audits being required. Fiona Osborne referred to the four recommendations within the report and queried how they would be addressed. Shauna McMahon advised the executives would discuss this with recommendations being referred to the Board. Lee Bond queried how near it was to patient records being digital. Shaun McMahon advised this was in the final stages.

6.3 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – NLG(23)143

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

7. Governance

7.1 Audit, Risk & Governance Committee Highlight Report & Board Challenge – NLG(23)145

Gill Ponder referred to the paper and reported on key highlights. It was noted the AR&GC Annual Report was listed as an item for information on the agenda, however, this required Board approval.

The Board approved the AR&GC Annual Report.

Dr Kate Wood referred to the point made regarding the level of clinical audits required and what the committee expected in response to this from the Board. Gill Ponder explained the committee had queried how it would be resourced and whether that level of audit could be afforded. Dr Kate Wood confirmed the Trust had no choice as these were nationally mandated requirements to ensure the audits took place.

7.2 Board Assurance Framework (BAF) – Quarter One – NLG(23)146

Helen Harris referred to the report and noted committees had reviewed and received the Quarter One report. The Board needed to have reviewed those strategic risks noted due to the disbanding of the Strategic Development Committee (SDC).

The report was received and approved.

8. Approval (Other)

8.1 Fire Annual Report – NLG(23)147

Jug Johal referred to the Fire Annual Report and highlighted some key points. In respect of the fire doors, it was noted there was more than 4,000 that had to be inspected. It was recognised the demand for fire training was high due to the face-to-face requirement.

The Fire Annual Report was approved by the Board.

8.2 Local Security Management Specialist (LSMS) Annual Report & Workplan and Security Annual Report – NLG(23)148

Jug Johal referred to the LSMS Annual Report & Workplan & Security Annual Report, it was noted the number of incidents had increased over the past year. NLAG was the first Trust to have in place a Joint Working Agreement, Jug Johal was looking to extend this at HUTH due to it being the same police authority.

The LSMS Annual Report & Workplan and Security Annual Report was approved by the Board.

8.3 Health Tree Foundation Trustees' Committee Terms of Reference

Gill Ponder referred to the report and sought Trust Board approval.

The Health Tree Foundation Trustees' Committee Terms of Reference were approved by the Board.

9. Items for Information

The following items were shared at the August 2023 meeting:

- F&PC Minutes – April & May 2023
- HTFTC Minutes – May 2023

- Q&SC Minutes – May & June 2023
- Nursing & Midwifery Assurance Report
- Workforce Committee Minutes – May 2023
- Freedom to Speak Up Guardian Report – Quarter One
- Guardian of Safe Working Hours Report – Annual Report
- AR&GC Minutes – April 2023
- AR&GC Annual Report to the Board 2022-23
- Communications Round Up
- Documents Signed Under Seal
- Trust Board Reporting Framework
- Covid Inquiry

10. Any Other Urgent Business

There were no items of any other urgent business noted.

11. Questions from the Public

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

12. Date and Time of the next meeting

Board Development
Date: Wednesday, 27 September 2023
Time: 9.00 am
Venue: Ashbourne Hotel, North Killingholme

Formal Trust Board Meeting
Date: Tuesday, 3 October 2023
Time: 9.00 am
Venue: Main Boardroom, DPOWH

The Private Trust Board meeting was due to follow at 12:35 hours.

Sean Lyons closed the meeting at 12:23 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	3	3	Shauna McMahon	3	3
Dr Peter Reading	1	0	Ellie Monkhouse	3	3
Lee Bond	3	3	Simon Nearney	3	2
Stuart Hall	3	2	Fiona Osborne	3	3
Helen Harris	3	3	Simon Parkes	3	2
Linda Jackson	3	2	Gillian Ponder	3	3
Jug Johal	3	3	Shaun Stacey	3	3
Sue Liburd	3	3	Kate Truscott	3	3
Ivan McConnell	3	3	Dr Kate Wood	3	3

NLG(23)169

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2023/2024

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting
2023/24

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.1	01.08.2023	Quality & Safety - Key Issues - IPR		IPR to include target dates within the report, the Executive Team would provide the information	Executive Team	Oct-23				
3.3	01.08.2023	Quality & Safety Committee Highlight Report - Board Development Session - PSIRF		Helen Harris to incorpoate the Patient Safety Incident Reporting Framework briefing session into the Board Development programme	Helen Harris	Oct-23				
5.1	01.08.2023	Key Issues - Finance - Month 03 - Additional Summary to be included within report		A request was made to include a summary of costs for particular vacancies, detailing premium costs	Lee Bond	Oct-23				

Key:

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

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting
2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.4	04.10.2022	Bank Incentives (raised in Maternity / Ockenden Update item)		It was agreed the Executive Team would review staff pay incentives when working bank shifts.	Dr Peter Reading	04.04.2023	Discussion had taken place with the Executive Team. A paper was now to be discussed at the Trust Management Board on options to be put forward for staff incentives. The paper would be shared with the board following discussion at that meeting. Further update to be provided as part of the CEO update at the April 2023 meeting.		Update shared at the April 2023 meeting as part of the CEO Briefing.	
2.2	07.02.2023	6 December 2022 Public Minutes - Items being referred to the TMB for recommendation		It was agreed a meeting would be held outside of the meeting on how to incorporate Best Practice Timed Pathways into the Integrated Performance Report as it was agreed this should not be the function of the TMB.	Dr Peter Reading / Shauna McMahon	04.04.2023	Further update to be provided at April 2023 meeting.			
5.1	07.02.2023	Key Issues - Finance - Month 09		Scrutiny of productivity being developed.	Dr Peter Reading, lee Bond, Shaun Stacey & Dr Kate Wood	04.04.2023	It was agreed a meeting would be held outside of the meeting to review this further.			
3.2	06.06.2023	Maternity Oversight Report		Information referring to the Patient Advice & Liaison Service data to be reviewed.	Nicky Foster	Aug-23	Update to be provided at the August 2023 meeting.		August 2023 minutes	
3.4	06.06.2023	Quality & Safety Committee Highlight Report - Record on the risk register		Dr Kate Wood to review whether this issue was on the Risk Register.	Dr Kate Wood	Aug-23	Update to be provided at the August 2023 meeting.		August 2023 minutes	
3.4	06.06.2023	Quality & Safety Committee Highlight Report - Issues around bank and agency spend		Simon Nearney to arrange a Workforce Deep Dive for the Trust Board.	Simon Nearney	Aug-23	A Deep Dive was arranged for the 1 August 2023 following the board meeting.			
7.2	06.06.2023	Board Assurance Framework (BAF)		A request was made to consider an earlier review of the BAF and for this to be considered as part of the Group Governance Workstream.	Helen Harris	Aug-23	The Group Corporate Governance Workstream considered the review of the BAF for NLAG and HUTH and agreed that this would be undertaken at a later stage.			

Key:

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

Page 3 of 3

NLG(23)170

Name of the Meeting	**Trust Board**	
Date of the Meeting	3 October 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Trust Board – Business Reporting Framework 2023-24**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is asked to note the Trust Board – Business Reporting Framework 2023-24.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Trust Board - Business Reporting Framework

REPORTING YEAR					2023 / 24					
Agenda Item	**Committee Oversight**	**Lead**	**Frequency**	**Action**	**April**	**June**	**August**	**October**	**December**	**February**
Business Items										
Declarations of Interest	N/A	Chair	Bi-monthly							
Chair's Opening Remarks	N/A	Chair	Bi-monthly							
Chair's Briefing	N/A	Chair	Bi-monthly	Noting						
Chief Executive's Briefing (to include Trust Priorities)	N/A	Chair	Bi-monthly	Noting						
Minutes of the Previous Meeting	N/A	Chair	Bi-monthly							
Trust Board Action Log	N/A	Chair	Bi-monthly							
Patient Story	N/A	Chief Nurse	Bi-monthly	Noting						
Integrated Performance Report	All Committees	Chief Information Officer	Bi-monthly	Noting						
Trust Board - Business Reporting Framework	N/A	Director of Corporate Goverance	Bi-monthly	Noting						
Register of Directors Interest and Fit & Proper Persons	N/A	Chair	Annual	Approval						
Trust Strategy	N/A	Chief Executive	3 Yearly	Noting						
Strategic Objective 1 - To Give Great Care										
F&PC Highight Report & Board Challenge	F&PC	NED Chair of F&PC	Bi-Monthly	Assurance						
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						
Medical Appraisal & Revalidation Annual Report (AOA)	WC	Chief Medical Officer	Annual	Assurance						
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						
Infection Control Annual Report	Q&SC	Chief Nurse	Annual	Assurance						
Safeguarding & Vulnerabilities Annual Report	Q&SC	Chief Nurse	Annual	Assurance						

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	3 October 2023
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer/Author	Jonathan Lofthouse, Group Chief Executive
Title of the Report	**Report from the Group Chief Executive**
Purpose of the Report and Executive Summary (to include recommendations)	This report is to provide an update to the Trust Board from the Group Chief Executive. The report includes: • Approach by the Group Chief Executive for regular communication to staff since starting in post on 14 August 2023 • Summaries of key issues across the Trust, including patient safety and quality of care; elective and urgent and emergency care performance; finance; workforce and digital • Includes briefing about the start of the public consultation on 25 September 2023 for Humber Acute Services • An update on the Trust's response to the Lucy Letby case as well as national figures regarding sexual harassment of NHS staff
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)	Not applicable

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Report from the Group Chief Executive

Tuesday 3 October 2023

1. Introduction

This paper outlines the key developments and issues since the last Board meeting, as well as providing an outline of my start with the organisation.

I started in post as Group Chief Executive on 14 August 2023. I have been very warmly welcomed to the Trust by colleagues and system partners. I have undertaken a number of walkarounds to meet our teams and see our services. I am heartened by the commitment and hard work I have seen from our colleagues and wish to thank once again the teams I have met. I look forward to continuing these walkarounds as often as possible, and will commit that Executive team colleagues will ensure they remain visible to our teams, too.

In respect of maintaining communication and feedback to staff, I have sent a weekly reflection email to all staff since starting in the role. On Friday 15 September 2023, we held the first of a new series of "Ask the Chief Executive" on-line meetings. This was open to all Northern Lincolnshire and Goole NHS Foundation Trust staff, as well as all staff at Hull University Teaching Hospitals NHS Trust (HUTH). I, and Executive colleagues, provided very short briefings about key issues in our hospital Group and answered questions submitted in the live chat. The session was recorded and is available via the intranet for staff not able to join at the time. Over 400 Group staff joined the session and 37 questions came from the session, many of which were answered live. All questions and answers have also been posted to the intranet for staff to read. The next "Ask the Chief Executive" session will be held on 19 October 2023 at 1 pm.

I was invited to provide closing remarks at the Consultants' conference on 8 September 2023. I was inspired to see so many of our senior clinicians, together with colleagues from HUTH, discussing and sharing experiences. I was also invited to provide opening remarks to the Trust's Nursing, Midwifery and Allied Health Professionals conference on 28 September 2023, which was based on the theme of Compassionate and Inclusive leadership. I shared my reflections with colleagues that compassionate and inclusive leadership asks a lot of us as individuals, but is instinctive and resonates with our core motivation to care for our patients and care for each other.

The overall position of the Trust is challenging and credit is due to all of our staff who are working hard to continue to deliver improvements in our Emergency Department (ED) and ambulance handover performance, as well as delivering our elective activity recovery plans. I cover these in more detail in this report.

2. Patient Safety, Quality Governance and Patient Experience

Maternity safety continues to be a key focus for the Trust. The Quality and Safety Committee is updated at each meeting on the current status with maternity and neo-natal service development. The key points of discussion have included positive progress with the Maternity Safety Support Programme hosted by NHS England and the positive news that the Trust has exited maternity special measures.

The Trust is also focussing on improving End of Life care, given its CQC rating, which was subject of a deep dive at the August Quality and Safety Committee. The Patient Experience annual report brought attention to Carol's Campaign on good End of Life Care, with Sarah,

Carol's daughter, being a keynote speaker at the Nursing, Midwifery and Allied Health Professionals' Conference on 28 September 2023.

The recent Patient Experience annual report highlights a number of actions that have been taken across the Trust as a result of learning from patient feedback. There is an action plan in place to increase the amount of training and support to staff to undertake quality and service improvements, particularly from listening to patients, and I am pleased to see this focus on learning from feedback.

In respect of inpatient and community care, there are no significant changes to the number of patient falls or patient pressure ulcers being reported by staff. The complexity of pressure damage cases is under close review for hospital admissions as well as cases being seen by the Trust's community teams, as these have increased significantly since last year. *Clostridium difficile* cases are a national concern; the Trust is reviewing its position against its annual threshold and is flagging up a risk about potential non-compliance as case numbers rise nationally.

The Trust continues to report at least one mixed-sex accommodation breach per month. There are no changes to the midwife to birth ratio to report to the Trust Board, which remains under acceptable levels, however, we are very pleased to have welcomed seven international midwives to the Trust in the last two months and have made unconditional offers of employment to 17 newly-qualified midwives. There have also been recent successes in staff retention in midwifery due to the support of the midwifery and senior leadership team, and recruitment to midwifery and maternity leadership roles.

In my walkarounds to the Endoscopy services at Grimsby and Scunthorpe hospitals, I was delighted to learn about the recent Joint Advisory Group (JAG) for both endoscopy units. The teams were rightly proud of this achievement. This gives assurance to our patients as well as to us as a Trust Board about the clinical quality standards that the team has in place, and that there is a plan to maintain these over the next five years until the reaccreditation visit.

3. Elective Care and Urgent and Emergency Care

The Chairman and I have approved a board assurance self-certification for protecting and expanding elective capacity. This being an NHS England required return in line with national policy priorities of elective capacity, particularly going in to what will be another challenging winter period.

The Board will be aware of the Trust's current position for patients waiting longer than 65 weeks for their care and that there is a plan that all outstanding patients will be dated by end October 2023. The Trust achieved the Faster Diagnosis standard for cancer in July 2023, however, has not met the 62-day or 104-day backlog standard for cancer care. The Trust is performing positively against the Elective Recovery Fund standard year to date; however the Trust has achieved 114% activity against the target of 120%; baseline and activity profiles are still to be signed off, so the financial impact of this is not clear as yet. Theatre utilisation and the uptake of Getting It Right First Time (GIRFT) recommendations are going in a positive direction within our planned care and productivity workstreams.

The key points highlighted to the August Finance and Performance Committee also referenced the continued breach rate in diagnostics, with further mobile scanning capacity planned. The Committee also reviewed the 7+ days extended stay patient figures and mitigating actions.

Whilst the Trust's four-hour Emergency Department performance does not yet meet the improvement trajectory, the Trust achieved 65.4% against the four-hour standard in August 2023. The number of patients in the ED more than 12 hours, and patients waiting for an admission bed for more than 12 hours, are both showing some signs of improvement; the next step is to work with community partners around admission and attendance avoidance and making best use of community pathways where possible.

4. Humber Acute Services

On 25 September 2023 the consultation on Humber Acute Services started, which attracted some regional and local media coverage. The 14-week consultation is being led by NHS Humber and North Yorkshire Integrated Care Board (ICB). It will run until 5 January 2024. Three drop-in consultation events are being held later this month in Goole (12 October), Grimsby (16 October) and Scunthorpe (20 October) and these will be well publicised in advance. People can also visit the consultation website at www.betterhospitalshumber.nhs.uk to find out more about the proposal, full details of the consultation events and provide their feedback. A Joint Overview and Scrutiny Committee set of meetings is being set up to feed in to this consultation as well. The clinical models, financial costs and savings will be finalised during the consultation and will be summarised within a Decision Making Business Case presented to the ICB by the end of March 2024.

This represents a significant milestone in this project, which has considered over 100 options and had significant public and stakeholder input of over 12,000 views to bring together the consultation options for the medium- and long-term future of urgent and emergency care services and paediatric services.

5. Financial Performance

Our Trust's Month 5 financial position a deficit of £2.4m, which is £300,000 better than plan. While the Trust's year-to-date position is also favourable against plan (£11.6m deficit, £2.2m favourable compared to plan), there are particular risks regarding achievement of the stretch Cost Improvement Plan (CIP) target, slippage on the core CIP, not achieving the Elective Recovery Target and continued cost pressures for un-funded beds. Industrial action and inflationary pressures as well as these CIP and elective recovery issues are contributing to a forecast outturn position of £12m away from plan. There are particular pressures on capital funding that the Finance and Performance Committee discussed in detail, alongside a Board Assurance Framework deep-dive in to infrastructure and quality of environment, which is a key concern of the Committee and the Trust Board.

6. Workforce Update

We are seeing good progress on recruitment of new staff. As of August 2023, we had 172 Whole Time Equivalent (WTE) vacancies, which continues a decreasing trend for the last six months. Also in August 2023, we welcomed a record 308 new starters to our organisation. I would like to extend a very warm welcome to our new colleagues and hope they are supported to settle in well and quickly to their roles in our Trust.

Staff absence and turnover has reduced. Staff absence is currently 5.2% and turnover is 10.8%. Staff core mandatory training is 91% against a target of 85% and staff appraisals are 83% against a target of 85%. I would like to thank staff for their continued focus on these important requirements and would like to see the appraisal target be met next month.

The National Staff Survey commences on 2 October 2023 and I encourage all staff to complete the survey. It is a wonderful opportunity for staff to feedback how good their team

is, how good the care is they provide and their desire to continually improve. It is also an opportunity to feedback where staff believe services, the Executive Team and Board needs to improve. I would like a minimum of 60% of staff to complete the survey. The Board will review and act upon staff feedback. We are listening, so please do complete your survey.

The Trust is launching its annual Flu and Covid vaccination campaigns. If staff have both vaccinations and the Trust achieves a take up of 75% then those individuals that have had the Flu and Covid vaccinations will receive an additional annual leave day.

Leadership development remains a focus; the Organisational Development (OD) Team delivered nine leadership events over the summer focused on our group leadership 'golden rules,' our Just and Learning Culture and leading with civility. The OD team in partnership with HUTH will be commencing a review and engagement exercise to develop a set of new values for the Group. The engagement process for this will start in the next two months, and the new Group values will be launched in April 2024.

7. Equality, Diversity and Inclusion (EDI)
The Workforce Disability Equality Standards and the Workforce Race Equality Standard annual reports have been scrutinised by the Workforce Committee and are on today's Trust Board agenda for review and approval.

Following the conviction of Lucy Letby, and the shocking figures regarding sexual harassment of female NHS staff, I have sent out messages via my Chief Executive's bulletin to all Trust staff to raise any concerns they have about colleague behaviour through our Speaking Up routes.

I am clear that inappropriate behaviour and compromises in patient care are absolutely unacceptable. I am meeting monthly with the Trust's Freedom to Speak Up Guardian, who reports on a quarterly basis to the Quality and Safety Committee. The Board is updated at every meeting on quality, safety and patient experience; our staff must have confidence that speak up makes a difference, and I am clear that Executive team members are accountable for drawing issues of concern to my attention. We will be signing up to the NHS England Sexual Safety Charter and have appointed a lead domestic abuse and violence. The Board will be briefed on what this entails in due course.

I am pleased to report that, following on from our successful EDI staff engagement events in July and due to popular demand, we are holding some more marketplace events during October. The themes will include intersectionality, increasing EDI visibility, celebrating Black History Month, Menopause support and promoting our staff equality networks.

8. Digital Programme
The Digital Programme is focused on the following critical projects at this time:

1. Patient Administration System (PAS) for HUTH & NLaG
2. Data Warehouse – upgrade to new Cloud Platform HUTH & NLaG
3. Electronic Patient Record Outline Business (EPR OBC) case for HUTH & NLaG
4. Enterprise Document Management System for HUTH & NLaG
5. Integrated Care System (ICS) Maternity System – Badgernet/Viewpoint for HUTH & NLaG – on track for go live in February 2024 in HUTH and March 2024 for NLaG
6. Single Sign On – Clinical Services (NLaG) is business as usual across the Trust, with three services with specialist software being on-boarded now
7. IT Service Management at HUTH and NLaG

The PAS migration remains a critical project in the alignment of clinical services, providing access to necessary clinical information and oversight of patient pathways across the Group. Moving to the new data warehouse will simplify and improve reporting across all services from ward to board. Once the NLaG Data Warehouse is stable and PAS migration settled, the team will plan for the migration of the old HUTH Data Warehouse to the new Cloud Platform.

This migration from NLaG PAS to the live Lorenzo PAS at HUTH is complex. While challenging it is essential that the data is as accurate as it can be ready for go live, which is 26 February 2024. Initial estimated costs for the revised go-live in February were £1.7m, with work ongoing to reduce this to £1.57m last month. There are some support charges for the current PAS as well as a cross-over month between systems that are being worked through currently.

The EPR OBC has been drafted and reviewed. There is a significant affordability gap of £68.5m, £20.5m Capital and £48m Revenue, for a single enterprise EPR. Further work on options available and their affordability are being considered, including extending the use of the existing Dedalus solution. The OBC will be revised once alternative options are confirmed. The single enterprise EPR was the preferred approach expressed from sessions held with consultants and clinical teams. We are looking at other options in the OBC, however, they come with risks. This was not a route that was seen as viable by clinicians and our risk assessment, we are investigating how we might work with the current HUTH Lorenzo supplier (Dedalus) to assess potential options with their ORBIS U clinical system. We may have to go to market with a price cap, which will significantly impact the suppliers that will bid and the expected levels of functionality required.

The ICS EPR Programme Board is the formal governance board with oversight of the EPR OBC work, which met on 8 September 2023. This meeting agreed that:

- The current dual procurement approach should continue and that HUTH and NLaG must stick to the agreed timelines
- HUTH and NLaG must urgently undertake further pre-tender market engagement on affordable options and work with procurement partners to explore suitable suppliers
- The ICB would arrange a meeting with the NHS England Finance Director team to lay out the agreed ICB position, specifically to highlight the risks for Harrogate District NHS Foundation Trust and York and Scarborough Teaching Hospitals NHS Foundation Trust of undertaking a ‘single lot’ procurement, but also to reinforce the need for HUTH / NLAG to remain separate
- The Yorkshire and Humber Care Record (YHCR) would be the core record for ensuring interoperability between Trust systems for the benefit of patient care, and that the ICB recognised the need for investment in this approach that may come from the acute Trusts

9. Good News Stories and Communications Updates

Through August and September the finalists for this year’s Our Stars awards were announced. The awards evening takes place on 24 November 2023 and I look forward to an excellent event, celebrating the innovation and compassion of our staff.

I am very pleased that Sir Julian Hartley, Chief Executive of NHS Providers and former Chief Executive at Leeds Teaching Hospitals NHS Trust, was the keynote speaker at the

Consultants' Conference on 8 September 2023. Sir Julian visited the new Emergency Department at Scunthorpe General Hospital before the conference, with Dr Kate Wood.

Externally the Trust promoted news about: the new surgical hub at Goole; external accreditations for the Macmillan Information Centre at Scunthorpe and the Trust's endoscopy services; and fundraising projects for the Health Tree Foundation.

Jonathan Lofthouse
Group Chief Executive

26 September 2023

NLG(23) 172

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	3rd October 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 August & September)	
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: • The Committee's request for Executives to progress delivery of solutions to evidence delivery of the 2023/24 Trust Quality Priorities • The recommendation by the Committee to approve the Annual Patient Experience Report • The continuing concerns with regard to vacancies in Midwifery and Pharmacy	
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)	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

Highlight Report to Trust Board

Report for Trust Board Meeting on:	October 2023
Report From:	Incorporating Quality & Safety Committees held on 23 August and 26 September 2023

Highlight Report:

The Committee received a referral from the Audit Risk and Governance Committee following a rating of Limited Assurance by Audit Yorkshire in relation to the World Health Organisation (WHO) Surgical Checklist. The Committee received information from a briefing from the Surgery Division to address the four areas of concern in the Audit Yorkshire report. The Committee are assured that patient quality of care and safety are being maintained and that positive action is being taken to address the issues outlined in the report.

The Committee heard through the Maternity and Neonatal Update that it has been confirmed that the Trust will be exiting Maternity Special Measures. The Committee would like to extend its thanks and congratulations to the teams involved in achieving this result. The Committee continues to be concerned about the level of vacancies in midwifery but are assured that patients are safe as the midwife to birth ratio for the Trust is 1:23, exceeding the acceptable ratio of 1:28.

Surgery Division presented their six-monthly update on quality governance activities, including key risks and challenges. Areas of concern include two high risk equipment issues i.e., the hemofiltration equipment replacement at Diana Princess of Wales Hospital (DPoW), although quotes to lease or purchase are progressing, and the **Magnetic resonance imaging (MRI**) scanner being out of use at Scunthorpe General Hospital (SGH) causing capacity at SGH to fall to 50%. Positive assurance has been provided through Joint Advisory Group on Gastrointestinal (GI) Endoscopy (JAG) accreditation for SGH Endoscopy service and improvements noted from their report.

An update on the Paediatric Audiology incident cluster was provided. The action plan resulting from the British Academy of Audiology (BAA) Review is progressing, as well as the review of the patients concerned, supported by external specialists. The new Head of Service is starting in October and a business case is being taken forward to address the resource requirements to provide an effective service, in line with best practice standards. The retraining plan of staff was also highlighted in the meeting, with external unit placements.

Pharmacy updates highlighted that staffing concerns were still high on the agenda although the team were responding by exploring different structures and approaches. These are to mitigate the wider issues with nationwide shortages in suitably qualified pharmacists. The Committee also heard that a potential risk remains around the rates of Medicines Reconciliations although this is being managed and rates are improving albeit below targeted levels.

The Committee received an update on the Patient Safety Incident Report Framework (PSIRF) which is ready for presentation to the ICB on 10th October 2023 for sign off. Once approved the Trust will enter a period of transition to the PSIRF model. This includes a

transition from the current Serious Incident (SI) reporting mechanism to the new model as we complete SI investigations through the previous model.

End of Life (EoL) and Community and Therapies updates were presented, illustrating the seven-day service provision at SGH has been implemented, improving service access in a timely manner. Training sessions on EoL recognition and care continues. Measures of quality improvement have been challenged with data, with plans to resolve this using manual data collection processes until a digital solution can be provided. The progress made on EoL project activities was recognised as contributory to Care Quality Commission (CQC) action assurance. Further quality improvement (QI) activities are in progress to use digital documentation through pilot areas.

Pressure Ulcers Deep Dive was provided, demonstrating the work in the Community context and inpatient areas to implement the evidence-based pressure ulcer risk assessment tool 'Purpose T'. Monitoring of rates of pressure ulcers in care home settings was used to support prioritisation of training. Placements of existing staff to participate in wound clinics has been used to improve community staff experiential learning. The pressure ulcer assessment Commissioning for Quality and Innovation (CQUIN) audit collection showed good compliance in most clinical areas, with a documentation redesign required for Maternity being taken forward.

The Integrated Performance Report data was discussed including a focus on Sepsis audit change in methodology for paediatrics, commencing in September following redesign of collection tools and a change of paediatric Patient Safety Lead Nurse. Confirmation provided that a review of stillbirths had identified no clinical management concerns and the external reporting and perinatal mortality review tool (PMRT) was being followed. C difficile was recognised as a challenging target and the Trusts good performance compared to peers was noted. The process of complaints management was commended in achieving 100% completion within the agreed timescales and evidence of sustained improvement.

An update in the Trust Quality Priorities was received and while Outcome Measures are being tracked, the Process Measures that inform the success of the building blocks to achieve the outcome measures caused the Committee some concern. Areas where process measures are currently limited include:

- Deceased patient recording tool not linked to the Power Business Intelligence (PowerBI) information reporting tool
- Sepsis recording in the Emergency Department (ED); Sepsis recording is in the WebV system, but ED utilise Symphony
- Weight recording to deliver safe medication calculations is currently recorded through the ePMA and WebV systems without automatic sharing of data

Executive colleagues on the Committee are championing progress to investigate and deliver solutions through discussion at the Executive meetings

The Nursing Assurance report discussion included discussion of the intensive support plan for the Stroke Unit at DPOW following a 15-steps review. A six-to-twelve-month surveillance to ensure the practice and culture is embedded.

The 15 Steps Annual Report was received by the Committee and outlined the excellent progress made in the year both within the areas being assessed on the 15 Steps Programme, but also the Programme itself which continues to evolve and develop based on the themes established on the visits. The Committee wishes to underline its support for the Programme and its contribution to continual improvement.

CQC action plan progress was reviewed with examples of prioritised actions and challenges with progress highlighted. Progress in September has been slowed as a result of the industrial action.

The Committee Received the Annual Patient Experience Report on behalf of the Board and commends the report to Board for approval. The Board are asked to note that through the Friends and Family test 85% of our patients recorded a positive experience. The report also described positive results from the National Inpatient Survey, National Maternity Survey and National Cancer Patient Survey, all of which recorded positive results. The Committee were assured that areas of themes for improvement had been identified and had been recognised within plans for a refreshed strategy.

The Committee received a notice of Proposed Deviation from the National Institute for Health and Care Excellence (NICE) Guidance related to the Endoscopy service. One element has been assessed as not compliant; Quality statement 3: Emergency Endoscopic Retrograde Cholangiopancreatography (ERCP) within 24 hours. The service is unable to provide a seven-day service and as a result this standard cannot be met at the weekend. The Committee were not assured of robust mitigations to support patients at the weekend and have requested additional information as to the impact to patients.

Learning from deaths was reported, linking to the Mortality Improvement Group and noted the investigation of pneumonia deaths. This reviewed the rate of pneumonia deaths rise over this winter and correlation with the Trust and national data. The Committee are assured that risk rating adjustment and proportional rates show no current concerns despite the trends of presentation.

Confirm or Challenge of the Board Assurance Framework:

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

Action Required by the Trust Board:

The Board is asked to note:

- The Committee's request for Executives to progress delivery of solutions to evidence delivery of the 2023/24 Trust Quality Priorities
- The recommendation by the Committee to approve the Annual Patient Experience Report
- The continuing concerns with regard to vacancies in Midwifery and Pharmacy.

Fiona Osborne
Non-Executive Directors

NLG(23)173

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	3rd October 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 Committee was not assured by the level of risk to the delivery of the financial plan and recommended a Board discussion to review the position and agree actions to mitigate risks. • The Committee were assured by the actions being taken to meet the new National Standards for Food and Hydration.	
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:	3rd October 2023
Report From:	Finance & Performance Committee – 23-08-23 and 20-09-23

Highlight Report:

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

- The Trust reported an in-month deficit for month 5 of (£2.4m), £0.3m better than plan and a year-to-date deficit for month 5 of (£11.6m), £2.2m favourable versus plan.
- The Trust is forecasting a £25.3m deficit before management action. Technical savings and improvement on CIP delivery bring the position in line with the planned £13.4m deficit.
- The Trust's Capital position is behind the year-to-date plan, but there are plans in place to achieve the planned position by the year end.
- Whilst the forecast for the year end is a balanced plan, risks include:
    - the 2023/24 activity and ERF plan included an increase in activity for the second half of the financial year.
    - the risk of an unfunded pay award being awarded to Consultants and Junior Doctors due to ongoing industrial action.
- The Committee was not assured that there was a clear and coherent plan in place to deliver the financial plan for the year and to reduce the underlying deficit, due to the level of risks and the continued high spend on temporary staffing. The Trust has spent £25.5m on agency and bank pay, £1.7m more than the same period in 2022/23.
- The Committee requested a Group Executive Team discussion on bank and agency spend, with the aim of reducing usage, thus reducing spend as there were concerns about the year end run rate and its potential impact on financial plans for 2024/25.
- The Committee also recommended a subsequent Board discussion to review the financial position and agree actions to mitigate risks.
- The system has a financial deficit which could be a risk to the Trust.
- Data from the 2021/22 National Cost Collection and Model Health System reports suggested that there were opportunities to improve productivity and reduce costs, but that report relied upon accurate data collection and submission by Trusts. The 2022/23 data was not yet available, so apparent opportunities may no longer be available due to recent improvements.

Facilities Services & National Standards for Food and Hydration

- New Food Standards were released in November 2022 which the Trust are obliged to meet.
- Organisations must have a designated Board director responsible for food (nutrition and safety) and report on compliance with the Healthcare Food and Drink Standards at Board level as a standing agenda item.
- The Committee were assured by the actions being taken to meet the new standards.

Sustainability Report

- The Committee were informed that the net zero target is a slow process and the Trust had hoped to have made more progress by now.That was partly due to the failed bid for funding through SALIX and the higher priority of backlog maintenance over sustainability in a capital constrained environment.
- Energy costs for 2022/23 were £6.7m, an increase of nearly 40% on the previous year. Price increases, the expanded footprint and additional energy intensive equipment such as scanners all contributed to the increase.
- Water costs for the Trust are increasing due to increased metering of water by the Trust, rather than increased consumption. Metering comes with many benefits including the potential early identification of water leaks on site.
- Green travel initiatives had contained travel claim spend for 2022/23 to c£1m, a similar amount to 2007/08.

Confirm or Challenge of the Board Assurance Framework:

The Committee reviewed the Board Assurance Framework Strategic Objective 1-1.4. The Committee questioned some entries on the high level risk register and requested that these were reviewed and updated where necessary. The Committee agreed that the current risk rating was appropriate.

Action Required by the Trust Board:

The Trust Board is asked to note the key points highlighted above and to consider the recommendation for a Board discussion on risks to achieving the financial plan.

Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)173

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	3rd October 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. • Deep dive requested on human factors affecting daily variation in ambulance handovers. • Lack of traction in reducing Outpatient follow-ups by 25%. • Diagnostic Magnetic Resonance Imaging (MRI) capacity insufficient to clear the backlogs of patients awaiting scans. • Industrial action continues to hinder elective care recovery	
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:	3rd October 2023
Report From:	Finance & Performance Committee – 23-08-23 and 20-09-23

Highlight Report:

Unplanned Care

- The Committee acknowledged an overall improvement in ambulance handovers but discussed the reasons for peaks and troughs in delays, which included flow through the hospital, demand, concurrent arrivals and staffing, many of which are constant issues. The Committee questioned whether daily performance varied due to human factors and requested a deep dive into any human factors affecting performance in the next Unplanned Care report.
- The Trust is one of the best performing trusts in the region for Extended Length of Stay and there has been further improvement in both the Elective and Non-Elective average length of stay.
- There is a small but inconsistent improvement in Emergency Department (ED) 4-hour performance.

Planned Care

- There is a lack of traction with the 25% target reduction in Outpatient Follow Up (non-Referral to Treatment (RTT)) pathways, required to create capacity for more new appointments to be scheduled to reduce waiting lists.
- Despite additional mobile units arriving onsite which will help with the Cancer backlog, the Diagnostic Magnetic Resonance Imaging (MRI) capacity is still not sufficient to reduce the backlog of other patients awaiting scans, as a scanner at Scunthorpe has broken down and is irreparable. The possibility of obtaining another mobile unit is being investigated and the Committee requested a revised backlog clearance trajectory in the next Elective Care report.
- Industrial action has impacted upon elective care and the likelihood is that the impact will increase if industrial action continues.
- The RTT waiting list continues to increase in size which is pushing down the 18-week RTT performance.
- Cancer 104+ day waiters have decreased slightly but the Committee requested plans to clear these in the next planned care update.
- Theatre utilisation performance was discussed in detail and the ongoing differences with methodology of formulae reviewed.
- The Trust has received national recognition over its current levels of productivity.
- The Committee discussed the elective recovery Board checklist which detailed measures the Trust were putting in place to ensure Elective care continues throughout the Winter period. Progress with these actions will be included in future Planned Care reports to the Committee.

Confirm or Challenge of the Board Assurance Framework:
The Committee reviewed the Board Assurance Framework Strategic Objective 1-1.2. The Committee identified some overdue high-level risks which required updating and were informed that communications had been issued to get these updated. The Committee agreed that the current risk rating was appropriate.
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)174

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	03 October 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 Board is asked to receive and note the content of this highlight report. The following matters are highlighted: 1. Apprenticeship Levy Annual Report and Levy underspend. 2. Approval of the Workforce Race Equality Standard Report. 3. Approval of Workforce Disability Equality Standard Report. 4. Limited assurance of Doctors in Difficulty activity reporting. 5. Limited assurance of the Care Quality Commission action plan for the completion of role specific and mandatory training. 6. Ongoing Industrial Action.	
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:	3 October 2023
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee

Highlight Report: Workforce Committee – 19 September 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) Apprenticeship Levy Annual Report

This item for escalation builds on the highlight report and discussion as to whether the Trust is maximising its apprenticeship levy which took place at the Board meeting of 01 August 2023. The Committee welcomed receipt of the Apprenticeship Levy Annual Report. The following was noted:

- In 2023/24, North Lincolnshire and Goole Foundation Trust (NLaG) are predicting a 22% underspend of the organisation's Apprenticeship Levy budget of £1,529,261. This is 2% lower than the actual reported underspend in the previous year.
- There remain organisational challenges to delivering against the Apprenticeship Levy contributing to a 38% enrolment drop. This includes - lack of a structured Learning Needs Analysis, the requirement for apprentices to have English and Maths, operational pressures, and the need to improve managers' detailed understanding of apprenticeship standards.
- Plans to mitigate organisational challenges and for better levy utilisation include marketing and promotion of apprenticeship opportunities to staff, improved education of managers and apprentices on the demands and commitment of undertaking an apprenticeship, and provision of support for attainment of the required standards in English and Maths.
- There is a projected development spend in Quarter 2 - Quarter 4 2023/2024 of £854,146.
- For improved assurance there is closer monitoring through the newly formed Workforce Development Portfolio Governance Board and monthly apprenticeship quality and data meetings.

(3) Workforce Race Equality Standard (WRES) Report

Research evidence suggests there is less favourable treatment of Black and Minority Ethnic (BME) staff in the NHS. Poorer experience or opportunities has a significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients. The Committee received and approved the Workforce Race Equality Standard Report. Items for noting and escalation:

- The relative likelihood of White staff being appointed compared to BME is 1.73 times greater. This is worse than Hull University Teaching Hospitals NHS Trust (1.3) and the national comparator (1.54).

- Percentage of staff experiencing harassment, bullying or abuse from **patients, relatives, or the public** in the last 12 months: White 23.5% BME 33.1%. BME staff report a 9.6% higher negative experience than their white colleagues.
- Percentage of staff experiencing harassment, bullying or abuse from **staff** in the last 12 months: White 27.9% BME 37.3%. There has been a slight decrease in white staff experiencing harassment, bullying or abuse from colleagues than in previous years. It remains significantly worse for NLaG BME staff with a gap of 9.4% between white and BME staff. This is almost 10% higher than the national acute trust average.
- Positively, In 2022 the relative likelihood of BME staff entering a formal disciplinary process compared to white staff was 1.4. In 2023, the relative likelihood of BME staff entering a formal disciplinary process compared to white staff decreased to 0.4. BME staff are no more likely to enter the formal disciplinary process than white staff. This decrease is attributed to the roll out of the Just and Learning Culture Framework.
- The Committee was reassured that the Equality, Diversity, and Inclusion action plan 2023/2024, mandatory training on inclusive behaviours and exploring unconscious bias for all staff, in conjunction with the culture transformation programme are mechanisms for the ongoing development and improvement of the WRES.

(4) Workforce Disability Equality Standard Report

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 Workforce Committee received and approved the WDES Report. NLaG as part of the Department of Work and Pensions scheme are a Disability Confident Employer and operate a guaranteed interview scheme for disabled applicants who meet the minimum person specification. Items for noting and escalation:

- Disabled staff are 12.3% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff. The gap has worsened since the 2021 staff survey.
- Disabled staff felt 8.60% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff.
- 69.3% of disabled staff from the staff survey feel NLaG have made adequate adjustments to enable them to carry out their work. This is a 1.2% reduction compared to the previous year.
- The Committee was reassured that the Equality, Diversity, and Inclusion action plan 2023/2024, mandatory training on inclusive behaviours and exploring unconscious bias for all staff, in conjunction with the culture transformation programme are mechanisms for the ongoing development and improvement of the WDES.

(5) Doctors in Difficulty (DiD)

The Committee received the DiD Group annual assurance report. The Group reviews, discusses and has oversight of doctors who potentially require additional support due

to on-going General Medical Council restrictions/investigations, those undergoing professional conduct investigation, on long-term sickness absence or where there is a breakdown in relationships between clinicians and/or internal procedures. The Committee had limited assurance in the reporting of activities and outcomes of the Group. It was noted that work is currently taking place to refresh DiD terms of reference and re-consideration of formal and informal reporting items and process is being undertaken.

(6) Mandatory and Role Specific Training

The Care Quality Commission (CQC) action plan progress was reviewed with examples of prioritised actions and challenges with progress highlighted. The Committee had limited assurance for the completion of role specific and mandatory training. This presents a risk to achievement of Trust set standards of 85% and delivery of CQC improvement plans. Although NLaG's cumulative score for mandatory training is above target at 91.24%, role specific mandatory training remains below target. Whilst improvement was noted in some areas, Safeguarding Leads training, Mental Health Capacity Act and Moving & Handling training in several departments were a notable outlier. It was also noted that temporary and agency staff induction and training requires continued attention. Mitigations are in place. These include task and finish groups, targeted promotion of the training and ensuring training availability. Progress will continue to be monitored by Committee.

(7) Industrial Action

The Workforce Committee noted across September and October, for the first time in the history of the NHS nationally, Consultants and Junior Doctors will co-ordinate their ongoing industrial action. Where there are joint days of strike action in September and October NLaG will provide 'Christmas Day' levels of staffing.

Confirm or Challenge of the Board Assurance Framework:

Nil 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 and the recommendation to approve the WRES and WDES reports.

Sue Liburd
Non-Executive Director and Chair of Workforce Committee

NLG(23)175

Name of the Meeting	**Trust Board – Public**	
Date of the Meeting	3 October 2023	
Director Lead	Sean Lyons, Chair	
Contact Officer/Author	Linda Jackson, Vice Chair	
Title of the Report	**Group Development Committees-in-Common Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a summary of the matters considered by the Group Development Committees-in-Common Meeting on 24th August 2023	
Background Information and/or Supporting Document(s) (if applicable)	Minutes	
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 the Trust Board

Trust Board	3 October 2023
Report From:	Group Development Committees in Common

Highlight Report:

Humber & North Yorkshire (H&NY) Integrated Care System/Collaborative of Acute Providers (ICS/CAP)

A discussion took place about how best to contribute, influence and meet the demands of the external environment as a Group. It was noted there was the possibility of a restructure within the ICB which would need to be considered when scoping the best approach. The Group CEO supported by the Interim Joint Director of Strategy will seek clarity on potential changes at both ICS and Place level and report back to the committees.

The Committees were informed that there had been a new workstream set up under the CAP to oversee Diagnostics. A Programme Director has been appointed from the region and it is envisaged this workstream will oversee the implementation of the community diagnostic hubs along with cancer performance and pathology. This workstream will sit alongside the existing Planned and Urgent and Emergency Care (UEC) workstreams already established.

Humber Acute Services Review (HASR)

The Committees received an update on the Pre-Consultation Business Case (PCBC) that sets out the preferred option for the delivery of UEC and pediatrics services with primary focus on Diana, Princess of Wales Hospital (DPoW) and Northern Lincolnshire & Goole NHS Foundation Trust (NLaG). The team are currently finalising the revenue savings that may occur from the change (which will form a key part of the Decision-Making Business Case (DMBC) along with the capital estimates based on the preferred option . Work is also continuing with the development of The Consultation Document and Consultation Questionnaire and Analysis ready for the launch of the consultation process in September.

A high level workplan has been developed to support the communication and engagement elements of the consultation. Senior operational resource has been allocated to lead on the development of the implementation plan. There were a number of key risks flagged which are currently being worked through prior to implementation at the end of March 2024 (subject to ICB board approval in January 2024) being: Resourcing, risk of challenge, a general election, and media management.

The committee also noted that the maternity and neonatal services were removed from the consultation at the request of the ICB/NHS England (NHSE). It was acknowledged that these services remain fragile and there may be a need to undertake a temporary service change. The Interim Joint Director of Strategy was requested to work with key members of the Executive team to map out what the triggers would be to enact any temporary change

Community Diagnostic Centres (CDC's)

The committee were updated on the progress to date to increase Diagnostic capacity within a community setting. When combined Hull University Teaching Hospital NHS Trust (HUTH) and NLaG have received £45.6 million of capital funding for CDC's:

- Hull hub – £16 million potential site Albion Place
- Scunthorpe hub - £19.6 million on Lindum Street Car Park
- Grimsby Spoke – Freshney Place

The Grimsby Spoke must go live from the CDC site from 1st April 2024, the Scunthorpe Hub from the end of June 2024 and the Hull Hub must go live 1st April 2025. All schemes however must provide activity from 1st December 2023 (this can be from a different site as long as it is not an acute NHS trust building).

The Committees were informed of the risks associated with the programme delivery and implementation being:

- CDC mobilising and opening - risk of delay to the build and mobilisation, availability of contractors, risk of kit notably Computerised Tomography (CT) / Magnetic Resonance Imaging (MRI)
- CDC Impact – increased activity and demand across Place. The resourcing of the workstreams- clinical pathways/workforce/digital enablers/financial impact

Programme governance has now been revised and fits within an ICB structure with all schemes reporting from Place to a ICB Diagnostic Board and through the CAP – which brings with it potential risk of duplication and lack of focus.

Updates from the Joint Development Board

- **Humber Clinical Collaboration Programme (HCCP) –** formerly known as Interim Clinical Plan. The HCCP has the primary focus of the 10 fragile and vulnerable specialties. The programme was launched in late 2020 and had been through multiple iterations of focus and leadership. An internal stock take has been undertaken of the work carried out to date highlighting successes and areas of focus. The work on moving this programme forward was paused in July whilst the Group Structure and Operating model is announced. A further consideration is the work now being undertaken by the CAP – (Planned Care Framework and Recovery being two key areas of focus).

  It was agreed that as work progresses with the Group Operating Model that there is consideration of what is being done on each of these programmes and whether HCCP is required in current or revised format within the Group Structure.

- **Consultant Engagement** – The Committees were updated on the joint consultant engagement session that recently took place facilitated by Mark Lansdown from Get it Right First Time (GIRFT). There were 37 clinical leads present and good debate and discussion took place about how the two Trusts can work better together. There are a further 3 sessions planned on September, October and November 2023 – September being a joint consultant conference. Further events will cover topics such as EPR and digital, the operational model and clinical pathways.

Group Leadership Structure

The committees were informed that the meeting schedule for 2024 will be ready to be distributed by the end of August, with automatic diary invites to follow. The new schedule moves the Trust Board meetings to a Thursday, keeps Board development on a Tuesday and all committees of the Boards will occur Wednesday - Thursday. The plan is to move to a pilot of the committee in common structure from 1st January – 31 March 2024 with full implementation on 1st April 2024.

In the next 2 months the review and alignment of the Board Reporting Framework and Board Committee work plans will be undertaken. This will be followed by the development of a committees-in-common principles framework and alignment of the terms of reference and harmonisation of reporting templates.

The Group CEO informed the committees that the formal consultation period on the proposed Group Executive Structure will be launched in September for a 4-week period with interviews planned for the middle to end of October. He also updated that a range of options on the Group operating model were being drafted for further review and agreement

Action Required by the Trust Board:

The Trust Board is asked to note the key points outlined with the report.

Sean Lyons
Chair

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	3 October 2023	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Ellie Monkhouse, Chief Nurse: Joint Clinical Champion Dr Kate Wood, Chief Medical Officer: Joint Clinical Champion Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee: Author	
Title of the Report	**Health Tree Foundation Trustees' Committee (HTF) Highlight Report – 7 September 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 7 September 2023 and worthy of highlighting to the Public Trust Board.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Only on Health Tree Foundation Charitable Funds	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	3 October 2023
Report From:	Health Tree Foundation (HTF) Trustees' Committee held on 7 September 2023

Highlight Report:

AAU & SDEC Skylight Panels

- A late paper was discussed concerning Feature Ceiling Panels, known as Skylight Panels. Whilst a 'Wish' had apparently been submitted in 2023 to have Skylight Panels fitted to the new AAU areas at both DPOW and SGH, it appeared that the requirement had not been included, or was too late to be included, in the scope of works statement for the builds. This contrasted with the 2 recently completed EDs, where HTF funded Skylight Panels, whilst the fitting cost was covered in the overall project budget. This late request was asking for HTF to fund both Skylight Panels and installation at both sites.
  Trustees were concerned that the fitting costs appeared excessive when compared with the cost of the panels, so a final decision was postponed until the contractor could be approached to secure a reasonable reduction in the price. This situation shows clearly how crucial it is for HTF to be brought into projects at the earliest possible stage to secure optimum funding and obviate unnecessarily large bills.

Working with Donors

- The regular Charity Manager's report to Trustees highlighted some very generous charitable donations to HTF from events organized by individuals. This sparked discussion on how the charity, and indeed the Trust, thanked donors in such cases; not only showing appropriate gratitude but also nurturing such generosity and taking care of donors over time. It transpired that whilst HTF did work closely with donors both before and after fundraising events, and had built up some excellent relationships, there was no formal process in place to ensure that a consistent approach was taken every time. Trustees felt that improvements could be made and asked the Charity Manager to produce a proposal for dealing with donors that would show support, appreciation and demonstrate, if possible, tangible fruits of their charitable labours.

Current Economic Factors

- The Finance Report for HTF showed a clear reduction in charitable giving over the past couple of years. This was despite renewed efforts on behalf of the charity to secure donations in ever more ambitious ways. Other Committee Members noted similar signs in other charities in which they happened to be involved and it was agreed that financial pressures across both the personal and corporate landscapes were likely significant factors causing this decline. Trustees felt that the Trust Board ought to be aware of this situation and note that additional efforts were being made by the HTF Team to counter this downward drift.

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)177

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 3 October 2023
Director Lead	Ellie Monkhouse, Chief Nurse/Executive Maternity & Neonatal Safety Champion
Contact Officer/Author	Nicky 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 oversight of the Trust's maternity services. Highlights of key areas are summarised for assurance and information. The Board is asked to note this report and its contents. **1. Workforce** Midwifery vacancy rate remains a challenge in July. Positively, 7 international midwives have joined the maternity service and a further 4 will be supported in the new year. Pastoral and Retention midwife role of supporting midwives (specifically early career) impacting positively on the service. Recruited to Head of Midwifery, Deputy Governance Lead, Maternity audit and compliance manager, Maternity Matron (Grimsby) and Gynaecology and Breast Matron (cross site) posts. Diabetes midwife post in the recruitment process. **2. Clinical Negligence Scheme for Trusts (CNST) V5** Maternity services have undertaken a benchmarking exercise to understand the changes from year 4 and expectations for year 5 and the CNST action plan is being progressed at fortnightly CNST meetings. Risks to compliance are addressed in Section 9. **3. Quality Improvement** Current ongoing Quality Improvement (QI) projects within maternity services include: Induction of Labour; Maternity Triage; Neonatal Thermoregulation; Antenatal clinic/Antenatal Day Unit. Progression of phase 2 of the Maternity Triage Service will commence as planned on 16 October, despite concerns raised by Health Care Assistants (HCA) and union involvement (dispute) due to banding and potential back pay issues. Both Human Resources and Estates teams are actively working with the Division to progress this work. **4. Patient Experience and Service User Feedback** The Maternity Service continues to receive relatively low numbers of new complaints and Patient Advice & Liaison Service (PALS) concerns. For June 2023 there were 2 new formal complaints and 7 PALS. Maternity and Neonatal Maternity Voices Partnership (MNVP) Lead post appointed on 08/08/23 and commences in September.

	5. Maternity Safety Support Programme The Trust is on the Maternity Safety Support Programme hosted by NHS England via the national maternity team, led by the Chief Midwifery Officer for England. The Maternity Sustainability plan is being progressed by the Family Services division with Trust wide/corporate support. We have a clear exit strategy, which will follow local, regional and national governance process with a plan for exit November 2023. **6. Maternity Safety Champions** Locally there are embedded monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the site venue each month. A *Shout Out Wednesday* event is also held each month enabling escalation by all staff of any safety concerns as well as the safety mailboxes open to all. An action log is collated ensuring learning and improvement opportunities are captured and progress monitored. Actions are progressing as planned. **7. Upcoming External Visits** • LMNS (Local Maternity & Neonatal Systems) assurance visit – 23 October 2023 • National Maternity Team visit – September 2023	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		

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

*Board Assurance Framework (BAF) Descriptions:

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

Maternity & Neonatal Oversight Report – September 2023 (July 2023 data)

1 Workforce/Staffing

Diana, Princess of Wales Hospital (DPOW)

- Registered 17.14 WTE (Whole Time Equivalent)
- Unregistered 2.69 WTE

Scunthorpe General Hospital (SGH)

- Registered 16.90 WTE
- Unregistered 0.01 WTE

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

Recruitment

- Pastoral and Retention midwife role of supporting midwives (specifically early career) continues to impact positively on the service.
- Head of Midwifery, Maternity audit and compliance manager, Maternity Matron (DPOW) and Gynaecology and Breast Matron and Deputy Governance Lead all now in post.
- Accredited Midwifery Support Worker training commencing at University of Hull September 2023

Maternity Wards Fill Rates and CHPPD Jul 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.2%**	▲ **1.0%**	**82.5%**	▲ **1.0%**	**11.8**	▲ **0.17**
Registered Nurses and Midwives	88.0%	▲ 1.6%	77.4%	▲ 0.7%	7.3	▲ 0.16
Care Staff	96.8%	▼ -0.1%	91.4%	▲ 1.6%	4.6	▲ 0.01
Central Delivery Suite	**84.4%**	▼ **-0.3%**	**55.3%**	▲ **0.3%**	**25.7**	▼ **-5.48**
Registered Nurses and Midwives	85.7%	▲ 1.1%	51.8%	▼ -1.3%	20.9	▼ -4.05
Care Staff	79.4%	▼ -6.1%	69.7%	▲ 6.9%	4.7	▼ -1.42
Jasmine & Honeysuckle	**93.9%**	▲ **3.5%**	**77.0%**	▲ **0.4%**	**11.3**	▼ **-5.21**
Registered Nurses and Midwives	91.9%	▲ 4.9%	78.0%	▲ 7.9%	7.4	▼ -3.25
Care Staff	98.0%	▲ 0.5%	75.0%	▼ -15.2%	3.9	▼ -1.96
Ward 26 SGH	**87.6%**	▼ **-3.2%**	**59.7%**	▲ **0.3%**	**6.7**	▲ **0.14**
Registered Nurses and Midwives	84.9%	▼ -5.9%	53.2%	▼ -3.8%	4.8	▼ -0.05
Care Staff	95.0%	▲ 3.9%	77.4%	▲ 11.5%	2.0	▲ 0.18
Total	**89.6%**	▲ **0.4%**	**69.9%**	▲ **0.5%**	**11.2**	▼ **-1.04**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	61.5%	▲ 0.5%
Central Delivery Suite	81.6%	▲ 1.3%
Jasmine & Honeysuckle	65.9%	▲ 1.1%
Ward 26 SGH	70.8%	▼ -2.2%
Total	**69.0%**	▲ **0.2%**

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In July 2023 the midwife: birth ratio for the Trust was 1:23 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. Fill rate and Care Hour per Patient Day (CHPPD) data for the two neonatal units is outlined below.

Fill Rate Dashboard Jul 2023

By day or night - display may exceed print limits

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

Northern Lincolnshire and Goole NHS Foundation Trust

Staff	Registered Nurses and Midwives						Care Staff						Nursing Associates		
Day or Night	Day			Night			Day			Night			Day		
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 %	Planned Hours	Actual Hours	Fill Rate %
NICU SGH	1,069.5	1,067.5	99.8%	1,069.5	1,070.0	100.0%	713.0	684.0	95.9%	713.0	659.5	92.5%	0.0	0.0	
NICU DPoW	1,782.5	1,559.0	87.5%	1,782.5	1,420.0	79.7%	713.0	425.5	59.7%	713.0	431.5	60.5%	0.0	0.0	
Total	**2,852.0**	**2,626.5**	**92.1%**	**2,852.0**	**2,490.0**	**87.3%**	**1,426.0**	**1,109.5**	**77.8%**	**1,426.0**	**1,091.0**	**76.5%**	**0.0**	**0.0**	

The fill rate for Registered Nurses (RN) at Scunthorpe NICU (Newborn Intensive Care Unit) is above the target of 95% for both days and nights.

At Grimsby the fill rate is less due to an increase in the establishment which is being recruited to with newly qualified nurses expected to start in the autumn. Bed occupancy is reviewed daily and shifts are only covered when necessary if there is full cot occupancy.

The fill rate for Health Care Assistants (HCAs) has improved at Scunthorpe due to vacancies being recruited to, however remains low at the Grimsby site. This position remains due to the daily review and movement of staff between Children and NICU to keep areas safe and some vacancy and long-term sickness gaps which are being managed appropriately.

CHPPD Dashboard Jul 2023

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

Northern Lincolnshire and Goole NHS Foundation Trust

Staff	Registered Nurses and Midwives				Care Staff				Nursing Associates				**Total**			
Ward name	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	**Actual Hours**	**Patients**	**Planned CHPPD**	**CHPPD**
NICU SGH	2,137.5	259	8.3	8.3	1,343.5	259	5.5	5.2	0.0	259	0.0	0.0	**3,481.0**	**259**	**13.8**	**13.4**
NICU DPoW	2,979.0	275	13.0	10.8	857.0	275	5.2	3.1	0.0	275	0.0	0.0	**3,836.0**	**275**	**18.1**	**13.9**
Total	**5,116.5**	**534**	**10.7**	**9.6**	**2,200.5**	**534**	**5.3**	**4.1**	**0.0**	**534**	**0.0**	**0.0**	**7,317.0**	**534**	**16.0**	**13.7**

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

The latest Trust wide Maternity Dashboard is shown in **Appendix I.**

2 Patient Experience/Service User Feedback

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

Formal Complaints and PALS Data

*** KPI -**Key Performance Indicator

Table A

Obstetrics	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**
Number complaints open/ongoing	3	4	4	3	5	6
Number of open complaints out of timescale	0	0	0	0	0	1
Number complaints closed this month	1	0	1	2	0	1
Number of new complaints	2	1	2	2	2	3
	Feb-23	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**
Number of PALS open	3	1	0	3	2	3
Number of PALS out of timescale	1	0	0	3	1	2
Number of PALS closed this month	2	5	3	3	9	5
Number of new PALS	3	3	1	6	7	6
	Feb-23	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**
% of complaints closed within timescale (KPI 85%)	**100%**	0	**100%**	**100%**	**0**	**100%**
Average length of time to respond to complaints closed (working days)	**N/A - withdrawn**	0	60	50	0	29
% of PALS closed within timescale (KPI 60%)	**0%**	**20%**	**33%**	**33%**	**33%**	**80%**
Average length of time to respond to PALS closed (working days)	10	7	10	10	12	4

Children & Young People including Neonates	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**
Number complaints open/ongoing	3	4	4	5	5	3
Number of open complaints out of timescale	0	0	0	0	0	0
Number complaints closed this month	1	1	2	0	1	2
Number of new complaints	3	3	4	1	2	0
	Feb-23	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**
Number of PALS open	4	2	2	4	5	7
Number of PALS out of timescale	2	2	1	4	2	4
Number of PALS closed this month	9	11	6	6	11	7
Number of new PALS	9	9	4	8	11	9
	Feb-23	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**
% of complaints closed within timescale (KPI 85%)	**100%**	**100%**	**100%**	**0**	**100%**	**100%**
Average length of time to respond to complaints closed (working days)	6	59	27	0	54	44
% of PALS closed within timescale (KPI 60%)	**0**	**55%**	**33%**	**33%**	**18%**	**80%**
Average length of time to respond to PALS closed (working days)	0	9	13	9	14	5

July saw one formal complaint closed in Obstetrics, this was closed in timescale, with a further 6 ongoing complaints open. Three new complaints were logged, with themes related to: clinical care at birth, staff attitudes and overall birth experience. There were 6 new concerns, the overarching theme being communication. Four of the concerns related to ward 26, the themes focussed on staff attitude, communication, and discharge. There was a positive increase in those concerns closed in timescale, with an average timescale of 4 days.

Children and Young People received zero new complaints and divisionally 2 complaints were closed, both of which were within timescale. There were 3 ongoing complaints. New logged PALS concerns decreased slightly compared to June, with 9 new concerns recorded. All these related to paediatric areas and not to neonatal areas. Medications and delays featured as themes, with access to audiology appointments highlighted. Number of concerns closed in timescale rose to 80% and the average length of time open reduced to 5 days.

One compliment was formally logged on Ulysses in July, this related to obstetric care given in a kind and compassion manner. It should be noted that the divisional teams hold multiple examples of cards and feedback at a local level and therefore this is not representative of all positive feedback.

As highlighted in June's report, due to the phased implementation of the new Friends and Family Test (FFT) provider system, a reduction in data collection was unavoidable. Obstetrics collected 29 responses, all of which were positive and detailed kindness as a key theme. This number is a considerable reduction as predicted. Maternity will be in the first phase the agreed digital model of feedback collection, and it is projected this could start in October. Interim paper collections continue, but the reduction of collected responses is a likely ongoing impact.

Children and young people gathered 11 pieces of positive feedback, all at Grimsby. The temporary Patient Experience Manager will be working with areas to ensure opportunities across all areas and continual staff engagement during this transition period.

3 Assurance

Two 15 Steps Challenge visits took place within Maternity Services and Neonatal Services during July 2023. Antenatal Outpatient Clinic at Scunthorpe General Hospital received a rating of good and Neonatal Intensive Care Unit (NICU) at Diana Princess of Wales Hospital received a rating of outstanding.

Acute 15 Steps Challenge Visits			
Date of visit	Ward/ Department	Rating 2023	Previous Rating
12/07/2023	Neonatal Intensive Care Unit Grimsby	12/07/2023	28/07/2022
19/07/2023	Antenatal Outpatients Scunthorpe	19/07/2023	12/01/2023
29/03/2023	Midwifery GDH	OUTSTANDING	GOOD

Outstanding	Good	Requires Improvement	Intensive Support

Areas for consideration and improvement were non-comparable between areas and with both areas achieving and/ or exceeding expected standards there were no common themes to report this month.

Supportive visits continue to take place across the women and children's services to review individual 15 Steps improvement plans and gain further assurance with ongoing actions.

Ward Assurance Tool (WAT) data, Maternity and Neonatal Services

Blueberry, Holly, Honeysuckle and Jasmine wards dropped below the expected 90% compliance with survey questions during the 4 weeks of July for Matron and Manager WAT surveys.

4 Feedback

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

The walkaround for July was undertaken at Scunthorpe. This was a positive walkaround and staff were keen to share the positives about their areas.

Escalated Issues:-

- Lack of superusers for CMIS (Maternity Information System) causing issues with obtaining NHS numbers and log ins. Need 24/7 cover
- Backlog of filing on ward 26 for current pregnancies due to the lack of ward clerk cover

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

The latest Safety Champions Action Log is attached as **Appendix II.**

5 Quality Improvement

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

This Quality Improvement Project aim is to implement a fully operational Maternity Triage Service across the whole of the Maternity Service in the Trust that utilises a Nationally recognised Triage Model (BSOTS). In order to enhance the patient experience and care. Following the successful rollout of Phase 1&2 – Telephone triage - the focus has now moved to Phase 3 for full implementation of the BSOTS model which following the above telephone triage of a patient, if it is deemed they need to be assessed face to face. This extensive service redesign includes changes to staff roles and the physical footprint of our wards and areas, although fundamentally the service will be doing the same amount of work but in a different way.

Work continues to resolve the final details in relation to the changes to the estate, recruitment, new staffing rotas and the ongoing unison challenge in relation to the Health Care Assistants role within the new triage service.

These elements are being managed by the divisional Senior Management Team and reported via the project governance to Maternity Transformation Board and are actively progressing the last elements to resolution. All focus is for a go live date of the 16 October 2023.

Antenatal Clinic (ANC) Quality Improvement (QI) Project
The divisional Senior Management Team have agreed for the commencement of a new QI project focusing on improving the Antenatal Clinics processes at both Grimsby and Scunthorpe. This work has been prioritised after initial scoping showed opportunity to improve the service across a number of quality and performance metrics including patient and staff experience, reducing clinic over runs, aligning ANC and scanning capacity and reviewing both midwifery and medical roles within the ANC. This work is at the initial stages of engaging key stakeholders and prioritising workstreams. Future updates will be provided as this work progresses.

6 Serious Incident (SI) Reporting

Open Maternity Serious Incident Investigations as at 12.09.2023

There are currently 5 Maternity Serious Incidents open in the Trust. Two of these incidents are being investigated by HSIB.

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
2022 20796	DPOW	HSIB - Unexpected baby death	Action Plan being written	The neonatal resus pro forma is being reviewed as it is not user-friendly for an emergency situation.	Not applicable due to HSIB investigating.
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.	28.09.2023
2023 10062	DPOW	IUD	Investigation	Matron discussed the case with the midwife regarding escalation. Educational supervisors discussed the case with the two registrars involved.	06.10.2023
2023 12695	SGH	Lower Segment Caesarean Section (LSCS) admitted to ITU	Investigation	There were no immediate actions or learning identified.	17.11.2023 Extension due to accommodate staff interviews and to write the draft report.

Maternity Serious Incident Completed Reports (August 2023) - None

2023 13122	DPOW	Maternal death	Investigation	This case was reported to MBRRACE as a maternal death and from the review of the case, there was no immediate learning identified.	29.09.2023
2023 13399	DPOW	HSIB - Maternal death	Investigation	Review of the postnatal care due to the large gap between reviews Email sent to all midwives for student midwives not to be given care without supervision Email sent to Consultants and Coordinators to ensure patients with safeguarding concerns to only be considered for transfer out when an absolute must eg <27 weeks gestation	Not applicable due to HSIB investigating.

Risks and themes

- No new risks or themes identified.

7 Sustainability Plan

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

These actions are monitored through divisional governance with Board assurance provided via the Division's regular report to the Quality and Safety Committee, through to Trust Board. The Maternity Sustainability Plan is monitored through the Maternity Quality Improvement meeting and Maternity Transformation & Improvement Board.

Sustainability Action plan position

As identified in the diagnostic review, the Trust has achieved the majority of the initial actions identified, with supporting documentary evidence. Of the 23 actions 18 are complete and 5 still in progress (on track).

Outstanding actions:

- To develop and refine the SMART (Specific, Measurable, Achievable, Realistic, Time-based) approach to QI plans in response to learning from incidents and complaints
- Develop a PMA (Professional Midwifery Advocate) QI plan around A-Equip model
- Multi-professional engagement workshops
- Proactive shared learning
- Multi-professional approach to positive safety culture

We have a clear exit strategy, which will follow local, regional and national governance process with a plan for exit October/November 2023.

8 Upcoming External Visits

- The planned National Maternity Team assurance visit will be replaced by an assurance visit from the LMNS on 23 October 2023
- National Maternity Team visit planned for 25 September 2023

9 Conclusion

The oversight report highlights all the work being undertaken within the maternity services.

Workforce/Staffing – Seven internationally educated midwives arrived at the Trust in March and May 2023 and have all passed their midwifery OSCE (Observed Structured Clinical Examination) Maternity services will be supporting a further 4 international midwives in the new year. In total 17 newly qualified midwives are due to commence cross site in the Autumn.

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.

Patient Experience - complaints and PALS (Patient Advice & Liaison Service) remain low and these are investigated and resolved within the expected time limits. Friends and Family results show excellent feedback and positive experience. Overall themes related to communication and kindness, with much of the positive comments relating to this.

Assurance

- Two 15 Steps Challenge visits took place within Maternity Services and Neonatal Services during July 2023. Antenatal Outpatient Clinic at Scunthorpe General Hospital received a rating of good and Neonatal Intensive Care Unit (NICU) at Diana Princess of Wales Hospital received a rating of Outstanding, both of these were increased ratings from previous visits.
- Positively the Maternity Voices Partnership Lead Role (MNVP) role has been recruited to and will commence September 2023. We look forward to working collaboratively.

Maternity Safety

- 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.
- Planning a Maternity Safety Conference – October 2023, based on the Ockenden Report – multidisciplinary and highlight on maternity safety
- Plan to implement Escalation Toolkit (Royal College of Obstetrician & Gynaecologists/Each Baby Counts) Multidisciplinary task and finish group commenced June 2023 and is progressing.

There are a number of on-going Quality Improvement projects including maternity triage services, induction of labour, neonatal thermoregulation and the Antenatal day unit/clinic review. All projects have full support from all the team and feedback from staff and service users is excellent. The triage service is currently providing consistent advice to women who ring with concerns and are signposted to the most appropriate area. The next stage of the project is the opening of an area at each unit which is specifically for women who ring with concerns and need to be seen. The planned date for commencing phase 2 is 16 October 2023.

Year 5 CNST (Clinical Negligence Scheme for Trusts) requirements have been released and a benchmarking exercise has been completed. to understand the changes from year four and expectations for year 5 is being undertaken. The maternity service have commenced fortnightly CNST meetings to monitor and ensure compliance with action plan.

Assurance and monitoring provided by:

- Family Service quad oversite and escalation as required
- Quality & Safety Committee and Trust Board oversight
- Multidisciplinary CNST meetings taking place fortnightly
- Introduction of Maternity Audit and Compliance Manager
- Development of CNST/Saving Babies Lives annual audit calendar in collaboration with central audit team
- Introduction of Saving Babies Lives implementation tool – allowing consistent ICB (Integrated Care Board) reporting/LMNS (Local Maternity & Neonatal Systems) oversight

Key Risks:

Safety Action 4 – Clinical Workforce
Detail: A) Obstetric medical workforce staffing shortfalls to meet standard 3 relating to RCOG (Royal College of Obstetricians & Gynaecologists) guidance on compensatory rest. B) RCOG guidance on the management of short/long term locums to be fully implemented.
Mitigation: Divisional Medical Director / General Manager reviewing consultant staffing levels and compiling business case. Action plan to be developed where shortfalls identified.

Safety Action 6 – Saving Babies' Lives
Detail: Element 6 requires women with pre-existing diabetes to be managed by a multidisciplinary team. Diabetes Midwife post currently going through HR recruitment process.
Pre-existing diabetes clinic takes place alongside Medicine division and has seen a significant increase in women requiring review.
Mitigation: Reviewing funding opportunities for additional consultants to introduce further multidisciplinary diabetes clinics.

Ockenden Report
Action plan following the initial Ockenden Report is now complete and work is progressing on the immediate and essential actions to improve maternity care, supported by the multidisciplinary team; 56 green, 28 amber and 0 red actions.

Serious incidents (SI) and HSIB (Healthcare Safety Investigation Branch) cases remain low with one newly reported SI in July 2023. As with complaints and PALS (Patient Advice & Liaison Service) due to the limited number there are no themes, however all learning is widely shared across all areas and reported into the LMNS (Local Maternity and Neonatal Systems), Perinatal Quality Safety and Assurance Group (PQSAG) and Perinatal Quality Safety Oversight Group (PQSOG) meeting.

Historic Serious Incident (SI) STEIS 2017 24617
Stillbirth 2017 – case involving former employee of NLaG (Registered Midwife) was heard at the Nursing and Midwifery Council (NMC)

- SI Action plan reviewed and all actions were completed.

Mandatory Training

K2 and PROMPT compliance
<u>K2 Perinatal Training Programme (PTP) – Fetal Monitoring</u>
Obstetric (Obs) Consultant 100%
Medical staff Obs Rota 94%
Midwives 97%
<u>Practical Obstetric Multi-Professional Training (PROMPT)</u>
Obstetric Consultant 94%
Medical staff Obs Rota 100%
Anaesthetic Consultant 92%
Anaesthetic staff on Obs Rota 100%
Midwives 96%
Health Care Assistants (HCA) 96%

Appendix I

Trustwide Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
Midwife to Birth Ratio	26.2	25.8 ↘	24.8 ↘	22.9 ↘	24.2 ↗	23.7 ↘	23.4 ↘	22.2 ↘	22.4 ↗	22.3 ↘	23.0 ↗	23.1 ↗
Red Flags	16.0 ↘	9.0 ↘	17.0 ↗	9.0 ↘	19.0 ↗	3.0 ↘	1.0 ↘	3.0 ↗	6.0 ↗	14.0 ↗	24.0 ↗	1.0 ↘
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or EI 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	2.0 ↗	2.0	0.0 ↘
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	2.0	1.0 ↘	1.0	0.0 ↘	3.0 ↗	1.0 ↘	0.0 ↘	2.0 ↗	2.0	2.0	0.0 ↘	0.0
(c) Missed medication during an admission to hospital	0.0 ↘	0.0	0.0	3.0 ↗	0.0 ↘	0.0	0.0	0.0	2.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘
(d) Delay of more than 30 minutes in providing pain relief	2.0	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	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	5.0 ↘	4.0 ↘	5.0 ↗	3.0 ↘	9.0 ↗	1.0 ↘	1.0	1.0	1.0	3.0 ↗	5.0 ↗	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	1.0 ↗	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.	6.0 ↘	3.0 ↘	11.0 ↗	3.0 ↘	5.0 ↗	1.0 ↘	0.0 ↘	0.0	0.0	6.0 ↗	15.0 ↗	1.0 ↘
Continuity of Carer %	12.0	12.0	14.0 ↗									
In Receipt of %	8.0 ↘	9.0 ↗	8.0 ↘									
CoC In Receipt of %	72.0 ↗	68.0 ↘	66.0 ↘									
Continuity Team Caseload	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 %	84.1	85.5 ↗	89.0 ↗	96.2 ↗	91.0 ↘	93.1 ↗	92.3 ↘	97.2 ↗	97.8 ↗	98.2 ↗	94.8 ↘	94.2 ↘
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	99.5 ↘	100.0 ↗	100.0	100.0	100.0	100.0
Vacancies	45.2 ↗	51.8 ↗	41.6 ↘	41.1 ↘	40.4 ↘	42.2 ↗	41.7 ↘	34.4 ↘	16.0 ↘	10.5 ↘	14.5 ↗	14.9 ↗
Vacancies - Registered	40.6 ↗	42.2 ↗	39.8 ↘	34.4 ↘	34.4 ↗	36.0 ↗	37.3 ↗	30.5 ↘	17.6 ↘	13.9 ↘	18.0 ↗	17.6 ↘
Vacancies - Unregistered	4.6 ↘	9.6 ↗	1.8 ↘	6.7 ↗	6.0 ↘	6.1 ↗	4.4 ↘	3.9 ↘	-1.6 ↘	-3.4 ↘	-3.5 ↘	-2.7 ↗
Serious Incidents	2.0 ↗	1.0 ↘	0.0 ↘	0.0	2.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0	1.0	1.0
Complaints	3.0 ↗	1.0 ↘	3.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	2.0 ↗	1.0 ↘	1.0	1.0	2.0 ↗	3.0 ↗
PALS	6.0 ↗	5.0 ↘	6.0 ↗	4.0 ↘	3.0 ↘	3.0	3.0	3.0	1.0 ↘	6.0 ↗	6.0	6.0
Sickness Absence (Division) %	6.4 ↘	6.0 ↘	6.5 ↗	5.0 ↘	6.7 ↗	5.6 ↘	5.5 ↘	5.9 ↗	6.0 ↗	5.7 ↘	5.2 ↘	

Appendix II – Safety Champions Action Log

	Overdue or Incomplete
	In Progress
	Completed

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Date Raised	How concern was raised	Site DPOW/SGH/ Trustwide	Concern Raised	Actions Required	Responsible Person	Action by Date	Status	Evidence Of Completion
19/10/2022		DPOW	Holes in theatre floor - previously been reported but no action has been taken as yet. Tracy Martin has liaised with Iona Johnson who was chasing up estates.	Has been reported previously to estates and Iona Johnson	Tracy Martin	30/09/2023		28/10/22 Further email sent to Iona Johnson to advise that repairs have still not been completed and is an infection control risk. 28/10/22 Iona will liaise with facilities regarding this. 6/12/22 update requested. 28/02/23 email sent for further update. 08/03/23 update from Tracy Martin that this is still ongoing. 27/04/23 Update from Iona, Claire shipley is now dealing with this and will be chasing up. 24/05/23 email sent to Claire Shipley for further update, still awaiting reply. 27/06/23 Natalie Jenkin working with Claire Shipley regarding this. 10/8/23 TM has meeting with Claire Shipley next week to discuss due to 18 month timesclae suggested by E&F.16/08/23 Update from TM, Claire Shipley is discussing with facilities tomorrow and maybe part of a bigger project regadring theatres, face to face visit planned 13/09/23.
21/12/2022		DPOW	Stores cages left obstructing maternity theatre corridor, not enough room to fit a bed through and dangerous in an emergency situation. This has previously been raised as a concern. Photo's taken and emailed to Bill Parkinson.	Email sent to Bill Parkinson & Iona Johnson (Iona already aware of situation as previously raised by a coordinator)	Bill Parkinson Iona Johnson Tracy Martin	30/09/2023		22/12/22 email from Iona to Keith Fowler & Keith Leech regarding providing further storage but also porters practices. Meeting arranged for 07/02/23, will request update. 28/02/23 email sent to ask for update on issue. 08/03/23 furteher update from Tracy Martin that this is still ongoing.27/04/23 Update from Iona, Claire shipley is now dealing with this and will be chasing up. 24/05/23 email sent to Claire Shipley for further update, still awaiting reply.27/06/23 Natalie Jenkin working with Claire Shipley regarding this. 29/7/23 on Safety Walkabout, Shaun Stacey to contact E&F to escalate issues further. 16/08/23 update from TM, qoute sent to Health tree foundation for storage cupboards, awaiting board approval.

18.04.22		SGH	The tiles on the wall in the sluice are falling off and have narrowly missed hitting a member of staff. They have been on since 1992 and the estates have said the recent hot weather has probably affected them	emailed ward manager to ask if it could be followed up for remedial work to be carried out for safety of staff using the area	Claire Brothwell & Shaliny Majara	31/10/2023		managers emailed 17/08/22 6/12/22 update requested. There is a mini refurbishment for ward 26 and should have this issue resolved. 18.01.23 update from manager- coflict in avalibility of funds between estates and division buisness manager so no further progress. 15.03.23 The mini refurbishment of ward 26 is underway and the wall area will have been resolved. 18.04.23 The tiles have not been replaced as planned and concerns are the old tiles will continue to fall off. Ward manager will issue a job requestion again to have the area made safe. 21.04.23 tiles have been re-secured but a request is being entered to replace with the plastic boarding which will be safer. 21.06.23 Ward 26 manager has applied for the perspex wall covering to replace all the remaining tiles. 17.07.23 awaiting repairs. 10/8/23 Claire Brothwell has not heard from Katherine Green regarding this since escalation - plan to obtain quote from E&F 12/9/23 New request sent to E&F for a quote for the works
17/05/2023		DPOW	Ward mobile phones should be taken into delivery rooms when caring for labourers, co-ordinators are receiving calls other staff members without correct information and sbar.	Email sent to ward managers	Vicki Booth Carla Siviter	30/09/2023		This is being discussed at the team meeting with all staff and ward managers are purchasing a second phone for each ward. 24/05/23 Vicki Booth in discussion with Keeley Gaunt & Wayne Woolrdige re purchasing further phones and improving the quality of the network. 9/8/23 TM continues to communicate with the Communications Dept to acquire more mobile phones. 12/9/23 Vicki Booth continues to chase for updates
17/07/2023	By cds and ward 26 ward managers	SGH	Both ward 26 and CDS do not have allocated stores workers who order and dispense stock for the areas. There has been an email sent from the incoming ward clerks and reception supervisor stating that the wards are not allowed to engage and help with the ordering of the stores. Stores are a time consuming process that needs a dedicated role and these areas are having difficulty in maximising the use of the appropriate people and time required . It is not feasible to continue using the 1 healthcare worker on either ward to carry this role as they are also tasked with caring for the patients and ward environment.	To agree a plan going forward as to how this job should be allocated.	Kendra Thomas and Claire Brothwell	31/12/2023		The email from the supervisor of ward clerks and receptionists stating they cannot support the ordering of stores is in the evidence file on the H-drive. This will need to be discussed at the next quality improvement meeting. 16.08.23 This has been discussed at the QI meeting and the ward managers have been requested to explore the feasibility of joining the Trust store allocation

19/07/2023	Shout Out Wednesday	DPOW	Covid stickers remain on the floor and are now scuffing and chipping and no longer required. For removal.	Email to facilities to see if they will remove	Tracey Martin	30/09/2023		Ticket logged with Estates for removal. Ref 427796. 16/08/23 still awaiting removal. 12/9/23 Chased Chris Crookes for an update for when works will be commenced
19/07/2023	Shout Out Wednesday	DPOW	A midwife stated Hull are no longer using agency midwives and are paying their midwives double time to bank. It was asked if our Trust would be doing the same to keep in line with HUTH.	Email sent to Nicola Foster to enquire if this would be a possibility.	Ellie Monkhouse	30/09/2023		25/07/23 Email sent to Nicky Foster. 26/07/23 Nicky is speaking with Ellie Monkhouse regarding this. 31/8/23 Ellie Monkhouse to escalate following Walkaround today
19/07/2023	Shout Out Wednesday	DPOW	When midwives are scrubbing in theatre they aren't able to welcome the birth partner into theatre or to provide support to the birthing person and partner. For Odp's to assist with this if possible.	Tracy Martin is liaising with Claire Major regarding this	Tracy Martin	30/11/2023		For discussion at Maternity Forum in September. 12/9/23 This was deferred to the next maternity forum due to the huge agenda
27/07/2023	Safety Champions Walkaround	SGH	Lack of superusers for CMIS causing issues with obtaining NHS numbers and log ins. Need 24/7 cover	For discussion within the Business team to provide support	Ant Rosevear/Claire Shipley	31/10/2023		Discussions being held at CMIS PAS Migration meeting. SOP is going through the governance process for out of hours NHS numbers to be produced
27/07/2023	Safety Champions Walkaround	SGH	Backlog of filing on ward 26 for current pregnancies due to the lack of ward clerk cover	Escalation to Michelle O'Neill	Ant Rosevear/Claire Shipley	31/08/2023		Email sent to MO for information about the lack of ward clerk cover and potential overtime for staff. 12/9/23 Now on the risk register

Appendix III – Maternity Sustainability Plan

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	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 15/6/23 Strategy in governance approval process - currently out for comment 23/6/23 Ratified at O&G Governance meeting June 23	Strategy ratified at Obstetric Governance Meeting and available on the Trust intranet		Chief Nurse	Assocoiate Chief Nurse	Jun-23	Strategy. 10/8/23 To provide further evidence of process for document control ratification and staff engagement 7/9/23 Evidence re Trust - document control process DCP001
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 15/6/23 Ongoing 23/6/23 Progress continues 14/7/23 Progress on action plan continues	Minutes of QI and Monitoring Group, Maternity Transformation Board and Trust Board. Completion of action plan.		Chief Nurse	Associate COO	Jul-23	10/8/23 Provide minutes of Trust Board meeting (Aug 23) and 3 months of MTIB minutes 5/9/23 - Email from Sarah Meggitt (PA) Trust Board minutes will be available after 3 October (date of Board) 5/9/23 Requested minutes from SM
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. SOP in place. 15/6/23 Work ongoing 14/7/23 Work continues - Quarterly Report will commence July (O&G Governance meeting for information)	Incident Review Action log and Minutes from the QI and Monitoring Group.		Chief Nurse	Associate Chief Nurse	Jul-23	In h/f amily services/divisional managers/maternity/self assessment tool Incident review action log, minutes QI and monitoring group. QI highlight reports.QI Strategy. 10/8/23 Provide further evidence, including action log, safety bulletin, PMRT newsletter, safety huddles, LMNS (PQSAG) Review SOP section 5.0 monitoring compliance and effectiveness 12/9/23 SOPS reviewed and reflect monitoring process
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 15/6/23 Gap analysis against the national steering group's 'principles for successful implementation of PMA teams' completed and completion of action plan in progress by PMA team.	Model implemented		Chief Nurse	Associate Chief Nurse	Jul-23	PMA strategy, PMA Guideline DCT168, PMA team implementation gap analysis. 10/8/23 PMA annual report to Trust Board (presented by PMA) Follow up offer from CK to support PMA Evidence of PMA action plan
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' 15/6/23 Matron - Gynaecology and Breast interview 16/6/23. Plan for matrons and B7 managers to attend the 'Leading with Kindness, Courage and Respect Programme' 26/6/23 Matrons booked onto course for September 2023 26/6/23 Matron posts for maternity and gynaecology and breast both appointed.	Matron for Gynaecology and Breast in post and Matrons booked onto the course.		Chief Nurse	Associate Chief Nurse	Jul-23	Email from Tori Hordon confirming course booking

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
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. 15/6/23 Recruited into Maternity audit and compliance manager post 9/6/23 (post will commence from August 23) Deputy Governance Lead post interview planned for July 23	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.15/6/23 Leadership Development Strategy				Tori Hordon, Organisational Development Business Partner	May-23	Leadership Development Strategy
MSAT2	Maternity strategy, vision and values	Maternity strategy in place for minimum 3-5 years	14/4/23 Draft document, awaiting illustration to be added prior to wider circulation for comments. 15/6/23 Strategy written and in governance process - due for ratification O&G Governance June 23. 23/6/23 Ratified T O&G Governance meeting June 23 (CN forward to be added)				Division Tri	Jun-23	Strategy 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned
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 15/6/23 As above.23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned
MSAT4	Maternity strategy, vision and values	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	14/4/23 as above 15/6/23 As above.23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy. 10/8/23 To provide further evidence of process for document control ratification and staff engagement
MSAT5	Maternity strategy, vision and values	Maternity strategy aligned with trust board LMNS and MVP?s strategies	14/4/23 as above 15/6/23 As above. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy. 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned
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. Sharing of Safety Intelligence from floor to board on safety and quality issues standard operating procedure DCR246 10/8/23 Safety champions – Gateshead good board - have emailed TC and CK today to ask for contact from Gateshead. 5/9/23 TEAMs chanel accesible to all staff re: Maternity and Neonatal Safety Champions. 12/9/23 Maternity and Neonatal Safety Conference - planning (minutes of meetings) Safety champion badges ordered.

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
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 planned safety days, improvement	Evidence required 23/7/23 Proposed date for Maternity Safety Conference (multidisciplinary and cross site) 18/10/23 - followed by quarterly sessions	Maternity and Neonatal Safety Conference			Division Tri	01/06/2023 Amended target date 31/12/23	
MSAT8	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	Evidence required. DS provided evidence				Dave Sprawka	Feb-23	Values based recruitment
MSAT9	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Evidence required 15/6/23 RD to contact BC (LMNS) 14/7/23 Intention for a 6 monthly review of the maternity patient safety profile and its link to the Patient Safety Incident Response Plan. Risk Profile and theming being taken forward, with a view to arrange a meeting with LMNS to progress during July/August and when inital plan agreed, to review 6 monthly with with learning and review of safety profile. PSIR policy in draft, setting out the PSIRP monitoring approach and orgnisation wide safety summit.				Richard Dickinson, Associate Director of Quality Governance	Sep-23	12/9/23 Maternity PSIRP. Attended national webinars and now developing PRSIP plan for maternity. Meeting between maternity and governance team 30/8/23. Need evidence KB
MSAT10	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	Evidence required. Divisional framework in development. 15/6/23 Evidence required from GD 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing change (change management and quality improvement methodology). •Culture work : oteam interventions available including team coaching and Insights training to provide team cohesion through self awareness and open discussions on personal style and preference, ocivility & respect training, building				HRBP	Jul-23	Leadership and management behavioural framework 12/9/23 NMC Code Quad attending Perinatal Leadership Course and second cohort planned. SCORE survey to be commenced Feb 2024. Managers all currently completing 'Leading with Courage, Kindness and Respect'
MSAT11	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	Evidence required. In progress at divisional level. 15/6/23 Evidence required from GD. Have maternity behavioural charter 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing change (change management and quality improvement methodology). •Culture work : oteam interventions available including team coaching and Insights training to provide team cohesion through self awareness and open discussions on personal style and preference,				HRBP	Jul-23	12/9/23 Strategic plan for NLaG, Values, Maternity specific behaviour charter, stress/civility,

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
MSAT12	Maternity governance structure	Maternity governance and leadership team roles review	Recruitment in progress for additional leadership roles 15/6/23 Review undertaken. Appointed to Maternity Audit and Compliance Manager role and Deputy Governance Lead post currently out to advert. 22/7/23 Deputy Governance Lead role appointed to.				Division Tri	May-23	
MSAT13	Proactive shared learning	Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	Evidence required 15/6/23 Update from RD - Sharing Learning document currently under review 14/7/23 Existing Learning Strategy document reviewed, consulting on through Quality Governance Group and PSIRF implementation Group. Awaiting responses as of 7/7/2023. Annual review date being applied to this version as last version was in 2020 on a 3 year cycle. Relaunch of Trust learning group to follow, with refreshed membership and focus.				Richard Dickinson, Associate Director of Quality Governance	Aug-23	http://nlgnst.nlg.nhs.uk/DocumentControl/Documents/Learning%20Strategy%20(DCP363).pdf#search=learning%20strategy / Learning Strategy 10/8/23 Review action with focus on maternity services
MSAT14	Safety huddles	Audit of compliance against safety huddle guideline/SOP	Evidence required 15/6/23 JL/TM completing SOP and audits. 30/6/23 SOP in governance process (out for comments to governance group)7/7/23 SOP ratified and on HUB - audit	SOP ratified and available on the HUB			Division Tri	Jun-23	13/9/23 Plan for MNVP lead coproduction/attendance at maternity study days.
MSAT15	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division
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 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division
MSAT17	Trust wide Swartz rounds	Broad range of specialties leading sessions	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division

Red	Overdue
Amber	On track
Green	Completed

NLG(23)178

Name of the Meeting	**Trust Board**
Date of the Meeting	3 October 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Board Assurance Framework (BAF) 2023-24**
Purpose of the Report and Executive Summary (to include recommendations)	**Purpose of the Report** The BAF brings together all of the relevant information on the risks to the delivery of the board's strategic objectives, highlighting risks, controls and assurances. It is an essential tool for seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Board can have confidence that they are providing thorough oversight of strategic risk. **Executive Summary** The Trust Board is asked to receive the BAF to gain assurance on the delivery of the Board's strategic objectives (SO). The Board is to note that the Board Committees will be undertaking a review of the BAF at Committee meetings in October and November 2023. The Quarter Two report will be presented to the Trust Board in December 2023. Six strategic risks are rated 'red', with scores of 15 and 20, as follows. • The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently = 15 • The risk that the Trust fails to deliver constitutional and other regulatory performance targets = 20 • The risk that the Trust's estate, infrastructure and equipment may be inadequate = 20 • 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 = 20 • The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities = 20 • The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate = 15. **Recommendations** a) receive the report and the BAF (see Appendix A) to gain assurance on the delivery of the Board's strategic objectives,

	b) review and consider each of the current strategic risk scores as detailed in Section 3, c) note the high-level risk register (see Appendix B), d) note the Finance and Performance Committee, Quality and Safety Committee, Workforce Committee and the Audit Risk and Governance Committees will receive and review the BAF at their respective meetings in October / November 2023, e) note the Trust Board will receive the BAF Quarter Two report at its meeting in December 2023.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ✓ Other: Group Executive Team
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working ✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Discussion ✓ Review ✓ Assurance ☐ Other: Click here to enter text.

Board Assurance Framework (BAF) 2023-24

1. Executive Summary

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

1.2. The Board is to note that the Board Committees will be undertaking a review of the BAF at their meetings in October and November 2023. The Quarter Two report will be presented to the Trust Board in December 2023.

1.3. Six strategic risks are rated 'red', with scores of 15 or 20.

- SO1-1.1: patients may suffer because the Trust fails to deliver treatment, care and support consistently = 15
- SO1-1.2: the Trust fails to deliver constitutional and other regulatory performance targets = 20
- SO1-1.4: the risk that the Trust's estate, infrastructure and equipment may be inadequate = 20
- 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 = 20
- SO3-3.1: either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities = 20
- SO3-3.2: the Trust fails to secure and deploy adequate major capital to redevelop its estate = 15.

2. Purpose of the Report

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

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

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

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

4. Principal Risks – Highlights and Lowlights

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

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

b) The Committee noted there was 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.

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

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

b) The Committee noted a key gap in control was 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.

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

a) The Board agreed the risk score of 12 at its meeting on 1 August 2023.

b) The Board noted that the risk score of 12 was due to the Integrated Care Board having approved the proposal to move forward to public consultation regarding the reconfiguration of certain services on the South Bank on 12 July 2023, subject to NHS England approval. The proposals recommended improving services at local Emergency Departments across the North and South Bank, enabling people to be treated quickly and tackling long waiting times.

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

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

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

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

a) Due to the disbanding of the Strategic Development Committee, the Trust Board agreed to have oversight of the risk to the delivery of the Digital Strategy. The Board agreed the risk score of six and noted the delivery of the Digital Strategy remains off track.

b) The Board, at its meeting on 1 August 2023, reviewed and considered the risk to the delivery of the Digital Strategy and noted the securing of resources to deliver the Digital Strategy and annual priorities remain off track with a completion date moved to the end of quarter two.

c) The Board noted on 1 August 2023 that the Audit Risk and Governance Committee reviewed the updates to the BAF at its meeting on 20 July 2023. The Committee noted the:

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

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

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

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

b) The Committee noted:

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

ii) the Bed Capacity challenges remain a gap in control. The Executive Led Bed Occupancy and Length of Stay Review meetings commenced on Thursday 29th June 2023. These meetings have been set up to allow the Chief Operating Officer to Challenge the Divisional Medical Directors and Associate Chief Nurse's on any patients staying on a ward for longer than expected.

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

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

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

ii) delivery of SO2 may be impacted due to the number of High-Level Risks, of note:
- No 2976, High registered nursing vacancy levels = 25
- No 3015, Insufficient estate resources to manage the workload demand = 20.

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

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

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

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

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

a) The Board agreed the risk score of 15 at its meeting on 1 August 2023. This was due to a significant risk with capital investment which was due to the availability of capital funding to meet our requirements, impact of capital decisions on accessing new hospitals programme funding and impact of national reports (Ockenden) on potential capital investment requirements.

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

a) The Board at its meeting on 1 August 2023 agreed the risk score of 12. The risk was scored 12 due to the Integrated Care Board having approved the proposal to move forward to public consultation regarding the reconfiguration of certain services on the South Bank on 12 July 2023, subject to NHS England approval. The proposals recommend improving services at local Emergency Departments across the North and South Bank, enabling people to be treated quickly and tackling long waiting times.

4.1.11. The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives - SO5

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

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

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

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

5. Recommendations

5.1. The Trust Board is asked to:

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

b) review and consider each of the current strategic risk scores as detailed in Section 3,

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

d) note the Finance and Performance Committee, Quality and Safety Committee, Workforce Committee and the Audit Risk and Governance Committees will receive and review the BAF at their respective meetings in October / November 2023,

e) note the Trust Board will receive the BAF Quarter Two report at its meeting in December 2023.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2023 / 24

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

Board Assurance Framework - 2023 / 24

The Trust's risk appetite is:

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

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

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

Context

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

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

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

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

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

Risk Appetite Assessment

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

Risk Management

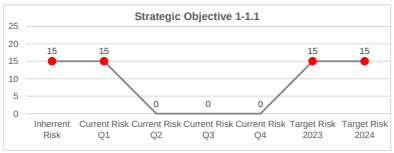
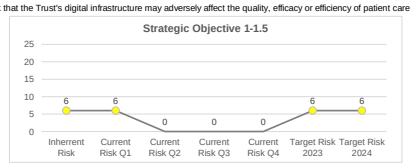
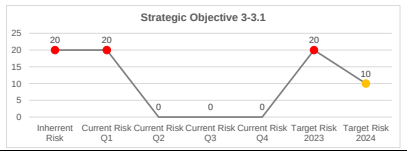
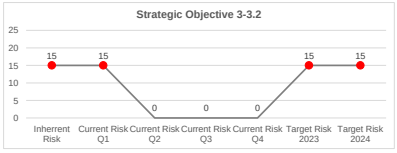
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity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

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

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

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Board Assurance Framework - 2023 / 24

Strategic Risk	High Level Risk Description and Risk Consequence / Likelihood Assessment	Risk Appetite	Owner	Committee
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard 	Low	Chief Medical Officer and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets 	Low	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy 	Low	Director of Strategic Development	Trust Board
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate 	Low	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care 	Low	Chief Information Officer	ARG / Trust Board
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope 	Low	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients. 	Low	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities 	Moderate	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital 	Moderate	Director of Strategic Development	Trust Board
SO4	The risk that the Trust is not a good partner and collaborator 	Moderate	Director of Strategic Development	Trust Board
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives 	Moderate	Chief Executive	WC

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	3	3				3
Risk Rating Score	15	15				15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 3 July 2023

Lead Committee: Quality and Safety Committee

Risk Owners: Chief Medical Officer and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan 2022/23
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Place Quality Meetings - N Lincs, N E Lincs, East Riding
- SI Collaborative Meeting with ICB, with Place Representatives
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare Live
- Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group
- Nursing Metric Panel Meeting
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing and Midwifery Board
- NICE Guidance implementation monitoring and reporting processes
- Learning from deaths process
- Mortality Improvement Group
- Vulnerabilities Group
- Incident control group chaired by NHSE to support Paediatric Audiology service.

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board, Learning from deaths annual and quarterly reports.
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- NICE Guidance Assurance Report to Q&SC
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Nursing assurance safe staffing framework NHSI
- Audit Outlier Report to Quality Governance Group
- 15 Steps Accreditation Tool
- CQC action planning, monitoring and assurance of action completion processes

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance
- NHSE External Review of Safe Staffing Establishment and Recommendations - February 2022
- Maternity Birth Rate Plus Review - 2022
- Internal Audit - CQC action plan compliance – Significant assurance
- Improved ratings in CQC inspection (Dec 2022 report) with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement
- Maternity CNST standards compliance submission
- Health Scrutiny Committees (Local Authority)

Planned Actions

Action	Quarter / Year	Assurance
Continue to develop metrics as data quality allows	Ongoing	Green
Delivery of deteriorating patient improvement plan	Q4 2023/24	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green
Implementation of the Learning From Patient Safety Events incident reporting requirements (we are in testing phase).	Q2 2023/23	Green
Review and implement changes to Audiology Service	Q2 2023/24	Amber
15 steps Star Accreditation Programme commenced	Ongoing	Green
Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas.	Q4 2023/24	Green
Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients	Q4 2023/24	Green

Future Risks

- Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train.
- Transition from SI reporting framework to PSIRF approach.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Gaps in Controls

- Estate and compliance with IPC requirements B12- see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust
- Paediatric audiology service

Gaps in Assurance

- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Safety and delays on cancer pathways
- Patient safety risks increased due to longer waiting times. (Refer to SO1-1.2)

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
No 2347 Deteriorating patient risk, Surgery = 15
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3114,Delays in children being reviewing in Paediatric Endocrine Service, may lead to failure to treat and manage the child's condition, leading to significant physical, mental issues, that could be life limiting = 20
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16
No 3196, Breast imaging service loss of capacity, will impact on delivery of 2ww service and delay patient pathways = 15
No 3221, Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 15
No 3226, Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	4	4				3
Risk Rating Score	20	20				15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)
- Emergency Department and Medicine Specialties Quality & Safetly Groups

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, A&E Delivery Board, MDT Business Meetings, System-wide Ambulance Handover Improvement Group, PCIP, PFIG
- Integrated Performance Report to Trust Board and Committees.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2022-23

External:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- NHSE Intensive Support Team
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022

Planned Actions

Action	Quarter / Year	Assurance
Progress with implementation of General Internal Medicine/Frailty Model and the link as a wider integrated frailty model across Northern Lincolnshire	Q2 2023/24	Yellow
Review of clinical pathways linked to HAS programme 1 Humber Clinical Collaborative Programme (HCCP), seven specialties	Q2 2023/24	Amber
Validation of all RTT Clock Stops back to 100%	Q2 2023/24	Amber
Develop divisional dashboards	Q2 2023/24	Yellow
Consultant job plans to be signed off for 2023-24	Q2 2023/24	Red
Completion of theatre refubishment programme	Q2 2023/24	Green
Implementation of 2023/24 Outpatient Clinic Configuration aligned to 2023/24 Activity Plan and NHS Operational Planning Guidance, reducing follow up activity and increasing capacity for new patients	Q2 2023/24	Green
Implementation of Gynaecology Service Review including the support the Integrated Acute Assessment Unit (IAAU) model of care	Q3 2023/24	Green
Expansion of Community Discharge and Admission Alternative Development workstreams (Virtual Ward capacity, Short Term care capacity and OPAT capacity)	Q3 2023/24	Green
Implementation of Criteria to Admit within ED to support reduction in admissions and use of alternative pathways	Q4 2023/24	Green
Review of pathways for High Intensity Service Users	Q4 2023/24	Green
Implementation of Clinical Frailty Score in ED	Q4 2023/24	Green
Review Dementia pathways in ED	Q4 2023/24	Green
Implementation phase 3 of AAU business case	Q4 2023/24	Green

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 64 weeks, 62 days and 104 days breaches.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to inability to access scanner and reporting teams externally
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS requires significant system change. Early adopters from July 23, with mandatory submission from July 24
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - not meeting constitutional standards and impact on diagnostic capacity
- Risk of no contracting for independent sector work
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Replacement of ward A1

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.
Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- High levels of staff sickness
- High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas.

Gaps in Assurance

- Quality of reports to board assurance committees
- Quality and timeliness of data
- Recruitment and development of Consultants, specialist nurses

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 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 2775, Scunthorpe MRI scanner past end of 7 year life, lack of capital availability, impact will be reduced capacity to deliver scans for some cancer pathways = 20
No 2949, Oncology Service = 20
No 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16
No 3201, Clinical capacity within colposcopy = 15
No 3204, One year wait for new referrals to see a Consultant Paediatrician into the ADHD post diagnostis support service = 15
No 3217, Breast Imaging Workforce Depletion, and delays to deliver care occuring to cancer standards = 15

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2023/24
- Humber and North Yorkshire Integrated Care System
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS)
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board (JDB)
- Committees in Common (CIC)
- Patient Safety Champions

Assurance (internal & external)

Positive:
- NHSE Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC
- Humber and North Yorkshire Integrated Care System
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
CIC / NED / Governor reviews	Q4 2022/23	Blue
Evaluation of the models and options with stakeholders	Q4 2022/23	Blue
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
Citizens Panel reviews	Q2 2023/24	Green
To undertake continuous process of stocktake and assurance reviews NHSE and Clinical Senate review	Q1 2023/24	Blue
Joint OSC - reviews	Q2 2023/24	Green
To undertake continuous engagement process with public and staff	Q2 2023/24	Green
Stakeholder Mapping	Q1 2023/24	Blue
Public Consultation	Q2/Q3 2023/24	Green
NHSE Gateway review	Q4 2023/24	Green
ICB Executive Assurance Board / IC Board Approval	Q4 2023/24	Green
Final report from Clinical Senate review (due Q1)	Q1 2023/24	Blue
HAS Risk Workshop with ICB Executives (30 May 23)	Q1 2023/24	Blue
Decision Making Business Case	Q3/4 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	4	4				4
Risk Rating	20	20				20

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 7 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24	Red
Complete refurbishment of old SGH ED (completion end of Q4ã)	Q3 2023/24	Red
Complete BLM 23/24 programme	Q4 2023/24	Amber

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
- Grimsby 21% CIR of the BLM
- Goole 11% CIR of the BLM
- Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance:Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	3	3				3
Likelihood	2	2				2
Risk Rating	6	6				6

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 July 2023

Lead Committee: Audit, Risk and Governance Committee / Trust Board

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:
- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:
- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Positive Assurance:
- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Planned Actions

Action	Quarter / Year	Assurance
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Pkus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23.	Q4 2023/24	Green
IPR - further review of current the IPR to align with how the Group model evolves. (ie. adding digital, finance and estates)	Q4 2023/24	Green
Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Depending when NHSE EPR digitisation funding is made available.	Q2 2023/24	Amber
The Data Warehouse with core activity data sets will be completed and running on the new platform by May 2023 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q2 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q2 2023/24	Green
Reconfiguration of local Digital Services functions commenced to move to group structure increasing resilience and its ability to deliver strategic change.	Q3 2023/24	Green

Future Risks

- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Achieve DSP Toolkit compliance - currently approaching standards.

Gaps in Assurance

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group.
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- IPC protocols implemented including mask wearing and rapid testing process
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)
- Industrial action planning (Strategic & Tactical Group)
- Emergency Preparedness, Resilience and Response Steering Group
- Bank Holiday Planing Group
- Executive Led Bed Occupancy and Length of Stay Review

Assurance (internal & external)

Internal:

- National and Regional exercises testing emergency plans, business continuity and planning assumptions (e.g. Artic Willow, Mighty Oak)
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP, Strategic & Tactical Group, Emergency Preparedness, Resilience and Response Steering Group, Bank Holiday Planning Group, Executive Led Bed Occupancy and Length of Stay Review

Positive:

- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance

External:

- Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core Standards rated substantial compliance
- NHSE review of emergency planning self-assessment 2021/22 rated substantial compliance
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance
- EMAS Audit of Trust CBRNe/HAZMAT arrangements with no recommendations (2022/23)

Planned Actions

Action	Quarter / Year	Assurance
Relaunch of loggist training and provision	Ongoing	Green
Review of Evacuation Plan	Ongoing	Yellow
Continuous Review of Evacuation Plan	Ongoing	Yellow
Planning for and response to industrial action (multiple unions)	Ongoing	Green
Inclusion of details of BC plans tested/implemented duirng exercises/incidents documented in reports.	Ongoing	Green
Rolling Schedule of annual business continuity plans	Ongoing	Green
Review of Major Incident Plan and Critical Incident Plan	Q2 2023/24	Green
Roll out of new Major Incident Triage Tool (MITT)	Q4 2023/24	Green
Flu / COVID Public Health campaign for Vaccinations	Q3 2023/24	Green

Future Risks

- COVID-19 surge.
- Availability of clinical consumables, equipment and some medications post EU Exit.
- Costs and timeliness of deliveries due to EU Exit.
- Additional patients with longer waiting times RTT, Cancer and Diagnostics.
- Increase in seasonal outbreaks (influenza, norovirus) impacting on bed capacity.
- National industrial action within healthcare and other sectors impacting on workforce levels.
- Increased risk of cyber attacks due to sanctions imposed on Russia.
- Risk of energy supply disruptions over winter period.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2023/24.
- Lower than expected uptake of influenza vaccination.

Gaps in Assurance

- BC Plans that are tested or implemented during exercises/incidents are not specifically named or captured within reports to evidence testing.
- Challenge in releasing workforce to attend specialist training (e.g. CBRN/HAZMAT).
- Recruitment pipeline to address medical staffing shortfalls and reduce reliance on agency.
- Recruitment pipeline to address nurse staffing shortfalls and reduce reliance on agency.

Links to High Level Risks Register

- No 2562, Constitutional A&E targets = 20
- No 3164, Nurse staffing = 20
- No 2976, Registered nursing vacancies = 25
- No 3063, Doctor vacancies = 16

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.
- Participation in national, regional and ICS/LRF exercising and testing of emergency plans.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	3	4				3
Risk Rating	15	20				15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 12 July 2023

Lead Committee: Workforce Committee

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recrutiment and retention group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- People Directorate - People Strategy Annual Delivery Implementation Plan 2023/24
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Workforce Development Portfolio Governance Boards, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board.

Positive:
- IPR decreasing trends
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year	Assurance
Develop and care for our own staff to improve retention (People Plan 23/24)	Q4 2023/24	Green
Develop the attraction and development of new staff (People plan 23/24)	Q4 2023/24	Green
Continue to improve our culture and staff engagement (People Plan 23/24)	Q4 2023/24	Green

Future Risks

- Pockets of low staff morale impacting turnover
- Seasonal illness may impact available workforce numbers
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Change impact of HASR and Group plans on NLaG clinical and non clinical strategies.
- Reliance on international pipelines to reduced vacancy position. Further local succession planning and future talent identification required.
- Increased demand on people services due to significant volumes of staff recruitment - potential for delays
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda
- National strike action driven by pay detracts from local ability to deliver cultural satisfaction.

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Attract, recruit, retain staff to work in the geographical area.
- Culture and staff engagement.

Gaps in Assurance

- Vacancy postion remain high particulary in medical areas
- Agency spend remains high
- Turnover remains high.

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3209, Risk to Junior Medical Cover - Recruitment Delays to Acute TG CT = 16
No 3217, Breast Imaging Workforce Depletion, and delays to deliver care occuring to cancer standards = 15

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment
- Place based educational collaboratives

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber and North Yorkshire Integrated Care System.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	4	4				2
Risk Rating	20	20				10

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify Cost Improvement Programme (CIP) schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2023/24
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Internal Audit Reports - Internal Control - significant assurance

External:
- Approval received at ICS Level for 2023/24 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2023/24
- Monthly meetings with NHSE Regional Team as a successor to Financial Special Measures regime.

Planned Actions

Action	Quarter / Year	Assurance
There is specific workforce planning ongoing - linked to Workforce committee (refer to SO2)		Green
Review of nationally specified control actions currently underway with a view to introduction.	Q2	Green
Exercise to identify and complete CIP planning process also underway	Q2	Green
HAS business case planned to go to public consultation	Q3	Green
Develop workforce plans for non-registered nursing and medical staffing	Q2	Red

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems
- Vacancy levels in medical and nursing driving an unplanned level of spend
- Inability to transform planned care pathways, including outpatient follow-ups and theatre productivity

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- Cost Improvement Programme not fully formed.
- Delivery plan to support activity targets no fully formed.
- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
- Month on month adverse variants against operational budgets
- Inability to recruit and retain staff to meet financial plannnig assumptions
- Have we systems in place to facilitate level of recruitment
- Systems and processes in place to facilitate reduction in turnover rate
- Uncertainty of existing systems to recruit and retain staff.

Gaps in Assurance

- Trustwide Budgetary Control System, not working to deliver financial balance with current plans
- Recurrent delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the lack of flow
- Individual organisational sustainability plans may not deliver system wide control total
- No assurance recruitment or retention will improve
- Not meeting productivity targets for theatres and outpatients

Links to High Level Risks Register

No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20
No 3174, Trust doesnot receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE = 15
No 3202, Non-delivery of Medicine Divisional Finance CIP = 16
No 3221, Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 15
No 3226, Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16

Future Opportunities

- Closer ICS working
- Provider collaboration and formation of the Group
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	3	3				3
Risk Rating	15	15				15

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Trust Board

Risk Owners:
Chief Financial Officer and
Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE - HAS Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- NHSE attendance at AAU / ED Programme Board
- CiC Minutes
- Place Boards

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Blue
Review and seek if there are ways of applying for future rounds of PSDS funding	Q2 2023/24	Green
Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies	Q3 2023/24	Yellow

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Links to High Level Risks Register

No 2775, Scunthorpe MRI scanner past end of 7 year life, lack of capital availability, impact will be reduced capacity to deliver scans for some cancer pathways = 20

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

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

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabing Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY ICS.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common
- Acute and Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)
- Place Boards

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process
- Consultation Institute Review
- Place Boards and Place Working Groups established

Internal:
- Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams
- Place Boards and Place Working Groups established
- Collaborative of Acute Providers Board

Planned Actions

Action	Quarter / Year	Assurance
HAS Programme:		
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Blue
Joint OSC - reviews	Q1 2023/24	Green
NHSE Gateway review	Q2 2023/24	Green
ICS Board approval	Q2 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
Decision Making Business Case	Q3/4 2023/24	
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Blue
Collaborative of Acute Providers:		
Development of H&NY Planned Care Strategy/Framework	Q3 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 12 July 2023

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS, Leadership and Culture Transformation Committee
- CQC and NHSE Support Teams
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders, VB Leadership Development, LIDA
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSE Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair, Chief Executive, Chief Financial Officer, Chief Information Officer, Interim Chief People Officer, Interm Director of Strategic Development and Interim Director of Estates and Facilities with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System.

Assurance (internal & external)

Internal:
- Leadership Strategy
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS, Leadership and Culture Transformation Committee.
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Board and Committee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:

External:
- NHS Staff Survey.
- CQC Report
- ICB Leadership forum

Planned Actions

Action	Quarter / Year	Assurance
Delivery against the Trust Leadership Strategy (2020 - 2024)	Q4 (23/24)	Yellow

Future Risks

- Funding for all leadership programmes is non-recurrent
- National policy changes.
- Impact of HASR and Group plans on NLaG clinical and non clinical strategies.

Strategic Threats

- Non-delivery of the Trust's strategic objectives
- Higher turnover of staff due to poor levels of leadership
- CQC rating and recommendations
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No ongoing investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration - particular focus on local education providers
- System wide collaboration to meet control total
- Group model and wider access to leadership development.

Board Assurance Framework - 2023 / 24	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated yellow - in progress, off track, with mitigation, and could pose a risk to the strategic objective being delivered
Green	Actions rated green mean they are on track to deliver.
Blue	Closed action which supports the progress towards the delivery of the strategic objective

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Med Gas	20	01/10/2023	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.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates - Heating/Ventilation	16	01/10/2023	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.	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Ophthalmology	15	01/10/2023	Work with the ICB to secure additional capacity in the independent sector.	Recent investment will not mitigate the shortfall in capacity	No data
2035	04/09/2023	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 are non-compliant with current regulations which may result in patients and staff being unable to move through the hospital sites safely and with dignity and respect.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Health & Safety	16	01/10/2023	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	19/06/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ventilation and Air Conditioning - HVAC - Trustwide	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...	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Heating/Ventilation	15	01/10/2023	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	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Fire Compliance	There is a risk failure of the fire alarm resulting in failure to detect fire/smoke leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Fire Safety	20	01/10/2023	Compliance Department have dedicated H&S/Fire staff resource.	No data	No data
2088	28/02/2023	30/09/2023	To provide care which is as safe, effective, accessible and timely as possible	Buildings, Land and Plant	Building Management Systems (BMS) Controller failure/upgrade	There is the risk of failure of elements of the Building Management Systems (BMS). The BMS 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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Building Management	20	01/10/2023	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.	Abolfazl Abdi	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Cancer Services	16	06/10/2021	(1) Weekly Cancer RTT waiting time meeting to challenge and review all cancer PTLs (62 day 1st, screening, consultant upgrade, 31 day 1st, subsequent surgery, subsequent drugs) (2) Automated RAG rated PTL (updated twice daily to reflect current position and available to all Divisional Managers). (3) 62 day Cancer Improvement Plan has translated into the Cancer Transformation Programme (2 year programme commencing 2021) (4) Cancer performance/ backlog is reported weekly to Operational Management Group (5) Improved visibility on all aspects of cancer pathways through the Cancer Power BI Performance report (which is updated daily and available to all Divisional Managers/clinicians. (6) Cancer Trackers attend Divisional Huddles in some specialties (Colorectal/Gynae) as a point of escalation. (7) A trust-wide clinical harm review process is in progress	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm	62 day backlog and 104+ days waits monitored weekly at Operational Management Group
2245	20/06/2017	31/03/2024	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance : Non compliance with RTT incomplete target	Given our current operating models, there is a risk that there is insufficient capacity to meet demand in a number of specialities which risks the RTT position and potential for adverse patient impact. Potential for 52 week breaches and potential to not meet current 40 week maximum RTT target This could result in clinical harm	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery (All)	16	22/09/2023	(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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Catering	16	01/10/2023	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.

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
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.	Christopher Evans	Trustwide - All Sites (DPoW, S	Digital Services	Information Governance	16	12/08/2023	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.	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery (All)	15	22/09/2023	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.	Simon Priestley	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Pharmacy	15	24/09/2023	We are trying to source locum cover for both pharmacists and technician posts but have had minimal response from locum agencies. We are working with existing staff to offer bank contracts and additional shifts, again with minimal uptake.	Difficulty recruiting permanent and locum staff. Difficulty retaining staff. Difficulties continue with finding and appointed appropriately experienced locum pharmacists. Situation not helped by current high cost locum rates (£40-£50 per hour) in community making hospital work financially unattractive)	We will have 1x locum pharmacist commencing on the Scunthorpe site in August 2022 for minimum of 3 months.
2562	13/01/2023	01/04/2024	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Failure to meet constitutional targets in ECC	Due to a high level of demand at the front door and challenges with patient flow through the hospital, ED waits are a challenge which has an adverse effect on patient safety. Risk that the Trust's 4 hour A&E performance target may not be achieved and that 12 hour trolley breaches may occur. Due to a high level of demand at the front door and challenges in patient flow through the hospital, ED waits are an ongoing challenge, which has an adverse effect on patient safety.	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Emergency Care	20	06/09/2023	- 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
2592	17/09/2019	31/01/2024	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within the cancer waiting times may result in poor patient experience and potential clinical harm. Risk register also relates to Risk ID 2244.	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Cancer Services	16	22/09/2023	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.

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Buildings	20	01/10/2023	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.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates - Heating/Ventilation	20	24/08/2023	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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Water	20	25/08/2023	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.
2755	11/07/2023	30/09/2023	To offer care in estate and with equipment which meets the highest modern standards	Equipment	SGH MRI scanner past end of 7 year life	Cause - due to lack of capital availability, the existing Scunthorpe MRI Scanner (scanner 1) has passed the 7 year life expectancy. Risk - there is potential for increased breakdowns due to its age which will impact on service delivery. This is the only scanner in the Trust able to deliver a full range of examinations. Update 2/6/21 this is no longer the only scanner able to deliver these examinations. Impact - is that should the scanner fail, then NLAG will have reduced capacity to deliver MRI scans for some cancer pathways.	Ruth Kent	Scunthorpe General Hospital (S	Directorate of Operations	Radiology - MRI	20	22/09/2023	Fully comprehensive OEM maintenance contract in place to support timely response to breakdowns. No end of life notice served as yet, meaning that parts remain available for this scanner. Scanner now down - environmental issues not covered by PM contract - not economically viable for repair	Scanner now down - environmental issues not covered by PM contract - not economically viable for repair	No data
2773	23/08/2023	01/04/2024	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk of clinical harm in Radiology due to lack of scanning and clinical capacity	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	Trustwide - All Sites (DPoW, S	Directorate of Operations	Radiology	16	22/09/2023	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.	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine (All)	16	21/09/2023	* 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.

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
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	Simon Tighe	Diana, Princess Of Wales Hospi	Estates and Facilities	Estates - Electrical	16	24/08/2023	Monthly test to start and run Diesel Generator for a period of 90mins	Non-compliant with HTM 06-01;17.88 Maintenance programmes should include a longer test run to establish the generator Engine's mechanical performance. A test to prove the generator engine's condition up to 110% full load should be carried out annually. The period of the test should be not less than 3 hours and ideally 4 hours. The Trust is currently only able to conduct an 80% max load test. Tests can currently only be ran for a period of 90 minutes. Potential frailty of equipment was highlighted in the 2019 Load Bank Test as it damaged a Cooling Pump & Radiator on a similar set. Non-compliant with BS7671:2018;414.2.1 Live parts shall be inside enclosures or behind barriers providing at least the degree of protection IP2X	Minor and major equipment services logged in compliance folders.
2949	12/05/2023	31/03/2023	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Oncology Service	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 2)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a shortage of chemotherapy nurses at DPoW and difficulties in training new chemotherapy nurses.	Jill Mill	Trustwide - All Sites (DPoW, S	Directorate of Operations	Oncology	20	28/09/2023	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 wihc will be produced monthly and reviewed at the joint Oncology meetings. 5)Very small number of patients affected, who could be admitted at HUTH to receive inpatient chemotherapy delivery. 6)Where clinically appropriate, SACT delivery from Lloyds community infusion clinic to reduce demand on SGH dat unit. Consider reducing the number of days SGH day unit opens to consolidate staffing. Continue to access external Level 6 SACT training for RN on Amethyst Unit at DPOW to increase chemo trained workforce.	No data	* 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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Electrical	20	24/08/2023	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.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Water	16	24/08/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.	No data	Hydrop defect portal giving real time data on progress of defects.
2953	22/02/2023	31/03/2026	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).	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates - Water	16	25/08/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.	Linked to on-going refurbishment works.	Hydrop risk assessment report which identifies location of taps.
2955	24/05/2023	30/06/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - SGH	There is the risk of failure of the oxygen delivery system if the demand exceeds design capacity, which could result in loss of oxygen supply to patients causing the Trust to divert patients to neighbouring hospitals.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates - Med Gas	15	25/08/2023	Daily monitoring of the oxygen consumption.	No data	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.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates - Buildings	16	25/08/2023	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.

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
2960	27/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk of inability to safely staff maternity unit with Midwives	The risk is the potential inability to safely staff the maternity unit in order to provide care and treatment to a defined establishment due to sickness, Covid isolation and vacancies. If the staffing levels are reduced, this will impact on the ability to provide safe care to women and their babies, resulting in increased incidents and potential poor outcomes.	Nicola Foster	Trustwide - All Sites (DPoW, S	Directorate of Operations	Obstetrics / Maternity	16	01/09/2023	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	Trustwide - All Sites (DPoW, S	People and Organisational Effe	Recruitment	25	20/09/2023	Funding accessed through NHSi to facilitate international recruitment providing additional pipelines.	No data	No data
3015	11/04/2023	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Staffing Levels & HR	Insufficient estate resources to manage the workload demand	Failure to recruit technical capital project team members to support current major capital project delivery programme which is impacting on the estates operational teams ability to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. It is anticipated that this risk will be reduced in 24/25 when capital funding reduces. The impact to the Trust if not actioned; inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance, lack of Engineer resource to complete mandatory work and project works, ineffective management of Pre-Planned Maintenance, ineffective management of water systems due to shortage of water APs (SGH), inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing), ineffective management of the estates leading to reactive maintenance (firefighting), inability to implement proactive management systems (MICAD helpdesk), impact to patient safety, loss of workforce due to on-going work pressure and employee market shortage (supply/demand), reduced staff morale, inability to support wider project delivery, durther degradation and serious incidents within the estates, loss of financial resources due to settlement of claims (majority of claims are under the excess levels so Trust would pay full cost), increase in overall BLM value (6 facet survey) due to limited resourcing levels in FY 21/22 & 22/23	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Health & Safety	20	24/08/2023	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.	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Emergency Care	16	22/09/2023	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	No data	No data
3045	16/03/2023	31/10/2023	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	Trustwide - All Sites (DPoW, S	Directorate of Operations	Gastroenterology	16	06/09/2023	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	No data

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
3048	13/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Operational	Challenges to recruitment of acute care physician vacancies in Acute	This risk is to highlight the difficulties in workforce recruitment and the increased pressures on staff, which has been exacerbated by the Covid-19 We have vacancies for acute care physicians (ACP) Trust-wide and it is proving very challenging to fill these posts. The cause has been due to a national shortage of ACPs and lack of applicants for the posts when we have advertised them. The impact would result in failure to recruit the required ACPs and this will delay the planned expansion of acute medicine service with extended hours with senior clinician presence on the shop floor and could result in failure to launch phase 3 of the IAAU development plan for 2023. There is a risk that due to the pressures created by having less workforce and increased demands placed on services as a result of not having a balanced workforce, this may result in the current ACPs becoming exhausted, leading to gaps in rotas and therefore not sufficient senior medical staff to ensure quality and safety of patients. In addition, this may also result in doctors withdrawing from our hospitals, exacerbating staffing issues.	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	General Internal Medicine	16	22/09/2023	Actively trying to recruit more clinicians through networks	No data	No data
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.	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine (All)	16	28/09/2023	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
3114	25/08/2023	31/05/2024	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Delays in Children being reviewed in DPOW Paediatric Endocrine Service	There is a risk that children do not receive the correct treatment or monitoring of their potential or actual endocrine condition, as a result of the large backlog of overdue appointments and repeated risk stratification. The cause of this risk is due to the Consultant for Endocrine, DPOW left service in September 2020 and the new Consultant didn't start in post until August 2021 which created a gap in provision and left the Endocrine Specialist Nurse to manage with the support from the SGH Endocrine Consultant. When the Consultant was in post prior to leaving she did 5 clinics per month each with 6 slots, and the SGH Consultant did a further 2. 6 x per year there was a joint clinic with Sheffield Consultant for complex cases and those who required a review with an Endocrinologist. In addition to the above, the new Consultant requires time to develop their knowledge, skills and experience in caring for children with Endocrine conditions and is not in a position to run clinics independently in this speciality at present. The impact of this risk could lead to failure to treat and manage the child's condition lead to significant physical, mental, emotional and social issues and complications; that could be life limiting.	Vijayalakshmi Hebbar	Diana, Princess Of Wales Hospi	Directorate of Operations	Paediatrics	20	No data	Incident reporting	Children waiting for a clinical review beyond the national recommendations New Consultant requires time to develop experience, knowledge and skills to run independently the Endocrine clinic To address the backlog ad hoc additional clinics undertaken.	No data
3129	23/02/2023	No data	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.	Umaima Aboushofa	Scunthorpe General Hospital (S	Directorate of Operations	Paediatrics	15	08/09/2023	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	No data	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).	Vijayalakshmi Hebbar	Diana, Princess Of Wales Hospi	Directorate of Operations	Paediatrics	16	23/08/2023	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.	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Obstetrics / Maternity	15	04/10/2023	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

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
3161	17/08/2023	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.	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Nursing (All Specialties)	15	16/09/2023	1.Divisional progress against targets is monitored via the Deteriorating Patient & Sepsis Group.	No data	No data
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.	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Nursing (All Specialties)	20	16/09/2023	1.Recruitment pipeline for Internationally Educated Nurses Recruitment pipeline and engagement with newly registered nurses	Inability to safely redeploy	No data
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.	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	Nursing (All Specialties)	20	20/08/2023	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	29/09/2023	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.	Vijayalakshmi Hebbar	Trustwide - All Sites (DPoW, S	Directorate of Operations	Newborn Hearing Screening	16	31/08/2023	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.	No data
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.	Lee Bond	Trustwide - All Sites (DPoW, S	Finance	Finance	15	23/08/2023	regular contact with information department for progress updates	No data	escalation to internal digital management
3196	06/07/2023	31/08/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Breast Imaging Service loss of capacity	Due to the retirement of current Consultant Radiographic Practitioner at end of August 2023, there will be a loss in capacity for new and review symptomatic breast imaging, and a reduction in interventional capacity. This will impact on delivery of 2ww service, and delay patient pathways	Jennifer Orton	Diana, Princess Of Wales Hospi	Chief Operating Officer	Breast Diagnostics	15	22/09/2023	Advertisement out for replacement of this post	no respondents to first advert - re run for further 2 weeks, with support of TA team - still no response	No data
3201	28/06/2023	31/10/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Clinical Capacity within Colposcopy	There is a risk we are not meeting the national targets as a result of increase referrals which may led to potential harm.	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Gynaecology	15	08/09/2023	All patients are currently being risk stratified	Due to the lack of capacity the national targets are unable to be met	No data
3202	07/07/2023	No data	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	Delivery of Balanced Financial position to include CIP savings	Non-delivery of Divisional Finance	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Finance	16	16/09/2023	General Budgetary Financial Management - includes reporting , variance analysis & actions/recommendations	No data	No data
3204	28/06/2023	31/08/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Up to 1 year wait for new referrals to be seen by Consultant Paediatrician (single handed service) into the ADHD post diagnosis support service.	There is a risk that patients who are not seen in a timely manner in the post diagnosis support service will be unable to cope with their daily living activities (eg education - concentrating at school; socialising with friends; following routines and boundaries), especially if they require medication. This then impacts on family life.	Claire Shipley	Scunthorpe General Hospital (S	Directorate of Operations	Paediatrics	15	03/09/2023	Ongoing meetings (fortnightly) with Commissioning Manager for Children (NHS Humber & North Yorkshire ICB), Assistance General Manager and Lead Nurse for Paediatrics to discuss current status and ongoing action plan.	Informal meetings / not minuted.	No data

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Specialty	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
3209	11/07/2023	No data	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce	Staffing Levels & HR	Risk to Junior Medical Cover - Recruitment Delays to Acute TG CT	There has been a high number of TG CTs within Acute Medicine (Trust wide) leaving to undertake training posts. Delays in recruitment, along with higher than expected numbers leaving, running the risk of significant lack of cover in the department until new recruits are cleared to start	Muhammad Imtiaz	Trustwide - All Sites (DPoW, S	Directorate of Operations	Acute Medicine	16	01/10/2023	No data	No data	No data
3217	28/07/2023	01/08/2023	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Clinical	Breast Imaging workforce depletion	There is a risk of not offering essential breast imaging steps in patient pathways, due to retirement of the Breast Imaging Practitioner, resulting in the need to refer patients outside the Trust and delays to deliver care occurring to cancer standards.	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Breast Care	20	08/09/2023	Team attempting to keep 2ww performance good to avoid excess workload at the end of August 2023	No data	No data
3221	28/07/2023	31/08/2023	No data	Financial	Badger Net Implementation	There is a risk to the implementation of Badger Net, as the Maternity Services EPR, due to potential failure to obtain funding required to upgrade the power and networking to support the end user operability which may result in an adverse impact on patient safety and Trust reputation.	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Obstetrics / Maternity	15	No data	Adequate monitoring systems in place through the groups which report to the MITS Project Board and Digital Maternity Group.	The Divisional Digital Maternity Group is due to start August 2023.	No data
3226	31/07/2023	31/08/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Quality and audit monitoring and reporting impacted by information services PAS/Lorenzo development freeze	If the information services department are not able to maintain or support delivery of new work requests relating to quality and audit work streams such as National clinical audits, NCEPOD, quality priorities, mortality or CQUINs then the Trust will not be able to participate in national mandated reporting activities and will not be able to determine which areas of work are off track and which require targeted support to improve patient safety and quality. This may result in reputational damage to the Trust or financial loss and would negatively impact on patients quality of care.	Katherine Wood	Trustwide - All Sites (DPoW, S	Chief Medical Officers Directo	Quality, Evaluation & Audit	16	No data	Existing clinical audits/CQUIN will continue where we already have access to refreshable patient sample.	Existing refreshable sample may not cover new audits/new NCEPOD studies or new mortality outlier alerts where specific patient samples are required.	No data

Name of the Meeting	**Trust Board**
Date of the Meeting	3 October 2023
Director Lead	Simon Nearney, Interim Director of People
Contact Officer/Author	Karl Portz, Equality, Diversity, and Inclusion Lead
Title of the Report	**Workforce Disability Equality Standard (WDES) Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to update Trust Board on progress against the Workforce Disability Equality Standard (WDES) Indicators, and: • To update on the trust submission, revised data, and information as per trust contractual requirements. • To highlight key priorities and actions required during 2023/24, to make improvements against the WDES. A summary is provided in Appendix 2 of this report. The report has been approved by the September Trust Workforce Committee and now requires Trust Board approval. The Trust Board are asked to: • To note the contents of this report against the NHS Workforce Disability Equality Standard. • Approve the data content which we are required to share with NHS England and trust commissioners. • To note the actions proposed for 2023/2024 and to monitor progress of those actions and wider culture transformation programme through the Workforce Committee.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce Disability Equality Standard (WDES) was introduced and forms part of the standard NHS contract. From April 2019 is also part of the inspection framework under the "Well Led" domain.
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)	As outlined in the report	
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

Workforce Disability Equality Standard (WDES) Report for Trust Board

1.0	**PURPOSE OF THE REPORT**
1.1	To update the Trust Board on progress against the Workforce Disability Equality Standard Indicators (WDES). https://www.england.nhs.uk/wp-content/uploads/2019/01/wdes-2021-metrics.pdf
1.2	To update the Trust Board on the trust submission and the data, as per trust contractual requirements.
1.3	To highlight key priorities and actions required to make improvements against the WDES.
2.0	**BACKGROUND/CONTEXT**
2.1	As set out in the National Health Service (NHS) Long Term Plan, 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. 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.
2.2	The NHS 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 WDES as a tool and an enabler of change.
2.3	The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.
2.4	The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission (CQC) inspections under the 'Well Led' domain.
2.5	It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
2.6	The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

3.0 DATA ANALYSIS – METRICS (a summary of the data is provided in appendix 2)

3.1 Metric 1

Metric 1 shows the percentage of Northern Lincolnshire and Goole NHS Foundation Trust NLaG) staff who have classified themselves as having a disability compared to those staff who do not have a disability using Agenda for Change (AfC) pay bands, medical and dental subgroups and Very Senior Managers (VSMs), (including Executive Board members). The percentages are clustered into 4 pay groups for non-clinical staff and 7 groups for clinical staff. This is due the small numbers of staff in each pay band.

This data has been collected from Electronic Staff Records (ESR) as of 31 March 2022 and 31 March 2023.

Metric 1a Non-Clinical Workforce							Mar-22	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1 AfC Band 1 – 4	55	3%	1519	88%	162	9%	1736	80%
Cluster 2: AfC Band 5 – 7	10	3%	272	89%	23	8%	305	14%
Cluster 3: AfC Band 8a – 8b	5	7%	62	89%	3	4%	70	3%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	1	2%	45	98%	0	0%	46	2%
Total	**71**	**3.29%**	**1898**	**87.99%**	**188**	**8.72%**	**2157**	

Metric 1a Non-Clinical Workforce							Mar-23	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	58	3%	1574	89%	145	8%	1777	81%
Cluster 2: AfC Band 5 - 7	16	5%	275	89%	18	6%	309	14%
Cluster 3: AfC Band 8a – 8b	5	7%	64	91%	1	1%	70	3%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	2	4%	43	96%	0	0%	45	2%
Total	**81**	**4%**	**1956**	**89%**	**164**	**7%**	**2201**	

Metric 1b Clinical Workforce							Mar-22	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	51	3.51%	1269	87.22%	135	9.28%	1455	30.21%
Cluster 2: AfC Band 5 – 7	86	3.43%	2195	87.45%	229	9.12%	2510	52.12%
Cluster 3: AfC Band 8a – 8b	3	2.48%	109	90.08%	9	7.44%	121	2.51%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	1	3.23%	29	93.55%	1	3.23%	31	0.64%
Cluster 5: Medical and Dental staff, Consultants	2	0.90%	192	86.10%	29	13.00%	223	4.63%
Cluster 6: Medical and Dental staff, Non-consultant career grade	1	0.57%	152	86.36%	23	13.07%	176	3.65%
Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	2	0.67%	246	82.00%	52	17.33%	300	6.23%
Total	**146**	**3.03%**	**4192**	**87.04%**	**478**	**9.93%**	**4816**	

Metric 1b Clinical Workforce							Mar-23	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	72	4%	1514	95%	16	1%	1602	31%
Cluster 2: AfC Band 5 – 7	103	4%	2494	96%	3	0%	2600	51%
Cluster 3: AfC Band 8a – 8b	3	2%	124	98%	0	0%	127	2%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	0	0%	28	100%	0	0%	28	1%
Cluster 5: Medical and Dental staff, Consultants	2	1%	227	99%	0	0%	229	4%
Cluster 6: Medical and Dental staff, Non-consultant career grade	1	0%	201	99%	2	1%	204	4%
Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	2	1%	299	99%	0	0%	301	6%

Total	**183**	**4%**	**4887**	**96%**	**21**	**0%**	**5091**

In the tables, metric 1a and metric 1b clearly show that the percentage of disabled staff in both the non-clinical and clinical workforce is very low standing at 3.62% of the total workforce. This percentage has increased slightly by 0.5% since 2022. This is comparable to what is reported nationally across NHS trusts (3.7% disabled staff worked within NHS in 2021). The tables above highlights that there are a small proportion of the workforce (2.54%) which record their disability status as either unknown, not declared or a null response. However, there are now much fewer unknown recordings when compared to last year (a reduction of 7.01%). This is largely to do with promotion of ESR self-service whereby employees can directly edit their own personal details, regular data cleansing exercises and consistent trustwide communications.

3.2

Metric 2

The table below shows the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts for 2021-22 and 2022-23.

	Indicator	2021-22			2022-23		
Metric 2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**
		Number of shortlisted applicants	287	4337	Number of shortlisted applicants	589	7632
		Number appointed from shortlisting	42	1080	Number appointed from shortlisting	88	1493
		Ratio shortlisted/ appointed Likelihood candidates are appointed from shortlisting	42/287= 0.15	1080/4337= 0.25	Ratio shortlisted / appointed Likelihood candidates are appointed from shortlisting	88/589= 0.15	1493/7632= 0.20
		Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts is 1.67			Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts is 1.31		

Note: This refers to both external and internal posts.

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts in 2021-22 was 1.67 times more likely to be appointed from shortlisting compared to disabled staff, in 2022-23 the ratio has improved to show that non-disabled staff were 1.31 times more likely to be appointed from shortlisting.

*It should also be noted that NLaG as part of the Department of Work and Pensions scheme

are a Disability Confident Employer, and therefore operate a guaranteed interview scheme for disabled applicants who meet the minimum person specification.

**If the organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.*

3.3

Metric 3

Metric 3 explores the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. Data is based on the number of staff entering the formal capability procedure from a two-year rolling average of the current year and the previous year. This metric applies to capability on the grounds of performance and not ill health.

	Indicator	2021-23		
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**
		Number of staff in workforce	264	6843
		Average number of staff entering the formal capability process for any reason	1	4
		Of these, how many are on the grounds of ill health only?	0	0
		As there are fewer than 10 Disabled members of staff (on average) entering the formal capability process over the previous two years. Therefore, this metric has been suppressed due to the small numbers involved.		

3.4 **2022 NHS Staff Survey Results Analysis Metrics 4, 5, 6, 7, 8 and 9a**

The metrics 4, 5, 6, 7, 8 and 9a overleaf represent unweighted question level responses to key findings in the NHS for NLaG staff. The staff survey results surrounding the disabled workforce between 2021 and 2022 are similar, with slight improvements to some of the metrics.

	Metric	2021 Staff Survey Result		2022 Staff Survey Result	
Metric 4.1	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months	Disabled	28.00%	Disabled	31.9%
		Non-disabled	21.00%	Non-disabled	22.7%
		NHS Average Score		NHS Average Score	
		Disabled	32.40%	Disabled	33.0%
		Non-disabled	25.20%	Non-disabled	26.2%
Metric 4.2	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	Disabled	22.50%	Disabled	20.3%
		Non-disabled	11.90%	Non-disabled	12.6%
		NHS Average Score		NHS Average Score	
		Disabled	18.00%	Disabled	17.1%
		Non-disabled	9.80%	Non-disabled	9.9%
Metric 4.3	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Disabled	30.70%	Disabled	34.3%
		Non-disabled	20.30%	Non-disabled	20.1%
		NHS Average Score		NHS Average Score	
		Disabled	26.60%	Disabled	26.9%
		Non-disabled	17.10%	Non-disabled	17.7%
Metric 4.4	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	Disabled	42.90%	Disabled	50.2%
		Non-disabled	44.00%	Non-disabled	46.9%
		NHS Average Score		NHS Average Score	
		Disabled	47.00%	Disabled	48.4%

		Non-disabled	46.20%	Non-disabled	47.3%

Metric 4

Staff feel harassment, bullying or abuse in the last 12 months from:

- Patient's, relatives or the public is 9.2% higher for disabled staff than non-disabled staff. However, this remains below the national NHS average
- Managers are 7.7% higher for disabled staff than non-disabled staff. This remains above the national average score
- Other colleagues are 14.2% higher for disabled staff than non-disabled staff. This is above the national average.
- Disabled staff are less likely to report harassment, bullying or abuse at work than non-disabled staff.

Metric 5	Percentage believing that the Trust provides equal opportunities for career progression or promotion	Disabled	47.20%	Disabled	44.0%
		Non-disabled	53.90%	Non-disabled	56.3%
		NHS Average Score		NHS Average Score	
		Disabled	51.40%	Disabled	51.4%
		Non-disabled	56.80%	Non-disabled	57.3%

Metric 5

Disabled staff are 12.3% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff. The gap has worsened since the 2021 staff survey.

Metric 6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled	35.80%	Disabled	30.5%
		Non-disabled	26.40%	Non-disabled	21.9%
		NHS Average Score		NHS Average Score	
		Disabled	32.20%	Disabled	30.0%
		Non-disabled	23.70%	Non-disabled	20.8%

Metric 6

Disabled staff felt 8.60% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff.

Metric 7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	26.70%	Disabled	28.4%
		Non-disabled	36.80%	Non-disabled	37.0%
		NHS Average Score		NHS Average Score	
		Disabled	32.60%	Disabled	32.5%
		Non-disabled	43.30%	Non-disabled	43.6%

Metric 7

Disabled staff felt 8.6% less satisfied that the organisation valued their work compared to non-disabled staff.

Metric 8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled	70.50%	Disabled	69.3%
		NHS Average Score		NHS Average Score	
		Disabled	70.90%	Disabled	71.8%

Metric 8

69.3% of disabled staff from the staff survey feel we have made adequate adjustments to enable them to carry out their work. A 1.2% reduction compared to the previous year.

Metric 9 Part a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Disabled	6.0	Disabled	5.9
		Non-disabled	6.6	Non-disabled	6.6
		Organisation Score	6.4	Organisation Score	6.4
		NHS Average Score		NHS Average Score	
		Disabled	6.4	Disabled	6.4
		Non-disabled	7.0	Non-disabled	6.9

Metric 9a

The engagement score for disabled staff is 0.7 less than that of non-disabled staff therefore disabled staff feel less engaged with compared to non-disabled staff. This is much worse than the national average.

Metric 9 Part b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) If no what actions are planed?	Yes As part of the Trust's Equality Objectives plans the Trust has developed a Disability Network to give disabled staff a voice.	Yes As part of the Trust's Equality Objectives plans the Trust has developed a Disability Network to give disabled staff a voice.

Metric 10

Metric 10	The percentage of NLaG Board and Executive Team who classify themselves as having a disability or long-term condition of 31 March 22. (Includes both executive and non-executive directors)	**31-Mar-22**			
		Trust Board and Executive Team	**Disabled**	**Non-Disabled**	**Not Declared**
			6.25%	93.75%	0.00%
		31-Mar-23			
		Trust Board and Executive Team	**Disabled**	**Non-Disabled**	**Not Declared**
			14.29%	85.71%	0.00%

The NLaG Board and Executive Team members who classify themselves as having a disability has increased since last year, from 6.25% in 2022 to 14.29% in 2023.

See Appendix 2 which gives a summary of the data and a comparison to National and local WDES data.

4.0 PROGRESS AND ACTIONS

4.1 Reporting and Assurance

- **Progress 2022/2023**
  - The Trust's new Equality, Diversity and Inclusion (EDI) Strategy which includes our Equality Objective (2023 – 202) are in place. This was approved at the June 2023 Trust Board meeting. In addition, an EDI action plan is now under development which will set out our commitment to actions required to redress disparity, progress, timescales and supporting evidence.
  - The Health and Well Being group is now the Health and Well Being and Equality, Diversity and Inclusion Steering Group with a dedicated EDI remit.
  - We are continuing to work closely with and support the wider People Directorate team and the Trust's Freedom to Speak Up Guardian.
  - All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias.
  - All new staff receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias. Additionally, we are delivering a managers leadership programme which includes unconscious bias and cultural awareness training.

- **Further Actions 2023/2024 (See Appendix 1)**
  - We continue to make progress against all WDES actions through the EDI action plan and included the wider engagement and culture transformation programme of

work.

- To provide reports as required against the EDI action plan.
- As part of strengthening culture awareness ensure that our staff equality networks (Disability Network) are represented and actively involved in the Health and Well Being and EDI Steering Group and the Culture Transformation Working Group.
- To break down data (where this is possible) to identify hotspot areas and take more bespoke action.

4.2 **Recruitment and Retention**

- **Progress 2022/2023**
  All recruitment panels include an equality representative. The Trust's Head of Recruitment has worked with the Trust EDI Lead through the Recruitment Review to ensure that all stages of the recruitment processes are fair and free from discrimination.

- **Further Actions 2023/2024 (See Appendix 1)**
  - To understand our recruitment and retention of staff and particularly, explore reasons staff leave the Trust by protected characteristic, and to identify any outliers.
  - To specifically include unconscious bias awareness in recruitment as part of the Leadership programme.

4.3 **Capability and Staff Experience**

- **Progress 2022/2023**
  - A key focus has been to engage with our staff and increase the visibility of EDI support in the workplace. Therefore, to give all staff an opportunity to openly discuss their concerns and experience we have held a number of face to face EDI engagement events with a diverse range of staff.
  - We arranged two large staff engagement events in Diana Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH) to celebrate inclusivity. These events gave our diverse staff and our Staff Equality Network members an opportunity to meet the EDI team and the wider people directorate team. We also arranged for some external providers to have stalls to show case how they may be able to support our staff in different ways. Feedback from both these events has been excellent.
  - We have grown and further developed our Disability staff equality network and have over 80 members who we correspond with. Our Disability Facebook group has nearly 40 members.
  - A number of staff took part and have successfully completed the NHS England Calibra Programme aimed Leadership for staff who have a disability.
  - DFN Project Search has been an amazing success giving young people with learning disabilities an opportunity to experience work. This has resulted in some interns gaining employment and attaining transferable skills for their future.
  - We have developed a Disability and Long Terms Conditions Policy and Procedure to support our staff.
  - We provide guidance in terms of supporting our staff who are neuro diversity also how to access reasonable adjustments.

- **Further Actions 2023/2024 (See Appendix 1)**

	➢ We are continuing to grow and develop our Disability staff equality network. ➢ To ensure the network is able to influence decision making which shapes and influences their employee experience we will ensure they are represented at the Health and Well Being, and EDI Steering Group. ➢ Arrange annually 4 large engagement events to celebrate inclusivity and intersectionality. ➢ We are continuing with the very successful DFN Project Search Programme and expanding the departments who are involved in this scheme. ➢ We will be creating a Staff App to engage with all staff on EDI engagement.
4.4	**Trust Board and Senior Leadership** • **Progress 2022/2023** We recognise that Trust Board and the senior leadership community has some elements of diversity. However, due to the small numbers these percentages are very fragile. We continue to review our data intermittently. • **Further Actions 22023/2024 (See Appendix 1)** ➢ To fully understand the impact of the new group structure and how this will affect the Trust Board diversity going forward. ➢ To interrogate in more detail the diversity within the senior leadership community to understand areas of under-representation and consider what positive actions are required to address the gaps.
5.0	**Recommendations.**
5.1	To note the contents of this report against the NHS Workforce Disability Equality Standard.
5.2	Approve the data content which we are required to share with NHS England and trust commissioners.
5.3	To note the actions proposed for 2023/2024 and to monitor progress of those actions and wider culture transformation programme through the Workforce Committee.

Appendix 1 - Workforce Disability Equality Standard (WDES) Action Plan 2023/24

The Action Plan 2023/24 has been developed, based on the 2022/23 WDES technical data results, to help close the gaps in workplace experience between Staff who have a disability and staff who don't have a disability.

Action	WDES Indicator	Timescale	Lead
Explore ways that the Trusts newly introduced Equality Diversity and Inclusion (EDI) strategy can strengthen the addressing of Workforce Disability Inequalities specifically taking into consideration the Group Structure of the organisation.	All	January 2024 / Ongoing	Workforce and Organisational Development (OD) EDI Team
Explore opportunities within the new Group Structure which can support this staff group – in particular, Leadership Development Opportunities	Indicator 1	October / November 2023	EDI Team and Leadership Team
As part of strengthening culture awareness ensure that our staff equality networks (Disability Network) are represented and actively involved in the Health and Wellbeing and EDI Steering Group and the Culture Transformation Working Group.	All	October 2023 / Ongoing	EDI Team
To look at breaking down data (where this is possible) to identify hotspot areas and take more bespoke action.	All	February 2024 / Ongoing	OD & EDI Team
To monitor recruitment and retention of staff and particularly, explore reasons staff leave the Trust by protected characteristic, and to identify any outliers.	Indicator 2	November 2023 / Ongoing	EDI Team and Head of Recruitment
To specifically include unconscious bias awareness in recruitment as part of the Leadership programme.	Indicator 2	November 2023	EDI Team
To grow and develop our Disability staff equality network. To ensure the network is able to influence decision making which	All	On-going	EDI Team

shapes and influences their employee experience we will ensure they are represented at the Health and Well Being, and EDI Steering Group.			
Arrange annually 4 large engagement events to celebrate inclusivity and intersectionality.	All	October 2023 January 2024 March 2024 July 2024	EDI / OD Teams
We are continuing with the very successful DFN Project Search Programme and expanding the departments who are involved in this scheme.	All	On-going	EDI Team
We will be creating and launching a Staff App to improve EDI engagement.	All	October 2023	EDI Team
To understand the impact of the new group structure and how this will affect the Trust Board diversity going forward.	Indicator 10	January 2024	EDI Team
To interrogate in more detail the diversity within the senior leadership community to understand areas of under-representation and consider what positive actions are required to address the gaps.	Indicator 1	April 2024	EDI Team

Appendix 2

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) Workforce Disability Equality Standard (WDES) Data Summary 2023

The table below shows a summary of the NLaG WDES data for March 2022 and March 2023, and it identifies where improvements are required. It also shows a summary of National Health Service (NHS) England's national picture of WDES data the average Acute Trust NHS Staff Survey data and the Hull University Teaching Hospitals (HUTH) data as a comparator.

WDES M1	March 22		March 23			HUTH Comparator 2023	NHS Comparator
	Percentage of Disabled Staff in total workforce	3.12%	Percentage of Disabled Staff in total workforce	3.62%	Slight Increase In-line with National Comparator and HUTH	3.42%	3.7% (2021 data)
WDES M2	March 22		March 23			HUTH Comparator	
	The relative likelihood of Non-Disabled staff being appointed compared to Disabled staff is	1.67 times more likely	The relative likelihood of Non-Disabled staff being appointed compared to Disabled staff is	1.31 times more likely	Small Improvement	1.56 times more likely	1.1 times more likely (2021 data)
WDES M3	March 22		March 23			HUTH Comparator	
There are fewer than 10 Disabled members of staff (on average) entering the formal capability process over the previous two years. Therefore, this metric has been suppressed due to the small numbers involved.						No data – Low Score	1.94 times more likely (2021 data)
WDES NHS Staff Survey 2022 Data M4 Disabled Staff feel harassment, bullying or abuse in the last 12 months from:						HUTH Comparator	
<u>Patient's, relatives or the public</u> is 9.2% higher for disabled staff than non-disabled staff. However, this remains below the national NHS average.					Improvements Required	Similar Trends	

Managers are 7.7% higher for disabled staff than non-disabled staff. This remains above the national average score. Other colleagues are 14.2% higher for disabled staff than non-disabled staff. This is above the national average. Disabled staff are less likely to report harassment, bullying or abuse at work than non-disabled staff.		
WDES NHS Staff Survey 2022 Data M5 Percentage believing that the Trust provides equal opportunities for career progression or promotion		
Disabled staff are 12.3% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff. The gap has worsened since the 2021 staff survey.	Improvements Required	Similar Trend
WDES NHS Staff Survey 2022 Data M6 Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		
Disabled staff felt 8.60% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff.	Improvements Required	Similar Trend
WDES NHS Staff Survey 2022 Data M7 Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.		
Disabled staff felt 8.6% less satisfied that the organisation valued their work compared to non-disabled staff.	Improvements Required	Similar Trend
WDES NHS Staff Survey 2022 Data M8 Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		
69.3% of disabled staff from the staff survey feel we have made adequate adjustments to enable them to carry out their work. A 1.2% reduction compared to the previous year.	Improvements Required	Similar Trend
WDES NHS Staff Survey 2022 Data M9 The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.		
The engagement score for disabled staff is 0.7 less than that of non-disabled staff therefore disabled staff feel less engaged with compared to non-	Improvements Required	Similar Trend

disabled staff. This is much worse than the national average.							
WDES M10	March 22		March 23			HUTH Comparator 2023	NHS Comparator
	Percentage of NLaG Board and Executive Team who classify themselves as having a disability or long-term condition	6.25%	Percentage of NLaG Board and Executive Team who classify themselves as having a disability or long-term condition	14.29 %	Positive but small numbers	5.88%	3.7% (2021 data)

NLG(23)180

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	3 October 2023
Director Lead	Simon Nearney, Interim Director of People
Contact Officer/Author	Karl Portz, Equality, Diversity, and Inclusion Lead
Title of the Report	**Workforce Race Equality Standard (WRES) Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to update the Trust Board on progress against the Workforce Race Equality Standard (WRES) Indicators, and: • To update on the trust submission, revised data, and information as per trust contractual requirements. • To highlight key priorities and actions required during 2023/24, to make improvements against the WRES. A summary is provided in Appendix 2 of this report. The report has been approved by the September Trust Workforce Committee and now requires Trust Board approval. The Trust Board are asked to: • To note the contents of this report against the NHS Workforce Race Equality Standard. • Approve the data content which we are required to share with NHS England and our commissioners. • To note the actions proposed for 23/24 and to monitor progress of those actions and wider culture transformation programme through the Workforce Committee.
Background Information and/or Supporting Document(s) (if applicable)	The Workforce Race Equality Standard (WRES) was introduced by the NHS Equality and Diversity Council (EDC) and forms part of the standard NHS contract. From April 2016, it has also formed part of the inspection framework under the "Well Led" domain.
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)	As outlined in the report	
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

Workforce Race Equality Standard Report for Trust Board

1.0	**PURPOSE OF THE REPORT**
1.1	To update the Trust Board on progress against the Workforce Race Equality Standard (WRES) Indicators.
1.2	To update the Trust Board on the trust submission and the data, as per trust contractual requirements.
1.3	To highlight key priorities and actions required during 2023/24, to make improvements against the WRES.
2.0	**BACKGROUND/CONTEXT**
2.1	The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the National Health Service (NHS) Equality and Diversity Council (EDC).
2.2	The link provided signposts to a short four minute video clip describing the Workforce Race Equality Standard. https://www.youtube.com/watch?v=G44C9yn-oo0
2.3	Research and evidence suggest less favourable treatment of Black and Minority Ethnic (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.
2.4	The WRES seeks to prompt enquiry to better understand why BME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.
2.5	In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BME staff in the NHS. The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator.
2.6	The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BME representation.
3.0	**IMPLICATIONS FOR THE ORGANISATION**
3.1	As of the 1st April 2015, the WRES forms part of the standard NHS (National Health Service) contract. From April 2016 it has also formed part of the CQC (Care Quality Commission) inspections framework under the 'Well Led' domain.
3.2	A fundamental component to enable making progress against this standard is staff engagement and involvement.

4.0 DATA ANALYSIS – METRICS FOR THE 9 WRES INDICATORS (a summary of the data is provided in Appendix 2)

4.1 WRES 1

	Indicator	31st March 2022		31st March 2023	
		Descriptor	**Indicator**	**Descriptor**	**Indicator**
WRES 1	Percentage of BME staff in Bands 8-9, Very Senior Managers (VSM), compared with the percentage of BME staff in the overall workforce *Note: VSM includes Executive Board Members and Senior Medical Staff but excludes Medical and Dental Grades e.g. Medical Consultants. There are a small number of staff with Ethnicity unknown/null and these have also been excluded	Number of BME Staff in Bands 8-9 and VSM	19	Number of BME Staff in Bands 8-9 and VSM	19
		Total Number of Staff in Bands 8-9 and VSM	268	Total Number of Staff in Bands 8-9 and VSM	270
		Percentage of BME Staff in Bands 8-9	**7.09%**	**Percentage of BME Staff in Bands 8-9**	**7.04%**
		Number of BME Staff in overall workforce	959	Number of BME Staff in overall workforce	1165
		Number of Staff in overall workforce (including all staff groups and not disclosed staff)	6973	Number of Staff in overall workforce (including all staff groups and not disclosed staff)	7292
		Percentage of BME Staff in overall workforce	**13.75%**	**Percentage of BME Staff in overall workforce**	**15.98%**

The table above shows that in 2023 BME staff represents 15.98% of all staff in Agenda for Change (AfC) bands 1-9, Medical Workforce and Very Senior Managers (VSM's). This is an increase on last year of 2.23%. The increase in BME representation is largely due to an increase in BME staff within the medical and dental workforce. The percentage of BME staff in a Band 8 position or above (including VSM) has remained largely the same. There is a lower percentage of BME staff in Bands 8-9 and VSM (7.04%) compared to BME representation within the overall workforce (15.98%).

As recommended by NHS England, Medical and Dental Grades (which includes Trainee Grades) are excluded in the Bands 8-9 and VSM figures as these groups generally have a much higher proportion of BME staff. This staff group in 2022 consisted of 503 BME staff and 138 white staff, and in 2023, 556 BME staff and 128 white staff. The total increase in BME representation within the medical workforce has increased by 3.79%.

4.2

WRES 2

	Indicator	31st March 2022			31st March 2023		
		Descriptor	**White**	**BME**	**Descriptor**	**White**	**BME**
WRES 2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	Number of shortlisted applicants	10469	717*	Number of shortlisted applicants	6040	2246
		Number appointed from shortlisting	1119	125	Number appointed from shortlisting	1324	285
		Ratio shortlisted / appointed	1119/10469	125/717	Ratio shortlisted / appointed	1324/6040	285/2246
		Likelihood candidates are appointed from shortlisting	**0.107**	**0.174**	Likelihood candidates are appointed from shortlisting	**0.219**	**0.128**
		The relative likelihood of White staff being appointed compared to BME staff is **1.46 greater**			The relative likelihood of White staff being appointed compared to BME staff is **1.73 times greater**		

The above table shows the relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts. The data periods used are between 1st April 2021 and 31st March 2022 and, 1st of April 2022 and 31st March 2023. The 2021/22 data shows white staff have a likelihood that is 1.46 times greater than BME staff to be appointed from shortlisting. In 2022/23 this likelihood increased, to a ratio of white staff having a 1.73 times greater chance of being appointed from shortlisting compared to BME applicants.

As a comparator from the 2022 WRES data the National Picture shows that white staff are 1.54 times more likely to be appointed from shortlisting than BME staff.

4.3

WRES 3

	Indicator	31st March 2022				31st March 2023			
		Descriptor	**White**	**BME**	**Unknown**	**Descriptor**	**White**	**BME**	**Unknown**
WRES 3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	Number of staff in workforce	5813	959	201	Number of staff in workforce	5916	1165	211
		Number of staff entering formal disciplinary process	78	18	6	Number of staff entering formal disciplinary process	13	1	2
		Likelihood of entering a formal disciplinary process	78/5813= 0.013	18/959= 0.019	n/a	Likelihood of entering a formal disciplinary process	14/5916= 0.002	1/1165= 0.001	n/a
		The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is therefore 0.019/0.013= 1.4 **(BME staff are more likely to enter a formal disciplinary compared to white staff)**				The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is therefore 0.001/0.002= 0.4 **(BME staff are less likely to enter the formal disciplinary process compared to white staff)**			

*Note: this indicator is based on year end data.

The table above shows the relative likelihood of BME staff entering a formal disciplinary process compared to white staff. In 2022 the relative likelihood of BME staff entering a formal disciplinary process compared to white staff was 1.4. In 2023, the relative likelihood of BME staff entering a formal disciplinary process compared to white staff decreased to 0.4. This indicates that BME staff are no more likely to enter the formal disciplinary process than white staff. This decrease is largely due to disciplinary cases and formal suspensions throughout the course of 2022-23 reducing significantly owing to the roll out of the Just and Learning Culture Framework implemented towards the end of 2021-22. The framework was developed to ensure a just and learning approach to the management of adverse events involving people ensuring a compassionate approach in the management of concerns at an informal stage. Demonstrating the Trust values of kindness, courage and respect, the framework enables a proportionate means of achieving resolution to the concerns, with support and protection of individuals as the priority in all cases.

4.4 **WRES 4**

	Indicator	31st March 2022				31st March 2023			
		Descriptor	**White**	**BME**	**Unknown**	**Descriptor**	**White**	**BME**	**Unknown**
WRES 4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	Number of staff in workforce	5813	959	201	Number of staff in workforce	5916	1165	211
		Number of staff accessing mandatory training	4985	884	182	Number of staff accessing mandatory training	5902	1152	211
		Likelihood of accessing non-mandatory training	4985/5813= 0.86	884/959= 0.92		Likelihood of accessing non-mandatory training	5902/5916= 1.00	1152/1165= 0.99	
		Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.92/0.86= **1.07 more likely**				Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 1.00/0.99= **1.01 more likely**			

The relative likelihood of white staff accessing non-mandatory training in 2023 is 1.01 times more likely than BME staff. Therefore, white staff are more likely to access non-mandatory training and Continuous Professional Development (CPD) than BME staff. An additional 268 BAME staff accessed non mandatory training in 2023 than in 2022 which is why the ratio has improved slightly.

4.5 **NHS Staff Survey 2022**

The WRES indicators 5, 6, 7 and 8 represent unweighted question level responses to key findings in the NHS staff survey for the Northern Lincolnshire and Goole NHS Foundation Trust staff. It also includes the average scores for acute Trusts as a comparator.

	Indicator	2021 Staff Survey Result		2022 Staff Survey Result	
WRES 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	Ethnicity	%	Ethnicity	%
		White	22.0%	White	23.5%
		BME	31.9%	BME	33.1%
		Average Acute Trust score White 26.5% BME 28.8%		Average Acute Trust score White 26.9% BME 30.8%	

WRES 5

BME staff report a 9.6% higher negative experience than their white colleagues. There has been an increase of 1.2% from the 21/22 for BME staff. This is above the average acute Trust score for the BME staff.

WRES 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Ethnicity	%	Ethnicity	%
		White	28.80%	White	27.9%
		BME	38.10%	BME	37.3%
		Average Acute Trust score White 23.6% BME 28.5%		Average Acute Trust score White 23.3% BME 28.8%	

WRES 6

There has been a slight decrease in staff experiencing harassment, bullying or abuse from colleagues for white staff. It remains significantly worse for our BME staff with a gap of 9.4% between white and BME staff. This is almost 10% higher than the national acute trust average.

WRES 7	Percentage believing that trust provides equal opportunities for career progression or promotion	Ethnicity	%	Ethnicity	%
		White	53.50%	White	54.7%
		BME	40.10%	BME	47.1%
		Average Acute Trust score White 58.6% BME 44.6%		Average Acute Trust score White 58.6% BME 47.0%	

WRES 7

In 2021, 40.10% of BME staff felt that the trust provides equal opportunities for career progression or promotion. This percentage has increased since to 47.10% which is a

step in the right direction and remains in line with the national average.

WRES 8	In the last 12 months have you personally experienced discrimination at work from the Manager/team leader or other colleagues	Ethnicity	%	Ethnicity	%
		White	8.50%	White	7.6%
		BME	21.40%	BME	22.4%
		Average Acute Trust score White 6.7% BME 17.3%		Average Acute Trust score White 6.5% BME 17.3%	

WRES 8

In 2022, BME staff felt 14.8% more likely to have personally experienced discrimination at work from their manager/team leader or other colleagues compared to white staff. This remains higher than the reported National average for BME staff.

WRES 9	Boards are expected to be broadly representative of the population they serve (data 31/03/23)	Ethnicity	%	Ethnicity	%
		White	87.5%	White	85.71%
		BME	12.5%	BME	14.29%

WRES 9

In 2023, the Trust Board BME representation has improved compared to the previous year from 12.5% in 2022 to 14.29% in 2023. However, the Trust Board BME representation is still less than the overall percentage of BME staff in the total workforce (15.98%).

See appendix 1 which gives a summary of the 2023 WRES data and a comparison to National and local data.

5.0 PROGRESS AND ACTIONS

5.1 Reporting and Assurance

- **Progress 2022/2023**
  - The Trust's new Equality, Diversity and Inclusion Strategy which includes our Equality Objective (2023 – 2027) are in place. This was approved at the June 2023 Trust Board meeting. In addition, an Equality, Diversity, and Inclusion (EDI) action plan is now under development which will set out our commitment to actions required to redress disparity, progress, timescales and supporting evidence.
  - The Health and Well Being group is now the Health and Well Being and Equality,

Diversity, and Inclusion Steering Group with a dedicated EDI remit.
- We are continuing to work closely with and support the wider People Directorate team and the Trust's Freedom to Speak Up Guardian.
- All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias.
- All new staff receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias. Additionally, we are delivering a managers leadership programme which includes unconscious bias and cultural awareness training.

- **Further Actions 2023/2024 (See Appendix 1)**
  - We continue to deliver progress against all WRES actions through the EDI action plan and included the wider engagement and culture transformation programme of work.
  - To provide reports as required against the EDI action plan.
  - As part of strengthening culture awareness ensure that our staff equality networks (BAME Network) are represented and actively involved in the Health and Well Being and EDI Steering Group and the Culture Transformation Working Group.
  - To look at breaking down data (where this is possible) to identify hotspot areas and take more bespoke action. This will include looking at our Medical Staff and Bank staff WRES data.

5.2 **Recruitment and Retention**

- **Progress 2022/2023**
  - All recruitment panels include an equality representative. The Trust's Head of Recruitment has worked with the Trust EDI Lead through the Recruitment Review to ensure that all stages of the recruitment processes are fair and free from discrimination.
  - A great deal of work has been done to support and retain our Internationally Educated Nurses. We have a stay and thrive working group which is providing wholistic support to this group of staff in terms of on-boarding, their development and pastoral needs. We have had a number of engagement events to ensure this group of staff have a voice but more importantly they feel valued. Our contribution to this activity has resulted in achieving the NHS Pastoral Care Quality Award.

- **Further Actions 2023/2024 (See Appendix 1)**
  - To proactively understand the recruitment and retention of staff and particularly, explore reasons staff leave the Trust by protected characteristic, and to identify any outliers.
  - To specifically include unconscious bias awareness in recruitment as part of the Leadership programme.
  - To expand the Internally Educated Nurse programme to include other staff groups and involve pastoral care groups with an aim to developing a system wide approach.

5.3 **Disciplinary and Staff Experience**

- **Progress 2022/2023**
  - A key focus has been to engage with our staff and increase the visibility of EDI support in the workplace. Therefore, to give all staff an opportunity to openly discuss their concerns and experience we have held a number of face to face EDI engagement events with a diverse range of staff.

	➢ We arranged two large staff engagement events in Diana, Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH) to celebrate inclusivity. These events gave our diverse staff including our Internationally Educated Nurses and our Staff Equality Network members an opportunity to meet the EDI team and the wider people directorate team. We also arranged for some external providers to have stalls to show case how they may be able to support our staff in different ways. Feedback from both these events has been excellent. ➢ We have grown and further developed our BAME staff equality network and have over 240 members who we correspond with. Our BAME Facebook group to over 90 members. We also have a Teams Channel for our Internationally Educated Nurse. • **Further Actions 2023/2024 (See Appendix 1)** ➢ We are continuing to grow and develop our BAME staff equality network. ➢ To ensure the network is able to influence decision making which shapes and influences their employee experience we will ensure they are represented at the Health and Well Being, and EDI Steering Group. ➢ Arrange annually 4 large engagement events to celebrate inclusivity and intersectionality. ➢ We will be creating a Staff App to engage with all staff on EDI engagement.
5.4	**Trust Board and Senior Leadership** • **Progress 2022/2023** We recognise that Trust Board and the senior leadership community has some elements of diversity. However, due to the small numbers these percentages are very fragile. We continue to review our data intermittently. • **Further Actions 22023/2024 (See Appendix 1)** ➢ To understand the impact of the new group structure and how this will affect the Trust Board diversity going forward. ➢ To interrogate in more detail the diversity within the senior leadership community to understand areas of under-representation and consider what positive actions are required to address the gaps.
6.0	**The report to be received.**
6.1	To note the contents of this report against the NHS Workforce Race Equality Standard.
6.2	Approve the data content which we are required to share with NHS England and our commissioners.
6.3	To note the actions proposed for 23/24 and to monitor progress of those actions and wider culture transformation programme through the Workforce Committee.

Appendix 1 - Workforce Race Equality Standard (WRES) Action Plan 2023/24

The Action Plan 2023/24 has been developed, based on the 2022/23 WRES technical data results, to help close the gaps in workplace experience between White and Black and Ethnic Minority (BAME) staff.

Action	WRES Indicator	Timescale	Lead
Explore ways that the Trusts newly introduced Equality, Diversity and Inclusion) EDI strategy can strengthen the addressing of Workforce Race Inequalities specifically taking into consideration the Group Structure of the organisation.	All	January 2024 / Ongoing	Workforce and Organisational Development (OD) EDI Team
Explore opportunities within the new Group Structure which can support this staff group – in particular, Leadership Development Opportunities.	Indicator 1	October / November 2023	EDI Team and Leadership Team
Continue to monitor progress against all WRES actions through the EDI action plan and included the wider engagement and culture transformation programme of work. To provide reports as required against the EDI action plan.	All	June 2024 / Ongoing	EDI Team and OD Team
As part of strengthening culture awareness ensure that our staff equality networks (BAME Network) are represented and actively involved in the Health and Well Being and EDI Steering Group and the Culture Transformation Working Group.	All	October 2023 / Ongoing	EDI Manager
To look at breaking down data (where this is possible) to identify hotspot areas and take more bespoke action. This will include looking at our Medical Staff and Bank staff WRES data.	Indicator 1,2, 3, 4	February 2024 / Ongoing	Organisational Development (OD) and EDI Team
To monitor recruitment and retention of staff and particularly, explore reasons staff leave the	Indicator 2	November 2023 / Ongoing	EDI Team and Head of Recruitment

Trust by protected characteristic, and to identify any outliers.			
To specifically include unconscious bias awareness in recruitment as part of the Leadership programme.	Indicator 2	November 2023	EDI Team
To explore expanding the Internally Educated Nurse programme to include other staff groups and involve pastoral care groups with an aim to developing a system wide approach.	Indicator 1,5,6,7,8	March 2024	EDI Team / Nursing
To grow and develop our BAME staff equality network. To ensure the network is able to influence decision making which shapes and influences their employee experience we will ensure they are represented at the Health and Well Being, and EDI Steering Group.	All	On-going	EDI Team
We will be creating and launching a Staff App to improve EDI engagement.	All	October 2023	EDI Team
To understand the impact of the new group structure and how this will affect the Trust Board diversity going forward.	Indicator 9	January 2024	EDI Team
To interrogate in more detail the diversity within the senior leadership community to understand areas of under-representation and consider what positive actions are required to address the gaps.	Indicator 1	April 2024	EDI Team

Appendix 2

Northern Lincolnshire and Goole NHS FT (NLaG) Workforce Race Equality (WRES) Data Summary 2023

The table below shows a summary of the NLaG WRES data for March 2022 and March 2023, and it identifies where improvements are required. It also shows a summary of NHS England's national picture of WRES data [WRES-indicator.png (800×446) (england.nhs.uk)](#) the average Acute Trust National Health Service (NHS) Staff Survey data and the Hull University Teaching Hospitals (HUTH) data as a comparator.

WRES 1	March 22		March 23			HUTH Comparator 2023	NHS Comparator 2022 Data
	Percentage of Black and Minority Ethnic (BME) Staff in Bands 8-9	7.09%	Percentage of BME Staff in Bands 8-9	7.04%	No Change Worse than National Comparator	Different Data Format	10.3%
	Percentage of BME Staff in overall workforce	13.75%	Percentage of BME Staff in overall workforce	15.98%	Improved Worse than National Comparator	18.7%	24.2%
WRES 2	March 22		March 23			HUTH Comparator	
	The relative likelihood of White staff being appointed compared to BME staff is	1.46 greater	The relative likelihood of White staff being appointed compared to BME staff is	1.73 greater	No Change Improvement Required Worse than National Comparator	1.3 greater	1.54 greater
WRES 3	March 22		March 23			HUTH Comparator	
	The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is	1.4 greater	The relative likelihood of BME staff entering a formal disciplinary process	0.4 less likely	Improved Positive Impact Better than National Comparator	1.06 greater	1.14 greater

			compared to White staff is				
WRES 4	March 22		March 23			HUTH Comparator	
	Relative likelihood of White staff accessing non-mandatory training and Continued Professional Development (CPD) compared to BME staff	1.07 more likely	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	1.01 more likely	No Change Positive Impact In-line with National Comparator	0.98 less likely	1.12 more likely

NHS Staff Survey	2021 Staff Survey Result	2022 Staff Survey Result		HUTH Comparator	Average Acute Trust
WRES 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 22.0% BME 31.9%	White 23.5% BME 33.1%	No Change Improvement Required Worse than National Acute Trust Score	White 28.8% BME 33.0%	White 26.9% BME 30.8%
WRES 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 28.80% BME 38.10%	White 27.9% BME 37.3%	No Change Improvement Required Almost 10% Higher than National Acute Score	White 21.5% BME 31.3%	White 23.3% BME 28.8%
WRES 7 Percentage believing that trust provides equal opportunities for career progression or promotion	White 53.50% BME 40.10%	White 54.7% BME 47.1%	Small Improvement More Improvement Required In-line with National Acute Score	White 58.1% BME 46.6%	White 58.6% BME 47.0%
WRES 8 In the last 12 months have you personally experienced discrimination at work from the	White 8.50% BME 21.40%	White 7.6% BME 22.4%	No Change Improvement Required Higher than National Acute Score	White 6.6% BME 16.4%	White 6.5% BME 17.3%

Manager/team leader or other colleagues					
WRES 9	March 22	March 23		HUTH Comparator	NHS Comparator 2022 Data
Boards are expected to be broadly representative of the population they serve	White 87.5% BME 12.5%	White 85.71% BME 14.29%	No Change Positive Impact	White 88.2% BME 11.8%	White 86.8% BME 13.2%

NLG(23)181

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	3 October 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Protocol for Reserving Matters to a Private Board Meeting**
Purpose of the Report and Executive Summary (to include recommendations)	**Purpose of the Report:** To present the updated Protocol for Reserving Matters to a Private Board Meeting. **Executive Summary:** The Trust Constitution was updated and the amendments agreed by the Trust Board and Council of Governors in January 2023. The protocol has been amended to reflect these changes. As per the Code of Governance, April 2023, section 2.17: "The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions." The Healthy NHS Board, section 142: "….when a compelling case can be made for an item to be considered in private, there is provision for attending to it in private…." **Changes:** i) Paragraph 2 of the protocol has been amended from: The Trust's Constitution provides, at paragraph 17.3 of Part III – Meetings of the Trust Board, that for 'special reasons', the Trust Board may resolve to meet in private session and exclude members of the public (which could include the press). This is sometimes known as 'Part II'; To: The Trust's Constitution provides, at Annex 7, paragraph 6.2.3 Calling Meetings / Extraordinary Meetings of the Trust Board, that for 'special reasons', the Trust Board may resolve to meet in private session and exclude members of the public (which could include the press). This is sometimes known as 'Trust Board (Private). ii) Reference Section: The Foundations of Good Governance: A Compendium of Best Practice has been replaced with; The Foundations of Good Governance – NHS Providers. Birmingham Children's Hospital : Protocol of Reserving Matters to a Private Board Meeting has been replaced with the Healthy NHS Board 2013 – NHS Leadership Academy. **Recommendation:** The Board is asked to approve the minor amendments to the protocol.

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

Northern Lincolnshire and Goole NHS Foundation Trust

Director of Corporate Governance

PROTOCOL FOR RESERVING MATTERS TO A PRIVATE BOARD MEETING

Reference:	DCM100
Version:	1.3
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:	October, 2026
Owner:	Helen Harris, Director of Corporate Governance
Document type:	Miscellaneous
Number of pages:	6 (including front sheet)
Author / Contact:	Alison Hurley, Assistant Trust Secretary

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.

In accordance with the Trust's Constitution, Northern Lincolnshire & Goole NHS Foundation Trust holds its Trust Board meetings in public.

The Trust's Constitution provides, at Annex 7, paragraph 6.2.3 Calling Meetings / Extraordinary Meetings of the Trust Board, that for 'special reasons', the Trust Board may resolve to meet in private session and exclude members of the public (which could include the press). This is sometimes known as 'Trust Board (Private).

Inevitably, some of the Trust's business is more appropriately considered in private session. The Board will usually consider as unsuitable for discussion in public, issues about the award of contracts, disciplinary matters and matters concerning staff or any identifiable patient. Other issues are harder to identify in advance.

In determining which matters should be reserved for private consideration, one factor that the Trust may consider is whether the information to be discussed would be exempt from disclosure under the Freedom of Information (FOI) Act 2000. If information would be exempt from disclosure under FOI laws, then it is likely that it should be considered during the private session of a Trust Board meeting.

This document has therefore been prepared in order to outline the exemptions most likely to apply to material considered by the Trust Board and to provide guidance for Directors on those matters which should be reserved for discussion within private session. **N.B.** It should be stressed however that, in order to ensure openness and transparency of decision making, the default position will remain that unless there is a clear exemption; matters will be routinely considered in public.

FOI section	Reason for Reservation	Examples
14 (1)	Vexatious Requests - The Act does not oblige the Trust to comply with a request for information if the request is vexatious Section 14(1) may be used in a variety of circumstances where a request, or its impact on a public authority, cannot be justified. **Vexatious Request definition - a** request that is intended merely to create frustration or annoyance.	
22*	Information Intended for Future Publication - Information where there is a settled intention to publish in the future.	• Annual Report (further to the NHS Foundation Trust Accounting manual, the Annual Report can only be made public once it has been laid before parliament). • Draft consultation documents.

24	Safeguarding National Security - The information is exempt if it is required for the purposes of safeguarding national security.	• Cyber security
31, (1)(a)-(c), (h) or (1)(g)*with section 31(2)(a)-(e), (i) or (j)	Law Enforcement - Where the disclosure of information would, or would be likely to prejudice: (a) the prevention or detection of crime (b) the apprehension or prosecution of offenders (c) the administration of justice (h) any civil proceedings which are brought by or on behalf of a public authority and arise out of an investigation conducted, for any of the purposes specified in s.31(2), or by virtue of powers conferred by or under an enactment) (g) the exercise by any public authority of its functions for any of the purposes specified in s. 31(2), which include: (a) the purpose of ascertaining whether any person has failed to comply with the law (b) the purpose of ascertaining whether any person is responsible for any conduct which is improper (c) the purpose of ascertaining whether circumstances which would justify regulatory action in pursuance of any enactment exist or may arise (d) the purpose of ascertaining a person's fitness or competence in relation to the management of bodies corporate or in relation to any profession or other activity which he is, or seeks to become, authorised to carry on	• Professional disciplinary or legal investigations into members of staff (information about which may also be exempt under s. 40 and s. 42 - see below). • Serious Untoward Incident (SUI) reports

	(e) the purpose of ascertaining the cause of an accident (i) the purpose of securing the health, safety and welfare of persons at work, and (j) the purpose of protecting persons other than persons at work against risk to health or safety arising out of or in connection with the actions of persons at work. **[Section 30 only applies to public bodies that can bring criminal proceedings or has a duty to investigate whether criminal proceedings should be brought. For Trusts the relevant section is 31(1)(g) with provisions in s. 31].**	
32	Information contained in court records	Information that we hold that was created explicitly for or was used in any court proceedings.
Prejudice to the free and frank provision of advice, exchange of views for the purposes of deliberation, or the effective conduct of public affairs (36(2)(b)(i-ii)&(c):		
36(2)(b)(i)*	Issues, the discussion of which in public would or would be likely to inhibit the free and frank provision of advice.	Matters in the initial stages of enquiry; early stages of strategic thinking; sensitive 'live' issues or 'blue sky thinking', for instance addressed or discussed in: • recommendations/advice from external organisations eg. Royal Colleges. • recommendations made by more junior staff to more senior staff. • professional advice tendered by professionally qualified government employees. • advice from external sources, or advice supplied to external sources. • options papers drafted

		internally.
36(2)(b)(ii)*	Issues, the discussion of which in public would or would be likely to inhibit the free and frank exchange of views for the purpose of deliberation. i.e. Disclosure would, or would be likely to inhibit the ability of staff and others, when deliberating or providing advice, to express themselves openly, honestly and completely, or to explore extreme options 'Deliberation' tends to refer to the evaluation of the competing arguments or considerations that may have an influence on the course of action. It will include expressions of opinion and recommendations but will not include purely factual material or background information. The information must reveal the 'thinking process' or reflection that has gone into a decision.	Matters in the initial stages of enquiry; early stages of strategic thinking; sensitive 'live' issues or 'blue sky thinking' discussed in: • emails • minutes of committees (e.g. Audit, Risk & Governance Committee Minutes – discussion on Fraud issues). • options papers drafted internally.
36(2)(c)*	Issues, the discussion of which in public would or would be likely to prejudice the effective conduct of public affairs Where the disclosure would or would be likely to prejudice the Trust's ability to offer an effective public service, or to meet its wider objectives or purpose (rather than simply to function) due to the disruption caused by the disclosure and the diversion of resources in managing the impact of disclosure.	• Issues the Trust is 'working through', where discussion in public may cause concern/panic. • Discussions about future public consultations where the Trust wishes to manage the timing and manner in which disclosures are made.
38	Health and Safety - Information where disclosure would or would be likely to: (a) endanger the physical or mental health of any individual, or (b) endanger the safety of any individual	• Disciplinary or grievance issues/information. • SI investigations. • Service changes which could affect the employment status of employees.
40(2)	Personal Data - Information containing the personal data of any living person, patient, staff member or any other person if disclosure would contravene any of the data protection principles in the Data Protection Act 2018. The first data protection principle requires that 'processing' personal data needs to be fair.	• Reports relating to the conduct of a particular employee. • SI reports relating to a particular (living) patient.

41	Information provided in confidence – Information from another person or organisation, if releasing that information would lead to a successful claim for breach of confidence.	• Patient records or information contained in them (including of patients who are no longer living). • Some technical information from suppliers.
42*	Legal professional privilege - Communications with solicitors and barristers, reports imparting legal advice, and information created in order to seek legal advice or to help prepare for a legal claim.	• Legal advice.
43(2)*	Commercial Interests - Disclosure of the information would be likely to damage the commercial interests of any person or organisations. Those interests may be those of the Trust, one of its suppliers or one of its customers.	• Current pricing information contained in contracts or tenders, prior to the conclusion of the tender. • Information that would damage the Trust's negotiating position if disclosed.
44	Prohibitions on Disclosure - Information, disclosure of which is prohibited by law.	• Information prohibited from disclosure by a Court Order or statutory provision prohibiting disclosure.

Those exemptions marked with an * are subject to the public interest test. This means that they will only apply if the public interest in withholding the information is stronger than the public interest in releasing it. In some cases, this may mean that the information will be considered in the public session of the Trust Board meeting.

[References:

The-foundations-of-good-governance - NHS Providers

TheHealthyNHSBoard-2013- nhsleadershipacademy

ISSUED: OCTOBER 2023

REVISED: OCTOBER 2023

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(23)182

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 3 October 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Ryan Sutton, Associate Director of Quality Improvement
Title of the Report	NHS Impact – Baseline & Assessment
Purpose of the Report and Executive Summary (to include recommendations)	This report is for approval of the NHS Impact self-assessment that provider organisation are required to complete with board approval by the 31st October 2023. 1. Approval of the enclose NHS Impact self-assessment for submission to NHS Impact by the 31st October 2023. 2. Approval for NLAGs NHS Impact Self-Assessment to be a critical part of shaping the future groups values and vision. 3. Approval for, in conjunction with HUTH self-assessment, to create a Group Quality Improvement strategy with a focus on moving each secondary driver to their next level. 4. Approval to rerun this self-assessment annually to measure organisational progression against NHS Impacts standards.
Background Information and/or Supporting Document(s) (if applicable)	https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality Governance Group, Culture Transformation Working Group
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working ✓ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable

	☐ 2
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

NHS Impact Provider Improvement Self Assessment

Situation

Northern Lincolnshire & Goole (NLAG) Foundation Trust Board are asked to review this document and contained NHS Impact Self-Assessment of the organisations Improvement culture and processes. Upon completion of this review approval is sought to submit this position to NHS Impact by the 31st October 2023.

This self-assessment is solely focused on NLAG with Hull University Teaching Hospitals (HUTH) completing their own self-assessment for approval.

Background

NHS Impact was formed by the Chief Executive of NHS England to *"inform the way we work across services and create the conditions in which continuous improvement is the "go to" method for tackling clinical, operational and financial challenges."* These "conditions" are outlined in "The delivery and continuous improvement review" and are summarised in figure 1 below, outlining 5 primary drivers.

Figure 1 – 5 Primary Drivers

Through the formation of NHS Impact provider organisations have been asked to complete a self-assessment of their current improvement culture and structure. This is required to be approved by the organisations Trust Board and submitted electronically to NHS Impact by the 31st October 2023.

Assessment

To ensure a collaborative approach a survey was created and sent to NLAGs Senior Leadership Community to ensure a true organisational view and response was collated.

Of the 5 primary drivers outlined in figure 1 above, 21 secondary drivers sit underneath making up the self-assessment questions.

The scoring criteria for each question consisted of 1=Starting, 2=Developing, 3=Progressing, 4=Spreading, 5=Improving & Sustaining.

Overall - of the 21 second driver self-assessment questions

- 12 were scored as 3=Progressing
- 8 were scored as 2=Developing
- 1 were scored as 1=Starting

A full detailed breakdown of the responses is captured on the NHS Impact self-assessment document contained in annex 1 at the end of this document for review and approval.

Recommendations

1. Approval of the enclose NHS Impact self-assessment for submission to NHS Impact by the 31st October 2023.
2. Approval for NLAGs NHS Impact Self-Assessment to be a critical part of shaping the future groups values and vision.
3. Approval for, in conjunction with HUTH self-assessment, to create a Group Quality Improvement strategy with a focus on moving each secondary driver to their next level.
4. Approval to rerun this self-assessment annually to measure organisational progression against NHS Impacts standards.

NHS Impact Self-Assessment

To be completed by 31st October 2023

NHS IMPACT
Improving Patient Care Together

Building a Shared Purpose & Vision

What this looks like in practice:	Themes:
• Create a vision and shared purpose in an inclusive and transparent way ensuring meaningful input from all, including those with lived experience. The executive leadership of the organisation must drive this work, but it cannot be designed and created by one team. • Involve communities and people with lived experience as partners in the design of the vision and shared purpose. • Find ways to make the vision and shared purpose practical, so that they are lived everyday by its people and are underpinned by core values. • Ensure all improvement work is focused on the shared purpose and vision and question any work which does not align to these. Start by focusing on the current NHS priorities and your own organisation's context, including the pressures it is facing. • Create a powerful, purpose-driven context and narrative for improvement work so that people are more likely to engage, based on commitment to the purpose rather than compliance with a process. • Understand the world in which frontline staff are working, their challenges, their successes, and the improvement they'd like to see to guide this vision and shared purpose, for example through methods of co-design and collaboration like crowd sourcing platforms or engagement events. • Take account of the current Care Quality Commission 'Well-Led' scores and where there are areas for improvement. • The shared purpose and vision should allow staff to understand the importance of their work and to see it from the patient or service user's perspective. Celebrate and share good practice where possible.	• Board and executives setting the vision and shared purpose • Translating this into a compelling narrative for staff • Improvement work aligned to organisational vision, purpose and priorities • Co-design and collaborate - celebrate and share successes • Lived Experience driving this work

Building a Shared Purpose & Vision

Indicated NLaG`s position

	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Board and executives setting the vision and shared purpose	We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan	Our board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Our board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrICB (e.g. Operations, Quality, Financial and People / workforce).	Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.	Our vision and shared purpose is well embedded and often referred to by the board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.
Improvement work aligned to organisational priorities	Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.	Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them	Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.
Co-design and collaborate - celebrate and share successes	We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.	The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.	We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Our leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.
Lived Experience driving this work	There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully	People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision, and may have a role in	Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of	Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at board level, including setting the strategic direction of the organisation and

Investing in People and Culture

What this looks like in practice:	Themes:
• Set the expectation (e.g. through new joiners' welcome and induction process) that all staff should have a common understanding of improvement, that it is a priority for the organisation and that they will be supported to make improvements in their own area of work. • Engage with people who work in healthcare roles and organisations and those with lived experience to design and implement the improvements based on what matters to them. • Facilitate opportunities for people to visit other systems and organisations to understand different ways of operating and different organisational cultures. • Invest in and support people to understand and own their work, enabling them to make improvements in their own area of work. • Undertake planned and deliberate cultural readiness work prior to any improvement programme or activity, to establish and maintain a shared set of values that everyone can align to. • Use a coaching-based approach to leadership in areas where improvement is required, encourage idea generation and run PDSA (plan, do, study, act) cycles regularly. Encourage the use of measurement to evaluate improvements and to learn. • Have a locally agreed method to measure and assess organisational improvement culture, including drawing on NHS staff survey information, to support organisational development and learning.	• Pay attention to the culture of improvement • Respond to what matters to staff, people using services and unpaid carers • Enabling staff through a coaching style of leadership • Enabling staff to make improvements

Investing in people and culture

Indicated NLaG`s position

	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Pay attention to the culture of improvement	There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.	Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement	Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	Leaders and managers at all levels understanding their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are 'walking the floor' (e.g., during 'go & see' visits).	We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g., NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and unpaid carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.
What matters to staff, people using services and unpaid carers	Our ways of understanding what matters most to staff, people using services and unpaid carers tend to be reliant on formal mechanisms (e.g., surveys) and the link to improvement is not strong or systematic.	We understand well as an organisation what matters most to staff, people using services and unpaid carers (e.g., through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Most of our services and functions have a good understanding of what matters most to staff, people using services and unpaid carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g., through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient sand carers into improvement priorities or goals.	Most of our teams have a good understanding of what matters most to staff, people using services and unpaid carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. People using services have a role in the development, prioritisation and monitoring of delivery of improvement goals	Most of our staff can describe what matters most to them, people using services and unpaid carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for people using services, which is energising. People with lived experience often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.
Enabling staff through a coaching style of leadership	There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g., through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.	A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g., to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered.	Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers and clinicians participate in improvement, celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.	A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.
Enabling staff to make improvements	Improvement activity is limited and may be centralised (e.g., led by a discrete 'improvement team' with relevant skills operating independently). Staff do not generally feel able to make	Some staff and teams feel able to make improvements (e.g., if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams	The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	The majority of teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative), and can solve problems	Staff and teams are systematically engaged in improvement activity as part of their day to day work and are proactive in sharing the learning, and in looking for ways to collaborate with people with lived experience and other teams and

Developing leadership behaviour

What this looks like in practice:	Themes:
• Have a clear leadership and management development strategy in place outlining capability requirements and access to training. • Understand current leadership styles and approaches through board development sessions identifying strengths and gaps for each individual and as a team. • Create leadership stability and continuity of approach. • Support leaders and managers across the system to live and breathe the values and behaviours of the organisation and hold leaders and managers to account for behaviours, not just improvement outcomes. • Clearly agree and outline the support which is in place for people to improve their own services. • Provide induction, training and development for everyone who has a formal leadership or management role so they have skills and experience of delivering improvements and can role model leading for improvement. • Encourage board development to better understand how current leadership and management behaviours are demonstrating organisational values, identifying strengths and gaps. • Engage with peer support networks to understand different approaches to the issues and leadership and management behaviours. • Empower teams delivering on the ground to carry out and test improvement projects.	• Leadership and management development strategy • Leadership and management values and behaviours • Leadership and management acting in partnership • Board development to empower collective improvement leadership • Go and see visits

Developing leadership behaviour

Indicated NLaG`s position

	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Leadership and management development strategy	Our board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model	Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role	Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement	Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	Our board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our board are visibly linked to future planning at a system level
Leadership and management Values and behaviours	Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach	Leadership values and behaviours are agreed across our organisation	Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation	Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to	A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation
Leadership and management acting in partnership	Our Leadership works to competing and misaligned goals lacking in clarity	Most of our leaders work in partnership with their fellow leaders and managers.	Our leadership team have shared goals with commissioners and work effectively with systems partners	Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy	Our board and system focus on constancy of purpose through multi-year journey with improvement at its core
Board development to empower collective improvement leadership	Our board discusses improvement at board meetings, but it is not a regular occurrence	Our board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every board meeting	Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement	Our leadership and management teams actively enable staff to own improvement as part of their everyday work	Our leaders and managers - CEO through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done
Go and see visits	Some senior leaders spend time on the 'shop floor' from time to time to engage directly with staff and teams but it is not routine or widely practiced	Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement	Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management	All levels of leadership and management 'walk the floor'/'go & see' as a matter of routine and the insights they gain informs decision making and problem solving to	Leaders undertake 'walk the floor'/'go & see' visits for external bodies to visit their site and to observe different ways of working

Building improvement capability and capacity

What this looks like in practice:	Themes:
• Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement. • Give all people access to induction, improvement training and support, so that everyone can run improvement projects and continuously improve their daily work. • Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience. • Demonstrate the impact of co-producing improvements with people who use services as an integral part of daily work. • Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace. • Create and embed a training strategy to increase improvement capability. • Leaders and managers attend teams daily huddle boards and work to unblock issues which teams are facing.	• Improvement capacity and capability building strategy • Clear improvement methodology training and support • Improvements measured with data & feedback • Co-production • Staff attend daily huddles

Building improvement capability and capacity

Indicated NLaG`s position

	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Improvement capacity and capability building strategy	We do not have a structured training or capability building approach for improvement skills Training is ad hoc and focused on small central teams We have some use of external resources (e.g. Academic Health Science Networks and Institute for Healthcare Improvement Open School)	Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement Staff have access to induction on joining, improvement training and a small group of staff support capability building	Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology Some learning is shared across the organisation A system exists to identify, engage and connect all those people that have existing improvement capability	Sustainability is addressed via 'in-house' training and development approaches including train the trainer models, Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams The programme is working towards being self-sustaining through developing its own improvement coaches	There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally
Clear improvement methodology training and support	No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS Impact components, alongside a dosing formula and skills escalator to support capability building ambitions	Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders	Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers	Learning from improvement activity is driving continuous improvement There is a common improvement language across the organisation Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy
Improvements measured with data and feedback	Our organisational approach to reviewing and tracking progress against goals has yet to be defined, At present Improvement doesn't feature in whole organisational measures	We are seeing minimal improvement in our organisational measures We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to deliver	We are tracking improvement over time for some of our organisational measures We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive	Improvement is sustained for most organisational measures Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required	Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively Our goals around longer term sustainability are reviewed regularly at organisational level
Co-production	We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors with no lived experience partners co-producing improvement	People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvements, but this is rarely shared across departments	People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach Staff, people with lived experience and other stakeholders have access to improvement capability development	Stakeholders including people with lived experience are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively together	Stakeholders are both supported and challenged to ensure success. People with lived experience and wider stakeholders are embedded within teams and are an integral part of the capability building process
Staff attend daily huddles	Any huddles are only traditional shift change clinical handovers	There is a plan in place for team huddle to focus on continuous improvements in all clinical frontline areas with clinical and	All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all	All operational/support/corporate areas have continuous improvement team huddles established	There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a

Embedding into management systems and processes

What this looks like in practice:	Themes:
• Develop an explicit management system that aligns with the strategy, vision and purpose of the organisation at board level and throughout all services and functions. • Put systems in place to identify and monitor early warning signs and quality risks with clear processes of how to respond to these. • Set up the management system as a standard way of operating that enables ongoing continuous improvement of access, quality, experience, and outcomes. • Building a management system which enables the organisation to respond to system and national priorities more easily and with greater agility as the organisation has a consistent and coherent set of management systems and processes. • A committed board and senior management team who own and use this approach to manage the everyday running of their organisation, including simple and visual ways of understanding performance with tracking progress.	• Aligned goals • Planning and understanding status • Responding to local, system and national priorities • Integrating improvement into everything we do

Embedding into management systems and processes

Indicated NLaG`s position

	1. STARTING	2. DEVELOPING	3. PROGRESSING	4. SPREADING	5. IMPROVING & SUSTAINING
Aligned goals	Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at board and senior leadership level but executives' and functions goals are often not well aligned with each other	Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.
Planning and understanding status	Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource	Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. HR, Finance, Comms, InformatICB) are also aligned to our improvement priorities	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective Staff and assets from enabling services (e.g. HR, Finance, Comms, InformatICB) are also aligned to improvement priorities and are shared across the system in an agile way	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.
Responding to local, system, and national priorities	We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting	Across the organisation, we believe having a management method (e.g., Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.	Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.	Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables Our technology, staff and facility decisions are aligned with our management system goals.	All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g., SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.
Integrating improvement in to everything we do	Improvement is seen as separate to the day to day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply, and may be sending conflicting signals within the organisation.	Improvement is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some front-line clinical areas	Improvement is starting generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas	As part of our management system, all parts of the organisation are using improvement methods, and learning occurs between areas (e.g., to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not	The way we understand, manage and improve performance across the organisation – including how we use and report data – is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases

NLG(23)183

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	3 October 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Fit and Proper Persons Policy and new Framework**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this paper is to present highlights of the new NHS England (NHSE) Fit and Proper Persons Test Framework and for the Board to note the Fit and Proper Persons Policy is currently under review to reflect the move to a Group structure. The report below provides detail of the requirements of the framework at a high level. The Trust Board is asked to note: i) the Trust's Fit and Proper Persons Policy is currently under review to reflect the move to a Group Structure and the new NHS England Fit and Proper Persons Test Framework (FPPT) which was published in August 2023, ii) the new requirements of the Framework highlighted within the report.
Background Information and/or Supporting Document(s) (if applicable)	NHS England Fit and Proper Person Test Framework for board members Guidance-for-chairs-on-implementation-fit-and-proper-person-test-for-board-members
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Group Executive Meeting
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A

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

Fit and Proper Persons Policy and NHS England Fit and Proper Persons Test Framework

1. Purpose

1.1. The purpose of this paper is to present highlights of the new NHS England (NHSE) Fit and Proper Persons Test Framework and for the Board to note the Fit and Proper Persons Policy is currently under review to reflect the move to a Group structure.

2. Background

2.1. In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all relevant individuals meet the requirements of the Fit and Proper Persons Test (Regulation 5).

2.2. Regulation 5 recognises that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care. For the purposes of Regulation 5, these individuals are board directors, board members and individuals who perform the functions equivalent of or to the functions of a board director and member (whether existing, interim, or permanent and irrespective of their voting rights).

2.3. NHS England has published a new Fit and Proper Persons Test Framework (August 2023), following recommendations made by Tom Kark of his review of the Fit and Proper Persons Test in 2019. Alongside the framework, guidance has been published for Chairs and staff on its implementation. There is an expectation that parts of the framework will be used from 30 September 2023 and full implementation is by 31 March 2024.

3. Fit and Proper Person Test Framework

3.1. The new framework aims to strengthen compliance of the regulations and includes additional checks to ensure regulatory requirements are met.

3.2. The framework details that the embedding of the Fit and Proper Persons Test will be quality assured by the Care Quality Commission, NHSE and external / independent review. The CQC will consider this as part of their well-led reviews. NHSE will review the annual submissions to the regional director and every three years the Trust will be required to internally audit the controls and undertake a sample test.

3.3. Annual Appraisals

3.3.1. The annual appraisal will feed into the Fit and Proper Persons Test assessment. Appraisals will also be required to use the NHS Leadership Competency Framework (not yet published).

3.4. Joint Roles

3.4.1. The host / employing organisation will undertake checks for joint appointments.

3.5. Accountability

3.5.1. Accountability rests with the Chair to ensure Fit and Proper Persons Tests are implemented effectively.

3.5.2. The NHSE Regional Directors now have responsibility to ensure Chairs meet the requirements.

3.6. Electronic Staff Record (ESR)

3.6.1. ESR will store the information related to the Fit and Proper Persons Tests.

4. Fit and Proper Person Policy

4.1. In line with the new requirements as detailed above, the policy will be amended to make reference to the NHSE Fit and Proper Persons Test Framework.

4.2. The policy will be revised to also reflect the move to a Group structure and will be presented to the Boards in Common at a future meeting.

5. Reporting Arrangements

5.1. An annual report will be presented to the Trust Board in June 2024, as per the requirements of the Framework and submitted to the NHSE Regional Director, with the outcome of the Chair's appraisal, by the 30 June.

6. Recommendations

6.1. The Trust Board is asked to note, the:

6.1.1. Trust's Fit and Proper Persons Policy is currently under review to reflect the move to a Group Structure and the new NHS England Fit and Proper Persons Test Framework (FPPT) which was published in August 2023,

6.1.2. new requirements of the Framework highlighted within the report.

Helen Harris, Director of Corporate Governance
September 2023

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(23)183

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	3 October 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Alison Hurley, Assistant Trust Secretary
Title of the Report	**Council Of Governors & Trust Board Engagement Policy**
Purpose of the Report and Executive Summary (to include recommendations)	The Engagement Policy outlines the mechanisms by which Governors and the Trust Board will interact and communicate with each other. This will support ongoing interaction and engagement, whilst taking into account the statutory role of Governors and their duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The policy has been reviewed and updated as per the usual Document Control cycle process to reflect: • general updates • the Health and Care Act 2022 • the Addendum (2022) to 'Your statutory duties – a reference guide for NHS foundation trust governors' • the NHS Code of Governance for Provider Trusts 2023 (Appendix B: Council of Governors and Role of the Nominated Lead Governor, Section 2.6 states: "The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director). • additional details to add clarity to the various sections. Trust Board members are requested to note that this has been approved at the Governor Assurance Group and Council of Governors. The Trust Board is asked to consider the updates and ratify the revised policy.
Background Information and/or Supporting Document(s) (if applicable)	**Council Of Governors Engagement Policy**
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: ✓ Governor Assurance Group and Council of Governors

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

Northern Lincolnshire and Goole NHS Foundation Trust

Director of Corporate Governance

COUNCIL OF GOVERNORS & TRUST BOARD ENGAGEMENT POLICY

Reference:	DCP231
Version:	3.0
This version issued:	July 2023
Result of last review:	Minor updates
Date approved by owner (if applicable):	
Date approved:	
Approving body:	Council of Governors / Trust Board
Date for review:	July 2026
Owner:	Helen Harris, Director of Corporate Governance
Document type:	Policy
Number of pages:	14 (including front sheet)
Author / Contact:	Alison Hurley, Assistant Trust Secretary

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

Contents

1.0 PURPOSE

This policy:

- outlines the mechanisms by which Governors and Executive and Non-Executive Directors (the Directors) will interact and communicate with each other to support ongoing interaction and engagement, and takes into account the role of Governors, set out in the:
  - National Health Service (NHS) Act 2006
  - Health & Social Care Act 2012
  - Health and Care Act 2022 (the Act)
  - Addendum (2022) to 'Your statutory duties – a reference guide for NHS foundation trust governors'
  - NHS Code of Governance for Provider Trusts 2023 (Appendix B, Section 1.2).
- This includes the duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors (detailed as the Trust Board);
- describes the methods by which Governors are able to engage with the Trust Board in order to support each other with ongoing interaction and engagement, ensure compliance with the Regulatory Framework and specifically provide for those circumstances where the Council of Governors has concerns about:
  - the performance of the Trust Board;
  - compliance with the Trust's Provider Licence (as granted by the Act); or
  - other matters related to the overall wellbeing of the NHS Foundation Trust.

2.0 AREA

2.1 Holding to Account definition

2.1.1 The Health and Social Care Act 2012 specified the duty of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board. The definition of this is open to interpretation, but broadly speaking this duty requires Governors to question Non-Executive Directors about how they have set the Trust's proposed strategy and forward plan and measured its performance against them, so that they are satisfied that the Board has acted to take the interests of members and of the public appropriately in to account and ensure that the Trust is not at risk of breaching its Licence. In performing this duty, Governors should keep in mind that the Trust Board manages the Trust and continues to bear ultimate responsibility for the Trust's strategic planning and performance and must promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

2.1.2 The Health and Care Act 2022 additionally requires Governors to also hold Non-Executive Directors, individually and collectively, to account for the Trust's contribution to the delivery of the objectives for the local Integrated Care System (ICS), being Humber and North Yorkshire ICS.

2.1.3 The process of engagement between the Council of Governors and Trust Board is clearly one which is already ongoing and routine, however, this policy, agreed between the Trust Board and the Council of Governors, aims to outline existing and additional mechanisms which have been agreed and which will be used by the Trust to ensure communication between the Council of Governors and the Trust Board and ensure that Governors are able to discharge the above duties effectively, harmoniously and recognising the different and complimentary roles of each body.

2.1.4 In support of the duty to hold to account, the Council of Governors also has the statutory power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or Directors' performance). Whilst it is recognised that this power will rarely be exercised, should this power be invoked, it must be reported in the report and accounts. The aim of this policy is to have agreed levels of engagement which will eliminate or at least minimise the need of Governors to ever invoke this statutory power.

2.2 Raising Concerns/Resolution of Disputes

2.2.1 Where material concerns exist regarding the performance of the Trust Board, compliance with the Trust's Licence or matters relating to the general well-being of the Trust, this policy should be followed. This policy is not to be invoked for minor issues raised by an individual Governor. A concern, in the meaning of this policy, must be directly related to:

- the performance of the Trust Board;
- compliance with the Trust's Licence;
- the welfare of the Foundation Trust.

2.2.2 The procedure for a situation in which the Council of Governors as a whole is in dispute with the Trust Board is covered in section 42.0 of the Trust Constitution. It is noted that the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute. The Chair has the authority to make a decision on behalf of the Trust, which will communicated in writing, to all members of both the Trust Board of Directors and the Council of Governors.

2.2.3 Governors should acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council, or the provisions of this policy, to impede the Board in fulfilling its duty.

3.0 DUTIES IN RELATION TO COMMUNICATION AND ENGAGEMENT

3.1 Throughout this document the Vice Trust Chair will deputise for the Trust Chair if and as required.

3.2 **Trust Chair/Vice Chair**

The Trust Chair/Vice Chair:

- acts as the principal link between the Council of Governors and the Trust Board and will therefore, have the main role in dealing with any issues raised by Governors, and will involve the Chief Executive and/or the Chief Finance Officer and other Directors as necessary;

- ensures that the Trust Board and Council of Governors work together effectively and enjoy constructive working relationships (including the resolution of any disagreements);

- ensures good information from and between the Trust Board, Committees, Council of Governors and members and between the Senior Management and Non-Executive Directors, members of the Council of Governors and Senior Management;

- ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties;

- constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate);

- encourages the participation of the Trust Board in the induction, orientation and training of Governors as required.

3.3 **Chief Executive**

The Trust Chief Executive:

- ensures the provision of information and support to the Trust Board and Council of Governors and ensures that Trust Board's decisions are implemented;

- facilitates and supports effective joint working between the Trust Board and Council of Governors;

- supports the Trust Chair in their task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Trust Board, elected and appointed members of the Council of Governors and between the Trust Board and Council of Governors;

- with the Trust Chair, ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties;

- with the Trust Chair, constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate);

- supports the Trust Board to request the Trust Chair to seek the views of the Council of Governors on such matters as the Trust Board may from time to time determine.

3.4 **Senior Independent Director**

The Senior Independent Director:

- can act as an alternative source of advice to Governors from the Trust Chair;

- shall be available to Governors if they have concerns which contact through the normal channels of the Trust Chair, Chief Executive and Chief Finance Officer has failed to resolve any issues which have been raised or for which such contact is inappropriate.

3.5 **Governors**

- Individual Governors have a responsibility to act in accordance with this policy, to raise concerns (as defined in this policy), and to assure themselves that issues have been resolved. In addition, the Council of Governors as a body has a duty to inform NHS England if the Trust is at risk of breaching the terms of its Licence.

- The Lead Governor shall make themself available to provide informal advice to any Governor who may seek it in advance of a concern being raised with the Director of Corporate Governor or the Trust Chair.

3.6 **Director of Corporate Governance**

As Trust Secretary for the Trust, the Director of Corporate Governance shall:

- be a further point of contact for any Governor or group of Governors who wish to raise a concern covered by this policy, and where possible, resolve the matter informally and/or advise as to whether it is appropriate to the take the concerns to the Chair; and

- arrange informal meetings between Governors and Directors (including the Trust Chair and the Chief Executive) outside of formal Council of Governor meetings to answer questions and confirm decisions taken by the Trust Board (where appropriate) where requested to do so by the Trust Chair.

4.0 ACTIONS

4.1 Holding to Account

4.1.1 The relationship between the Council of Governors and Trust Board is critical and there are a number of ways an open and constructive relationship can be achieved between the two. Non-Executive Directors and Governors should have the opportunity to meet at regular intervals and Governors should feel

comfortable asking questions regarding the management of the Trust. Executive Directors should keep Governors appropriately informed, particularly about key Board decisions and how they affect the Trust and the wider community via their reports to Board committees and the subsequent Committee Highlight Report to the Governor Assurance Group and Trust Board meetings. Governors are also invited to attend Trust Board meetings and have access to the associated documentation.

4.1.2 Governors will hold the Trust Chair and other Non-Executive Directors to account partly through effectively undertaking the specific statutory duties summarised here:

- Governors are responsible for appointing the Chair and other Non-Executive Directors and may also remove them in the event of unsatisfactory performance;
- Governors have the right to receive the annual report and accounts of the Trust, and can use these as the basis for their questioning of Non-Executive Directors;
- Governors have the power to appoint or remove the external auditor;
- Directors must take account of Governors' views when setting the Forward Plan for the Trust, giving Governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in the strategy. Where Directors put a proposal in the forward plan for an activity outside of the principal purpose of the Trust, the Governors must decide whether carrying on the activity, to any significant extent, interferes with the Trust's principal purpose, and must notify the Directors of its determination. However, Governors should understand there may be valid reasons why member views cannot always be acted upon. Governors and Non-Executive Directors should have enough time to discuss these matters so Governors can be satisfied with the reasons behind the Board decisions;
- Governors have the power of approval on any proposal by the Trust Board to increase non-NHS income by 5% a year or more. They therefore need to be satisfied with the reasons behind any such proposals;
- Governors also have the power to approve amendments to the Trust's Constitution, approve 'significant transactions' and approve any mergers, acquisitions, separation or dissolution and will need to be satisfied with the reasons behind any proposals (as per Section 45 of the Trust Constitution).

4.1.3 It is clear that there are already a number of well-defined mechanisms in existence within the Trust for Governors to receive or seek information from and hold the Board and the Directors and Non-Executive Directors to account including:

- receiving the agenda and minutes of Board meetings and requesting any specific papers. Governors are also invited to attend Trust Board meetings and have the opportunity to ask questions as public members on the contents of the Board minutes and decisions at Council of Governor meetings;

- receiving the annual report and accounts and asking questions on their content;

- receiving the annual Quality Account and asking questions its content;

- receiving in-year information updates e.g. finance, performance ,quality and workforce and asking questions on their content;

- receiving performance appraisal information for the Trust Chair and other Non-Executive Directors, via the Appointments & Remuneration Committee, and using this to inform decisions on remuneration for the Trust Chair and the other Non-Executive Directors;

- the attendance of the Chief Executive, other Executive and Non-Executive Directors at Council of Governors meetings and using these opportunities to ask them questions;

- the attendance of the Chief Executive, other executive and Non-Executive Directors at the annual review of performance of the Council of Governors;

- receiving information on internal consultations, developments and media releases;

- receiving information on issues or concerns likely to generate adverse media interest and providing Governors with the opportunity to raise questions or seek information or assurances;

- involvement of Governors in the Trust's strategy and planning process through the holding of an annual planning / briefing session for Governors led by the Chief Finance Officer.

4.1.4 The following additional measures (some of which are mandatory under the Health & Care Act), are intended to support Governors in their role and to ensure that Governors are well briefed about the decisions which they may be required to make and the context in which the Trust Board is working. This includes the requirements of relevant external stakeholders including Commissioners, NHS England and the Care Quality Commission, have and are being introduced:

- engagement with Directors to share concerns or raise questions about performance, such as by way of joint meetings between the Council of Governors and Non-Executive Directors (which can be conducted within the Governor Assurance Group) or separately and without the Trust Chair (and in private) if required;

- receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions and questioning the Directors on these;

- receiving information on documents relating to non-NHS income, in particular any proposals to increase this by 5% a year or more, and questioning the Directors on these;

- the holding of Governor briefing and training opportunities, not least in order to ensure that Governors are equipped with the skills and knowledge they require in order to fulfil their role;

- the attendance of the Chair of the Governor Assurance Group at meetings to set the agenda for the Council of Governors;

- each Council of Governors meeting to include a briefing(s) for Governors from the Trust Chair, Chief Executive or appropriate Executive Director or senior officer;

- the submission of a formal bi-monthly briefing from the public Trust Board to Governors on key decisions made following each Board meeting;

- the provision of an annual report to the Governor Assurance Group from each Trust Board committee Chair to include the outcome of the annual review of performance and in turn a report from the Governor Assurance Group to the full Council of Governors;

- Governors have elected a Lead Governor (and a Deputy Lead Governor to deputise when the Lead Governor is unavailable). This role has specific responsibilities in terms of Governor and Board engagement built into the role description for this position. Joint meetings regularly take place between the Chair, Lead Governor, Deputy Lead Governor and the Director of Corporate Governance. Feedback from these meetings is provided to the Governor Assurance Group.

4.1.5 Additional statutory means available to Governors for holding Non-Executive Directors to account (where serious concerns exist and in extreme circumstances):

- dialogue with NHS England via the lead Governor. **Note**: "The existence of a lead Governor does not, in itself, prevent any Governor making contact with NHS England directly if they feel it is necessary" but see also 4.3.3 below.

4.2 Raising Concerns

4.2.1 Governors should not raise concerns that are not supported by evidence. That evidence must satisfy the following criteria:

- any written statement must be from an identifiable person or persons who must sign the statement and indicate that they are willing to be interviewed about its contents;

- other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

4.2.2 Newspaper or other media articles will not be accepted as prima facie evidence, but may be accepted as supporting evidence.

4.2.3 Governors (operating as a group or on their own) may raise concerns in the following circumstances:

- the performance of the Trust Board;

- compliance with the Trust's Provider Licence; or

- other matters related to the overall wellbeing of the Trust.

4.2.4 Notwithstanding the central role of the Trust Chair in providing the link between the Council of Governors and the Trust Board, it is highly recommended that any Governor or group of Governors who have concerns covered by this policy should, in the first instance, consult the Director of Corporate Governance for advice and guidance. They will seek to resolve the matter informally and will certainly be able to advise the Governor/s on the acceptability of the evidence offered and so whether it is appropriate to take their concerns to the Trust Chair. The advice of the Director of Corporate Governance is not, however, binding upon the Governor/s and they retain at all times the right to raise the matter with the Trust Chair. For concerns which it would be inappropriate to raise with the Trust Chair, for example, regarding his or her own performance, the role of the Trust Chair as described in this section will be undertaken by the Senior Independent Director.

4.2.5 The Trust Chair (or Vice-Chair if the dispute involves the Chair) shall investigate all concerns brought to them by Governors, involving the Chief Executive and/or the Chief Finance Officer at their discretion. The Trust Chair will endeavour to resolve the dispute informally, through discussions within the Council of Governors following investigation which shall include a review of the evidence offered and discussions with Trust officers as appropriate.

4.2.6 As soon as practicable after the conclusion of the investigation the Trust Chair shall meet with the Governor/s to discuss the findings. This meeting has three possible outcomes:

- the Governor/s are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required;

- the Governor/s are satisfied that their concerns have been resolved during the course of the investigation. The Trust Chair shall write a report on the concerns and the actions taken and present this the Council of Governors;

- the matter is not resolved to the satisfaction of the Governor/s. The Trust Chair shall call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution to consider the matter further. That meeting may choose either to take no further action or, if two thirds of the Governors present agree, to invoke the escalation process described from section 4.3.1 onwards.

4.3 **Escalating Concerns**

4.3.1 At this stage of the process the Senior Independent Director takes over the lead role from the Trust Chair. Should the Senior Independent Director be unavailable, or be prevented from participating because of a conflict of interest, then the Council of Governors may choose any other Non-Executive Director to fulfil the role.

4.3.2 The first duty of the Senior Independent Director is to establish the facts of the matter. This will be accomplished by reviewing the evidence offered by the petitioner/s, the process of the investigation and any documentation produced and also by meetings/interviews with the Governor/s and any Trust officers involved. In carrying out this process the Senior Independent Director shall seek the agreement of all interested parties and shall have the authority to commission whatever legal or other advice is required.

4.3.3 Once the facts are established to their satisfaction, the Senior Independent Director shall make a decision on the course of action to be followed in the best interests of the Trust and shall describe the reasons for that decision in a written report. The decision of the Senior Independent Director shall be binding upon the Trust. In the first instance, the Senior Independent Director shall present the decision and the report to the Governor/s and to interested parties within the organisation.

4.3.4 The Trust Chair shall then, at the request of the Senior Independent Director, call a closed extra-ordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the Senior Independent Director to present his or her report and decision and for the council to give its response. Three outcomes are possible:

- the Council accepts the decision of the Senior Independent Director. In this case no further action is necessary;

- the Council does not accept the decision of the Senior Independent Director but chooses not to escalate the matter further. No further action is prescribed by this policy but the Council of Governors may choose to keep the matter under review at future meetings;

- the Council votes to refer a question for legal review. The seriousness of the latter cannot be overemphasised. If such a question or any other important issue or uncertainty arises, Governors should always seek to discuss it in the first instance with the Trust Chair or another Non-Executive Director. NHS England strongly encourages all FTs and

Governors to try to resolve questions internally before posing a question for legal review only as a last resort. The Council of Governors should only consider referring a question for legal review in exceptional circumstances, where there is uncertainty within the Council about whether the Trust may have failed, or is failing, to act in accordance with the Trust's Constitution or with Chapter 5 of the 2006 Act, and this uncertainty cannot be resolved through repeated discussions with the Trust Chair or another Non-Executive Director.

A Governor may only refer a question for legal review if more than half of the members of the Council of Governors voting approve the referral. Individual Governors may not bring a question for legal without the approval of the Council as a whole. It is noted that once a legal response is provided, the Trust will not necessarily be required to adhere to the legal advice provided.

5.0 MONITORING COMPLIANCE AND EFFECTIVENESS

This policy will be kept under review, compared with the provisions developed by other Foundation Trusts and revised in accordance with emerging best practice and national guidance.

6.0 ASSOCIATED DOCUMENTS AND REFERENCES

6.1 NHS Code of Governance for Provider Trusts 2023

6.2 Trust Constitution

6.3 Monitor Your statutory duties: a reference guide for NHS Foundation Trust Governors, Monitor, 2013

6.4 Addendum to 'Your statutory duties – a reference guide for NHS foundation trust governors' 2022

6.5 National Health Service (NHS) Act 2006

6.6 Health & Social Care Act 2012

6.7 Health and Care Act 2022 (the Act)

7.0 DEFINITIONS

Chair means the Trust Chair of the Trust appointed in accordance with the Constitution.

Chief Executive means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with the Constitution.

Constitution means the Constitution of the Trust.

Council of Governors means the Council of Governors of the Trust as constituted in accordance with the Constitution.

Director means a person appointed as a Director on the Board of Directors (whether executive or Non-Executive Director) in accordance with the Constitution.

Director of Corporate Governance is the Company/Trust Secretary of the Trust.

Governor means a member of the Council of Governors, being either an elected or an appointed Governor.

Independent Regulator the independent regulator of Foundation Trusts known as is NHS England (NHSE), previously Monitor.

Lead Governor means one Governor appointed by the Council of Governors to communicate directly with NHS England in certain circumstances.

NHS England is the independent regulator of NHS Foundation Trusts and Trusts (and superceded Monitor).

Petitioner(s) is a Governor or Governors raising concerns under this policy.

Provider Licence means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006.

Senior Independent Director means the Non-Executive Director appointed by the Trust Board to provide an alternative to the Trust Chair as source of advice to Governors.

Trust means the Northern Lincolnshire and Goole NHS Foundation Trust.

Trust Directors means the Board of Directors as constituted in accordance with the Constitution.

8.0 DISSEMINATION

8.1 This policy will be made available to Trust staff as a controlled document on the intranet/hub.

8.2 This policy will be distributed to all Governors as soon as possible after their election or appointment and whenever it is revised.

9.0 CONSULTATION

9.1 Council of Governors.

9.2 Trust Board.

10.0 EQUALITY ACT (2010)

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

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

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

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

11.0 FREEDOM TO SPEAK UP

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this policy, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Trust's Freedom to Speak Up Policy and Procedure (DCP126). Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg.tr.ftsuguardian@nhs.net. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian or with one of the Associate Guardians can be found on the Trust's intranet site.

NLG(23)185

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	3rd October 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 – July and August 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 July and August 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

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 25 July 2023 from 1.30pm to 4pm
Via MS Teams

Present:

Kate Truscott	Non-Executive Director **(Chair of the meeting)**
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director

In attendance:

Dr Kate Wood	Chief Medical officer
Ellie Monkhouse	Chief Nurse
Jenny Hinchliffe	Deputy Chief Nurse
Shaun Stacey	Interim Chief Executive
Ashy Shanker	Interim Chief Operating Officer
Abdi Abolfazl	Deputy Chief Operating Officer
Richard Dickinson	Associate Director of Quality Governance
Nicky Foster (item 194-95/23)	Deputy Associate Chief Nurse, Midwifery
Debbie Bray (item 196/23)	Associate Chief Nurse, Family Services
Elaine Graham (item 197/23)	Interim Associate Director, Path Links
David Welburn (item 198/23)	Mental Capacity and DoLs Specialist Nurse
Jo Loughborough (item 201/23)	Patient Experience Lead Nurse
Belle Baron-Medlam (item 202/23)	Interim Inspection Compliance & Assurance Manager
Ian Reekie	Governor (observing)
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

188/23 Welcome and Apologies for Absence

Apologies for absence were received from: *Fiona Osborne, Ellie Monkhouse first part of the meeting (Jenny Hinchliffe to rep), Ashy Shanker first part of the meeting (John Awuah to rep), Lydia Golby,*

189/23 Opening remarks

Kate Truscott welcomed members to the meeting and advised that she would be chairing the meeting in Fiona's absence. All papers would be taken as read and

attendees would be asked for a two minute introduction of their papers emphasising any key points before moving on to questions.

190/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

191/23 To Approve the Minutes of the Previous Meeting held on 20 June 2023

The minutes were accepted as an accurate reflection of the previous meeting.

192/23 Matters Arising

There were no matters arising.

193/23 Review of action log

137/23 Maternity Safety Oversight Update, request for update on three year plan – the benchmark was included in the report last month so covered the update on the three year delivery plan. **Action closed**

137/23 Maternity Safety Oversight Update, Jenny Hinchliffe to request the safety mailbox section in the Maternity Report to include the Mitigations for unresolved actions next month. – the mitigation would be included in the updated plan and would be included in the August report. **Action date to be changed to August.**

139/23, Annual Safe Staffing Review – This has been raised with the Chair of Finance and Performance (F&P Committee). The following response had been received. "The F& P Committee understand that the bed configuration will not increase the bed base and therefore staffing levels. It would configure the current bed stock in the most appropriate financial and workforce reliant way using economies of scale through opening not just one or two beds but instead opening a whole ward to achieve those economies of scale. Consolidation of HOBS beds and work to reduce medicine LOS will support the model. As a result, no additional funding will be required and patient quality of care can be maintained." Shaun Stacy did raise a caveat that although that was the aim that there no would be no further cost at the moment the Trust was unable to categorically state there would be no further adjustment from the existing bed configuration for its nursing team as the workforce reviews continue. It would take at least six months to embed the review but the detail was correct. The misleading issue was the bed configuration linked to the nursing establishment. **Action closed**

166/23, PSIRF awareness – Richard Dickinson was due to attend the Operational Management Group (OMG) meeting last week however that was stood down due to the Junior Doctors Strike therefore it would be taken to the next meeting.

171/23, Patient Experience Manager post to be discussed at Trust Management Board (TMB) – upon further Executive discussion it was agreed this was not for TMB discussion and an optimal remodelling was being worked on to ensure the service was sustained and to support financial resources. **Action closed.**

173/23, LeDER details, Lydia Golby was going to provide Vicky Thersby with the LeDER details - Laura Coo had checked with Vicky and she was still waiting for this information to come through.

175/23, Nursing and Midwifery Assurance Report including bed numbers - Shaun Stacey had previously mentioned that the report should not include the escalation bed

numbers Jenny Hinchliffe advised that the numbers were still included as they were part of the main data.

176/23, Paediatric Audiology reporting – For context Richard Dickinson explained that the report was taken to the Quality Governance Group (QGG) with the action plan and progress would be fed through from that route. Kate Wood noted that this had already been agreed at a previous meeting so could be removed from the action log. **Action closed.**

178/23 Neonatal Screening - this was an issue concerning the transport of samples out of hours for neonates . A business case was being considered. Richard Dickinson had picked it up with Nicky Foster outside of the meeting. The issue was a greater risk on bank holidays and using Royal Mail so they were monitoring as well as looking at alternatives. **Action closed**

Regular Reports

194/23 CNST Update

Nicky Foster referred to the report distributed which was taken as read and summarised the key points.

The Clinical Negligence Scheme for Trusts (CNST) year five requirements had arrived at the end of May. This outlined a requirement to demonstrate the Trust had achieved all of the ten safety actions as of 1 February 2024.

The only safety action that needed work on was action six, Saving Babies' Lives. Work was ongoing with the care bundle and Nicky did not envisage it would be a problem and they would manage to achieve this.

Nicky invited any comments or questions.

Gill Ponder referred to page 11 of the report, the last paragraph under current position stated that '*There requires to be an oversight report that covers staffing/safety issues to the Trust Board every 6 months during the year 5 period'*. Gill thought that contradicted itself. Nicky clarified there needed to be an additional review in between those times.

With regards to the Saving Babies Lives care bundle Gill asked if they were on track to do that. Nicky confirmed that was the case.

Sue Liburd commented that she was aware of Nicky's depth of understanding for CNST but felt the report was a little bit more educative and at points lacked clarity. In terms of assurance ,Sue had limited assurance from the report but acknowledged that her own understanding of the subject had assisted her rather than the detail of the report.

Richard Dickinson wondered whether having an action plan with a breakdown of the steps needed to be taken to gain compliance might help. i.e. for Saving Babies Lives although there were some elements not met there was most likely a plan in place and that might be a useful way to bring the updates together.

Action: Nicky Foster to bring an action plan including timescales to the next meeting.

195/23 Maternity Safety Oversight (including Ockendon & metrics)

Nicky Foster referred to the report distributed which was taken as read and highlighted the key points.

Workforce

- The midwife to birth ratio in April was 1:22 which was below the acceptable level of 1:28 ratio is within the expected range of 1:28
- The Midwifery vacancy rate was slowly improving although remained challenging.
- The Pastoral and Retention Midwife role of supporting midwives, specifically for newly qualified Midwives had had a positive impact on the new cohort of midwives and the overall service.
  Hayli Garrod had been recruited to the Maternity Audit and Compliance Manager post and Natalie Jenkin to the Maternity Matron DPoW post
- The Head of Midwifery and Deputy Governance Lead posts were in the recruitment process

A Maternity Learning event was due to be held in October and Ockenden would be incorporated into that.

Nicky highlighted that the Maternity Triage service Phase one was in place and hoped progression of phase two would commence in October. This would be a physical service cross site. Both HR and Estates were working with the Division to progress this.

NLaG was on the Maternity Safety Support Programme hosted by NHS England via the National Maternity Team. The Division had had a positive meeting with the NHSI Maternity Support Midwife ED observation to review the sustainability plan. It would now progress through the national and regional processes over the next 3 months.

Sue Liburd referred to the beginning of the report under item one Workforce / Staffing where it mentioned escalation of staffing levels and covering wards and asked how often that occurred. Nicky estimated it was once or twice a month. It was generally Blueberry Ward which was consolidated.

Sue had noticed that there were some escalations outstanding that had been raised as part of the Maternity walk-arounds ie. one from March about the hydration stations and wondered how long they took to be actioned. Nicky advised that action had been put on hold, but the cages action had now been closed.

Sue referred to the action log and the action dated 19th October about a hole in the theatre floor. It was raised in July 2022 and was still there in July 2023 there only seemed to be email exchanges noted but no action. Sue asked what could be done to move this forward quicker. Nicky believed the theatre floor had been fixed.

Gill Ponder referred to page 12 of the report and asked what the 'WAT" survey' was and why there was only one out 12 completed. Nicky clarified that was the Ward survey and that meant that one out of 12. This did not correlate with the 88% completed figure.

Referring to page 12 again Gill commented that complaints numbers and page 10 did not align. Nicky knew there was an issue with the data pulling through as an inconsistency in the data was picked up at Trust board too.

Sue noticed that the updated guidance and process for the Induction of Labour (IOL) Improvement (page 18) was due to go live on 22nd June and wondered if that had happened. Nicky confirmed that it did go live and that communications had been

distributed ensuring consistency cross sites and all women being given the same opportunities.

Nicky Foster left the meeting at 2.08pm

196/23 Children & Young Persons Update (including facing the future)

Debbie Bray referred to the report distributed which was taken as read and highlighted the key points.

There had been a reasonable amount of progress made across all workstreams and it was finally becoming a business as usual mindset. Key challenges remained around financial investment particularly focused on workforce. They were still reliant on some of the wider spread service configurations happening before changes could be made.

Debbie invited any comments or questions.

Gill Ponder referred to page 14 referencing that discharge papers were intermittently problematic and asked what was being done to address that. Debbie explained that it was the doctors' responsibility to complete the discharge letters within the timeframe. The Clinical Leads on both hospital sites were well sighted on the challenges and were trying to embed into practice completing them at the time of actually seeing the patient during Ward round rather than letting them build up. Compared to where we were six months ago the position had massively improved and only occurred intermittently now. Gill thanked Debbie for the explanation as that gave more assurance and . that it was moving in the right direction. However, that position was not conveyed within the report.

Page 25 referenced financial investment required to achieve standards and the incompatibility of HASR timelines. Gill was interested to understand how that impacted plans to meet the standards and asked what was being done to address that.

Ellie Monkhouse joined the meeting at 2.10pm

Debbie felt that the pace of the HASR programme should not dictate the service improvements that needed to be made moving forward. This was about the organisation not being constrained by HASR timelines but keeping in mind that there would a considerable amount of work over the next couple of months to align NLaG to be HASR ready. The risk was being mitigated and there was limited concern. They were particularly focusing on workforce. They mitigated the risks robustly across the Divisions and had a clear escalation process in place for Nursing and Medical staffing workforce requirements.

Sue Liburd referred to the area that was highlighted as red on page 19 about the challenges for a link Consultant Paediatrician for each local GP practice group. It read as though the mitigations in place were really solid so Sue questioned what else other than the existing mitigations was being done to address that. Sue also asked if they felt their mitigations were suitable then why was it still red.

Debbie felt it was reasonable mitigation but it was always a bit of a dilemma as to whether to mark an action red or amber but the reason that was still red was because they had not managed to progress with it as they did not have an identified consultant link with GP practices and our Clinical Leads. Work was ongoing with colleagues in

Primary Care and consultants did have a link with GPs but they did not actually meet the standards which was why it was red.

Kate Truscott thanked Debbie Bray for the update.

Debbie Bray left the meeting at 2.18pm

197/23 Pathlinks Update

Elaine Graham referred to the update distributed which was taken as read and highlighted the key points.

Since the last meeting Pathlinks had been subject to many external assessments and all were progressing quite well.

The UKAS inspection resulted in minimal findings and the teams were recognised for their commitment to the quality management system. Evidence had been submitted to address the findings and outcomes were pending, they were not anticipating any issues.

Following the visit from MHRA, minimal findings were documented and the teams were complimented on the effectiveness of the QMS. The associated action plan had been approved by MHRA. This was being led by the Hospital Transfusion Committee.

The CQC action plan for the mortuary was on target and was meeting the target dates for actions.

Operation risks – a number of risks had been removed however the potential impact of high temperatures on service delivery remained. There were mitigating actions and Business Continuity Plans are in place but were limited due to the estate.

New equipment had been provided within all Directorates to enable repatriation of some tests improving turnaround time and range offered.

Kate Truscott thanked Elaine Graham for providing a comprehensive summary.

Kate Truscott asked about the operational risks. They had mitigated most of the risk and put business continuity plans in place for most of them which were mostly relating to high temperatures and the ability of the equipment to continue to operate in excessive heat. The fact they were a network service gave them the resilience they would not have otherwise to be able to cope with some of that. They were going out to tender to replace equipment, the suppliers would look at the provision of the environment and whether equipment would be suitable. Any additional alterations to that cooling should be proposed as part of the main blood sciences tender for at least the blood site areas and they were in the middle of rolling out provision of equipment.

Sue Liburd referred to the key points of concern with mitigation noted within the update and queried why they had a high turnover of staff and asked if they were happy with their mitigation. Elaine stated that they knew why they had issues. Boston for example was a particularly difficult site to recruit to mainly due to location. The University of Lincoln hub were mitigating by supporting from fellow sites because they are a network and were looking at how training resources could be shared to minimise the burden of repeated training that could be done centrally. They also had a high turnover of Band Two and Band Three staff but that was more to do with the cost of living pressures forcing staff to consider alternative careers and look outside the NHS to improve their

earnings. They were trying to give staff career opportunities by developing them and hopefully creating more interest in the roles.

Gill Ponder referred to page 12 which mentioned that a staff consultation was in development but wondered what that meant and what could be done to expedite that to recruit additional people for the seven day service. They had already gone out to recruitment for the seven day service but that service would take time to implement as staff would need to be trained etc which was not something that could be delivered quickly. They were currently working a five day service which was why it had to go out to consultation since this would present a change in staff terms and conditions of service.

In terms of the back log some work had been outsourced to help them catch up as the locum staff had had leave which had caused the backlog to build. There was always a backlog and at the moment it was running approx. 800 cases higher than it should be and approx. 600 had been outsourced. This was the first time they had needed to outsource in a while but they did not want that backlog to build up again.

Kate Truscott asked about the recruitment and retention premium that they were thinking of introducing and if there had been any progress with that. Elaine did not think it was the solution because of the staff grades involved. They were conscious that they needed to maintain grade alignment otherwise the agreement model would not be met for the service going forward.

Kate Truscott thanked Elaine for the update.

Elaine Graham left the meeting at 2.30pm

198/23 Quality Priority 2 - Mental Capacity

David Welburn referred to the presentation distributed which was taken as read and highlighted the key points.

Quality Priority Two concerned the Mental Capacity Act and improving the performance and experience of our patients and their families. David had recently been appointed as the Named Nurse for MCA DoLs.

Following staff attendance at Quality Improvement session four months ago, a quality action plan had been produced.

There was a varying level of degrees of understanding of the Mental Capacity Act. The plan had been to start work on three wards doing some intense supervision, however, due to limited capacity, that had been reduced to one ward. The work would commence with an audit.

The team had RAG rated the capacity assessments and the best interests documentation which the staff group had completed on Ward basics at Grimsby.

The Quality & Audit team had been extremely helpful and had provided Microsoft forms for staff to use to streamline the process. This gave a clearer presentation of the data and gave a better understanding of staff's level of competence.

Starting on Ward B6, David had identified one day a week for support and was always available through email and virtually. A working group was to be established ,comprising key Nurses, Managers and Divisional Leads to cascade what works well. This would be rolled out to Community Services. There were some clinical pressures on the Ward so David had to be sensitive to this and leave at an appropriate time.

Resources were a little short at the moment so the project had to be scaled down .Engagement from the Divisions had been slow but with the help of Fiona Moore from the Quality Assurance Team, David hoped that the situation would start to improve. All the data that had been collected was off WebV.

Kate Wood thanked David for the update. This had clearly been chosen as a quality priority because of the challenges presented by the successful implementation of the requirements of the Act. David had brought some of that realism to the presentation., The issue could not be resolved overnight. Kate suggested that it would be useful to have clarity on targets and timescales for action in future reports so that if additional support were needed this could be taken into account.

Although it was challenging the Trust was not alone, the NHS nationally were struggling with the Mental Capacity Act so NLaG was not in an unusual position.

Gill Ponder asked how long David would be on his own. David's previous post was currently out to advert so would hopefully be filled soon.

David Welburn left the meeting at 2.40pm

199/23 IPR

Dr Kate Wood referred to the report distributed which was taken as read and highlighted the key points.

The Trust currently has no means of benchmarking mortality rates since the transfer to CHKS has not yet taken place. Kate advised that we were aware the SHMI rate was down but not the detail and ratios to be able to understand the breakdown of figures.

Kate also raised her concerns about doctors ability to conduct Structured Judgement Reviews (SJR) going forward. It had always been a challenge to get medical staff to complete them but great progress had been made using the system supported by NHSE. NHSE having withdrawn their support. The lack of a suitable system could compromise that positive position. When the doctors inputted the data it was not stored safely and was often lost which meant doctors were not willing to waste their time completing them. At the moment the doctors do not have the ability to drill down into the detail of care. A business case proposal had been put forward to get another system bolted on to what we had already but IT needed to work on it. If the Trust were not able to put that solution in place Richard Dickinson was to design something on Microsoft teams. Kate Wood was aware the themes would not change overnight but Kate was worried that when we did get another system in place doctors would need to be retrained and re-educated which would take time. This was already on the risk register.

Ellie Monkhouse highlighted that unfortunately the IPC national targets had not been changed on the IPR and the C.diff target continued to be a significant challenge. The target had been reduced to 20.

Ellie pointed out that there had been four Mixed Sex Accommodation (MSA) breaches not nine as stated in the report.

Ellie invited any comments or questions.

Gill Ponder referred to page nine of the dashboard where it referred to observations where it stated the recording and response rate for recording NEWS 2 score for unplanned critical care admissions was 42.9% which seemed quite low. Linked to that the percentage of adult sepsis screening completed within 15 minutes in response to elevated NEWS 2 score was low too at 21.8%. Kate Wood pointed out that the run chart showed improvements in sepsis screening in general. Compliance had doubled in the Trust from 25.8% in December to 51.2%.

Hopefully, the narrative, numbers and charts would be updated for the next iteration of the report.

Ellie highlighted the Community pressure ulcers were not included in the report this month because there was a data issue,- the numbers appearing in the IPR were significantly different to the numbers they had reviewed. Ellie added that the majority of the Community pressure ulcers that they had looked at this month were in care homes.

200/23 Nursing & Midwifery Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read.

Ellie highlighted the differences between the IPR and this report and noted that pressure ulcers was not included as there was a data issue.

The majority of the Community pressure ulcers they had looked at this month were in care homes. There was a very complex stage four case which was down to deterioration . There was found to be no lapse in care it was just an unfortunate rapid deterioration.

Kate Truscott referred to page seven of the report and the fill rates for some wards there seemed to be an issue with nights and significant levels of sickness absence particularly on Ward 17 the registered nurse fill rate was 36%. That did not mean they had 36% of nurses on the Ward but Ellie agreed it was low but quite normal too and that was why it was highlighted to ensure there was no potential concerns around care. There was an increase in agency staffing and the long standing Ward Manager had retired. There was also some very long standing agency staff who had probably been there longer than some of our substantive staff who tended to work in these areas as well. This was all triangulated but for openness and transparency was brought here to demonstrate how carefully these areas were monitored as well as the standards they were delivering.

Sue Liburd asked where the conversations were taking place about finance versus the care provided. That was some of Ellie's nervousness around the assumptions that a change in bed base would not cost anything. We needed to carefully consider demographics and acuity when reviewing staffing numbers and bed numbers.

How we manage patients with supportive needs was discussed. It was highlighted there is currently no mechanism for identifying and funding this within the establishment. Our use of supportive observation was probably lower than other organisations because we look at things differently. However, there is no budget provided for providing care for these patients who need a more intense level of support, and that can come in many

shapes or forms. Our role is to make the environment as safe as possible for those patients and some of that is around that supportive observation, and it is an area of nursing that is not getting looked at in terms of what care is going to look like in the next five to ten years.

Sue Liburd wondered if there was a need for a board session on patient acuity and the financial implications. Shaun Stacey supported that idea. Ellie suggested it should also be included as part of a workshop. The Board had a Deep Dive on Workforce scheduled at the next Trust Board meeting which was an opportunity to raise this point.

Kate Truscott would include a summary of this conversation in the highlight report to the Board.

201/23 Complaints Annual Report

Jo Loughborough referred to the report distributed which was taken as read and highlighted the key points.

Jo invited any comments or questions.

Sue Liburd asked how common a “failure to resolve” was. Jo stated that 25% of those cases were from families who had suffered a loss and that for some families nothing could ever be done to remove the feeling that they had been let down. Gill Ponder asked what follow was in place to share the learning.

Jo explained that there was an electronic learning log, however the transition from Datix to Ulysses had created a delay which was now resolved and everything was stored in a central place. It was still work in progress and in a pilot phase so was reliant on the clinical team to guide the non-clinical team to make sure the learning was reflective of what needed to be done. All suggestions from learning lessons would be reflected in the learning log and would be fed into the PSIRF work about what needed to be fed out into the whole organisation. Ellie Monkhouse thanked Jo and the Team for their hard work over the last three years. It had not been an easy job and they had basically changed the whole complaints process.
Kate Truscott seconded that on behalf of the Committee and did not underestimate the challenges it had presented to the team. Jo felt the Complaints team had a really good working relationships with the Divisions which massively helped too.

Jo Loughborough left the meeting at 3.20pm

202/23 CQC Framework

Belle Baron-Medlam referred to the report distributed which was taken as read and highlighted the key points.

A number of actions had passed the timescales initially set. This had been due to the Division and leads needing to have a full understanding rather than any misjudging of timings.

Sue Liburd referred to page three of the update about relating to really core practices requiring being re-opened and wondered why as they were core to surgical behaviour and activity. Belle would clarify that at the next meeting. Kate Wood added that was

part of the reason that we did sense checks and was about embedding rather than just signing off. We are all human and sometimes it takes a long time to embed practice and sometimes it was not always sustained. This was a process that Belle had put into place which Kate Wood thought was brilliant practice which meant there was just a bit of additional work to be done to get something sustained. Sue thought Kate Wood made a very valid point that for any change the moment you relaxed you get a change in behaviour. Shaun Stacey agreed and thought the process that NLaG followed was good. The more important thing was that this had been observed and the reality was that looking at the biggest reason for lapses in care or process was down to culture. Kate Wood added that it was impossible to monitor everything all of the time which was why we had priorities and robust assurance processes before anything was signed off and that was why we go back and check things.

The action from the last meeting for Belle to speak to Ashy around temperature monitoring in rooms not in fridges. Belle had not needed to speak to Ashy as Simon Priestley had contacted Belle and it would be rolled out in the next three to four weeks.

203/23 Register of External Agency Visits

Belle Baron-Medlam referred to the report distributed which was taken as read and highlighted the key points

Previously there had been comprehensive discussion about the format of the report and how it could be more assurance focussed.

Action plans were still being loaded onto the hub and there were no visits recorded as open.

The Quality Governance Group (QGG) recommended 10 visits for closure and all were approved.

The closure and notification forms had been slightly amended based on feedback and were approved by QGG.

There were no comments or questions.

Belle Baron-Medlam left the meeting at 3.32pm

202/23 Key SI update including Maternity

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points.

There had been three maternal SI's; one was a patient who had a cardiac arrest who fortunately survived and went home and two maternal deaths last year. One patient lived in the Lincoln area and chose to deliver at DPOW. An email was received from Lincolnshire Local Maternity and Neonatal Systems sadly notifying us of the maternal death at 23 weeks gestation. HSIB were contacted, the patient's partner did not consent to sharing the patients record and so this was declined. The onus for investigation then fell on the Trust.
The more recent tragic case was tragic was of a patient with a normal vaginal delivery. The patient had a complex set of medical issues and discharged herself with a raised BP. 12 days post natal the community midwife who was due to visit was informed by the patients partner that the patient had died at home following a seizure.

The Trust was notified by the Nottingham Regional Cleft Palate Centre of two children with delayed diagnosis of cleft palate. This had resulted in hearing loss and significant speech and language impairments and lack of support for families in the early stages with regards to feeding, health issue and speech and language development. An SI investigation was to be conducted due to the harm and learning around missed opportunities to diagnose.

205/23 Potential Deviations from National Documentation

Richard Dickinson advised there were not any deviations to discuss.

206/23 PSIRF update

Richard Dickinson referred to the update distributed which was taken as read and highlighted the key points.

Richard had used some discrete bullet points in context of what they were working on. Richard had planned to attend the Operation Management Group (OMG) last week however that did not go ahead due to the Junior Doctors strike so would attend the next one.

Kate Wood added that previously Angie Legge came to a board development day to give a briefing about what PSIRF was in the very early stages and it might be worth Richard doing something similar again. Sue Liburd thought there would be real value for everybody knowing about it and agreed a briefing was a good idea.
Kate Wood suggested taking it to Trust Management Board (TMB) too.

207/23 Board Assurance Framework (BAF)

Kate Truscott referred to the report distributed which was taken as read and highlighted the key points.

The Committee were asked to review the BAF Appendix 1 and to note the current risk rating which was 15 as well as the high level risks and the planned actions.

Gill Ponder referred to the risk appetite, if our target was still to be 15 by the end of March 2024 and was currently 15 what was being done to reduce it. Richard Dickinson thought the BAF was ready for a refresh and perhaps needed to be structured differently. This also linked to some other work in terms of reviewing the risk strategy.

Kate Truscott asked if the risk was reduced due to those additional actions being put in place. Had a target score of 15 but a risk appetite of four to six which did not seem appropriate.

Ellie Monkhouse did not feel the Trust could go below 15, particularly at a time when the Trust was going into a huge transformation process with a huge workforce element all of which would affect sustainability and improvement. Once transformation is completed this would be revisited.

Richard added that there was a Risk Management meeting held each month. Richard felt there was plenty more that could be done to improve it and would be happy to be involved to help improve it. Kate Wood finds the BAF very large and cumbersome and

did not feel it articulated the risks properly. It would be better to have a view of strategic risks rather than just operational risks. As it stands in its current format all agreed we would be aiming at risk rating of 15.

Kate Truscott took from the conversation that there was no appetite to change the score at this time and concluded that there was no evidence to support changing the score at this time.

Highlight reports

208/23 Quality Governance Group (QGG)

The report was taken as read.

209/23 Mortality Improvement Group (MIG)

Richard Dickinson referred to the highlight report distributed which was taken as read. Sue Liburd asked if there were suitable mitigation in place for the mortality coding process or did it need referring Workforce Committee. The change to coding could have an impact on mortality rates and the risk to exposure. It was important the detail was right so we had that depth of knowledge. Richard thought it was a challenge that needed to be managed in the right places but thought it was important to highlight it. Kate Wood agreed and thought it would be a good idea to report it across to the Workforce Committee. With regards to the SJRs and clinical engagement, we had a really good group of clinicians who sit with the coders. Our mortality rates could potentially fall back and our audit teams would be inundated so this was a real risk to the organisation but Kate Wood thought it should be considered through Workforce Committee. Shaun Stacey did not think it was a Workforce Committee issue and suggested it to go through the Trust Management Board. The operational risk was not being managed because until reading that report Shaun was not aware of the back log building up.
Action: Shaun Stacey to raise at TMB

210/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

211/23 Quality Governance Group (QGG) minutes

Distributed for information.

212/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

213/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

214/23 Any Other Business

None raised.

215/23 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Kate Truscott agreed to add the following points to the highlight report to the Trust Board.

- The Committee received a comprehensive report for Facing the Future
- The Committee received the Annual complaints report
- The Committee received an update on Quality Priority two on Mental Capacity
- It was recommended for there to be some form of Board update on PSIRF
- Issues around coding resource for Mortality
- Pathlinks provided a significant amount of evidence and assurance
- National Dementia Audit assessment etc included in Kishore Sasapu's update.
- SJR issue
- Ellie asked about the outcome of the discussion about the acuity. Sue Liburd would raise that with Simon.

216/23 Meeting review

As a new person reading the papers Gill Ponder felt there was an awful lot of overlap in the information and wondered if they could be slimmed down. There were also a lot of acronyms within the papers.

Linking to Gill's comment Sue Liburd thought there needed to be a discussion about the vagueness and that the reports needed to be tightened up.

Ellie Monkhouse informed that the CNST paper and Maternity papers were not meant to be separate, this had been discussed and agreed previously.

217/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 22nd August 2023
Time: 1.30pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 4.25 pm

QSC Annual attendance log

Name	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023
Michael Proctor	✓	✓												
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	
Maneesh Singh	✓	x	✓											
Dr Kate Wood	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	
Ellie Monkhouse	x	✓	x	✓	x	✓	✓	✓	x	✓	x	x	✓	
Dr Peter Reading	✓	x	x	x	x	✓	✓	x	x	x	x			
Shaun Stacey	x	x	✓	✓	x	x	x	✓	x	x	x	✓	✓	
Susan Liburd				✓	✓	✓	x	x	✓	✓	✓	✓	✓	
Kate Truscott				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 22nd August 2023 from 13:30-16:00
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
Jenny Hinchliffe	Deputy Chief Nurse
Shaun Stacey	Chief Operating Officer
Richard Dickinson	Associate Director of Quality Governance
Lydia Goldby	Nursing Lead for Quality, Northeast Lincolnshire Health and Care
Debbie Bray	Associate Chief Nurse, Family Services
Jennifer Orton	Divisional General Manager – S&CC
Rachel Greenbeck	Deputy Head of Nursing/Service Lead
Ian Reekie	Lead Governor (observing)
Michelle Green	PA to the Chief Medical Officer **(minute taker)**

218/23 Welcome and Apologies for Absence

Apologies for absence were received from: Belle Baron-Medlam represented by Richard Dickinson, Jo Loughborough represented by Mel Sharp, Robin Hewson represented by Rachel Greenbeck,

219/23 Opening remarks

Fiona Osborne welcomed members to the meeting and advised all papers would be taken as read and attendees would be asked for a two-minute introduction of their papers emphasising any key points before moving on to questions.
The case of Lucy Letby was brought to the groups attention who had been convicted of murdering 7 babies and attempting to murder another 6 at the Countess of Chester

Hospital. Fiona underlined how important it is for the Committee to gain assurance with regard to our own procedures. That assurance is gained through thematic reviews of mortality regularly reviewed by MIG reported to the Committee through the highlight report, in addition to a deep dive report on mortality on the workplan.
Fiona advised that the Annual Organ Donation report has been deferred to November. Fiona referred to the Maternity Neonatal report that had been circulated in the document pack but was not on the agenda. Ellie advised that she understood that once the maternity support programme was complete a decision would be made whether to go bi-monthly. Fiona advised that the workplan had been in place since January with the report going bi-monthly from July. Ellie requested the report return to monthly reporting on the basis that Board meetings are held bi-monthly and there are monthly requirements for Board level oversight as well as the need for a regular report for CNST purposes. Fiona agreed to take Ellie's concerns and request forward to the agenda set meeting on her behalf.

220/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

221/23 To Approve the Minutes of the Previous Meeting held on 25th June 2023

Ellie raised that there were a number of amendments that needed to be made to the minutes. It was agreed that Ellie would forward the changes to Michelle copied to Kate T and Fiona to amend the minutes outside of the meeting.

222/23 Matters Arising

Fiona advised a referral had been received from the Audit and Governance Committee regarding the Audit Yorkshire report on the WHO surgical safety checklist who had asked the Committee to seek assurance on the quality aspects of the report. A request for a deep dive report to address the concerns would be brought back to the Committee in September. It was noted from the Audit Risk and Governance Committee meeting there were 2 further limited assurance reports regarding Nutrition & Hydration and Complaints. It was queried where this will be picked up. Fiona advised no additional referrals had been received and she is checking if this Committee needed to pick them up.

ACTION: Fiona to follow up with the Chair of Audit, Risk & Governance with reference to the Audit Yorkshire Reports on Food & Hydration and Complaints

Ellie noted she did not agree with this audit report with regard to Nutrition & Hydration but there was limited time to look at issues. Part relates to things that already have plans in place and some to the Estates & Facilities element of food provision and quality. Ellie advised the Complaints audit has no issues it regards the process and how learning is applied, and these processes are currently being embedded.

223/23 Review of action log

137/23 Maternity Safety Oversight Update, request for update on three-year plan – this to be picked up next month when the report is received.

166/23 PSIRF awareness - Richard attended OMG. There was a positive interaction to support. **Action closed.**

172/23 LeDER details - Lydia confirmed item can be closed. **Action closed.**

175/23 Nursing & Midwifery Assurance Report - This is still on the nursing assurance report. Ellie noted bed states are still not correct meaning data returns are being skewed. The bed base needs re-setting. Shaun updated this is an operational matter. The challenge is there is an information variance which is taking some time to get together. It would be preferred the assurance be on the patients and quality of nursing care not the bed states. The Committee agreed the action should be closed. **Action closed.**

194/23 Maternity CNST incentive scheme - Due to come back to the committee in October.

209/23 Shaun has asked for a formal response from Shauna that the quality of clinical coding be maintained.

Regular Reports

224/23 Surgery Deep Dives

The report was taken as read. Jenn noted areas of focus are equipment lifespan, with 2 specific issues highlighted in the Scunthorpe site MRI scanner being out of use and hemofiltration equipment replacement. The divisions activities around the Quality Priorities were discussed, with focus on Deteriorating Patient (DP) and sepsis. The area of concern regarding the internal audit report regarding the WHO safe checklist report will come back to the next meeting.

Audiology mitigation and actions currently being taken around the audiology incident were discussed. An external national and regional specialists team are helping with this. An increase in capacity at weekends from external providers means high risk patients in Paediatric Audiology PTL and our Community Paediatric Clinic PTL Audiology will be seen by 1st October. Support being given with training of staff who have been impacted by the incident. OD work going ahead with staff to further support them. The National Team have given congratulations for delivery of how the incident has been dealt and the Trust has been asked to and is giving supporting to other Trusts. The whole of Audiology will be assured once through the process. The new Head of Service starts in October. A business case is ongoing to look at the establishment, and appointment lengths that are in line with national practice and also to include a new audiology booth at DPoW.

Regarding the hemofiltration machines at DPoW Kate T queried what mitigations are in place while waiting for repair as this is a high risk. Debbie responded a meeting is in place to discuss procurement and that costs have been reduced and repairs are being looked at. Kate W noted we can additionally lease machines into the organisation and SGH also have machines that can be used.

Fiona noted a level of assurance is needed to mitigate regarding this report. It may be the report needs to be filled in differently. Additionally, there are a number of items in the last report that are not showing as updated. There was a statement at the last meeting of deteriorating patients. Debbie responded that actions are in place with the ward manager and new clinical sister, and deteriorating patients was to be discussed in detail at a subsequent Quality and Safety Committee. There are no significant incidents. It was confirmed there is a level of assurance with ward B3. Regarding monitoring incidents regarding discharge, the numbers have reduced. There are still incidents related to discharge with B6 relating to medication. This is being worked on and monitored with governance and has improved.

ACTION: Debbie/Jennifer/Richard to have a discussion regarding progress from the last report, what is proposed to deliver before the next meeting, risks, bottle necks that need support and successes.

The high-volume low-complexity hub at Goole commenced. A quality improvement project was started and will continue throughout the hub working. This now has facilitated day cases in hips, knees and shoulders. First patients have been back for their follow up appoints. This is working well for some patients to go home the same day. A rehabilitation garden has now opened at DPoW. Colleagues are working weekends in the garden and a positive patient story has been received. JAG accreditation has been acquired at SGH for the next year. The CT scanner at SGH A&E is up and running.

Fiona noted the report is marked for approval and clarified that the Committee receive the report for assurance not approval which was ticked on the front sheet proforma.

225/23 End of Life (including C&T) Update

The report was taken as read. Rachel presented the item. Celebrating the implementation of the 7-day service in SGH which began at the beginning of August 2023. Feedback is this is being well utilised at a weekend. EOL training is continuing to rise. The use of respect forms is now rolled out in all areas. The main issue is with data and being able to evidence improvement as the data has moved from the Hub to WebV which has caused some problems. Raw data is being pulled and information to be available towards the end of the month.

Sue queried regarding page 8 Pain Assessment Tool as she couldn't see if the usage of the tool corresponded with the management of pain. Response was that the results of the tool don't show if the pain is being managed. There is still work to do on re-assessment.

Kate T queried if patient feedback showed quality and quantity of re-assessment as it would be good to see the effort reflects the work. Ellie noted the QI first phase covered the recording of pain assessment. She clarified that staff are going back and reassessing the pain but not always documenting this as there need to be a clearer way of doing this on WebV to ensure this is captured. This second phase module will not be adapted till later in the year or next year due to competing priorities in the Digital Team.

Fiona queried if this needs to be highlighted in the board report that the second phase. Kate W noted that the proposed timing allowed the process to be reviewed so the change can be delivered in a sustainable way. It was agreed that the Board Highlight would reflect that

manual collation of data will continue until an IT solution is in place and the work to deliver this is progressing in a sustainable manner.

Rachel noted regarding community nursing that WebV is not used for pain assessment and SystmOne has been looked at for pulling information. After discussion with Dr Adcock, it would be more beneficial to audit the responsiveness of pain relief from call to the end. This will be looked at separately.

Richard noted this is a Trust wide set of data. Regarding the patient experience metrics on page 10 it shows pain relief patient complaints are very low. This evidences that it's not about the provision of pain relief for patients but more about the process of how EoL pain assessments are documented.

Sue queried about the End of Life relatives booklet and if it has been designed to be fully inclusive as a comprehensive tool ie. Braille, other languages, culturally sensitive. Rachel will confirm this.

Action: Rachel to confirm if the End of Life relative booklet is inclusive and accessible e.g. Braille, other languages, culturally sensitive.

Fiona queried regarding the CQC report that it references management of patient records and queried if the reports references to Respect documents if this covers their concerns as the language used in both documents is different. Rachel confirmed that the Last Days of Life document in the EoL report corresponds to the CQC point referring to patient records. The QI team are working with pilot areas to make it digital looking at what works, what doesn't and what has to be included to ensure data can be pulled. Kate W noted for clarity where the EoL report states Respect, EPACCs or Care in the Last State of Life that this is the documentation that fulfils the CQC requirement.

Fiona queried that in the quarterly CLIP report End of Life has been added this quarter. Fiona queried despite the extensive good work that has been completed, are the actions sufficient or will it take time to embed? Rachel clarified was that the QI work will take time to embed then be rolled out.

Ellie noted End of Life care complaints are pulled out and treated differently through their own process and are dealt with quickly and with sensitivity for the patients and family. The Committee agreed this gave assurance.

226/23 Pressure Ulcers Deep Dive

The report was taken as read. Rachel advised the paper provided an update on the new process that had previously been presented to the Quality Safety Committee. A review has been done on the risk assessment process using the Braden scale and to reduce unwarranted variation. A weekly review has enabled the 10-day timescale be met, learning is identified and immediate actions taken. It was noted there were a number of moderate harms related to catheter care in homes. Review of these cases show the securing device to the patient was not used. The bladder and bowel team have gone in to care homes to do education and training. A static position is now being seen despite an increase in number of visits. Last 6 months of data shows an equal split in care homes and patients own home. Issues with own home is around compliance and lapses in care. Domiciliary care needs to be looked at with education and training. Care homes with highest levels of pressure ulcers

need a focus on moving and handling, slide sheets, pressure ulcers from shearing, incontinence team and pressure management. Turnover in care home of staff means there is the need for constant training. Once the Associate Chief Nurse is in place a process map needs to be done with staff to look at improvements. The wound clinic will have a rotation of teams to address a possible theory practice gap that can be put into practice.

Fiona thanked Rachel for turning the report around in a short space of time.

Sue queried that on page 5 it indicates it will take 6 months for the new templates, training etc to take effect although on the options table it states 1 year. Rachel advised that Braden has been implemented as a quick fix and PurposeT will take longer reflecting the 1-year expectation while the move across takes place.

Kate T noted the report was very comprehensive. It was noted that Sir John Mason House has particular issues. Kate T queried if task force has been sent in. Rachel advised that the intermediate care nursing staff need to be worked with more. This is a very small team so reliant on carers in the care home. Patients here are generally straight out of hospital meaning there could be an impact on development of PUs, often with significantly reduced mobility whilst rehabbing. Kate T referred to an SI recorded which Rachel clarified was an issue in delivery of equipment which was ordered over a bank holiday weekend which wasn't delivered in a timely manner.

227/23 IPR

The report was taken as read. Kate W updated that the SHMI data continues to remain in the "as expected" range. The infection diagnostic lead group is stable. There have been challenges obtaining sepsis data and they are looking at other ways of obtaining the sepsis data. Kate W advised they are constantly looking at other ways to triangulate episodes or instances of harm. Recording of adult observations are better. End of Life areas of concern are gaps of data due to the Lorenzo PAS freeze on data sharing. Mitigations are in place around manual data.

Fiona queried the statement that "previous methods of paediatric sepsis screening measurement are no longer appropriate" and asked for some clarification. Richard responded previous the audit method was back to front as they looked at identified patients at risk rather than the screening process. The audit tool to be used will look at several patients on the screening tool. Richard met with Debbie Bray and team in the previous week. The tool has been designed and will be tested before taking this forward. A change in clinical practice will be needed. Support for clinicians to use the tool properly will be in place to ensure the patient is assessed correctly. Fiona further queried if there was sufficient resource to train the clinicians on use of the tool. Richard confirmed Debbie and the team were confident this can be put in place and that there is a mindset change as the clinicians and doctors haven't felt the need to document in this way. A practice change is an outcome. There is also the opportunity to use documentation captured elsewhere on the tool.

Sue queried that on page 27, relating to maternity and its instrumental 3rd and 4th degree tears, why are these increasing? Ellie has reviewed the maternity NHS digital dashboard which will be included on the maternity paper. There hasn't been the opportunity to

triangulate this with the team but are within the expected range. This may relate to difficult and complex births. Details to come to the next meeting.

Ellie picked up the run chart for still births. There is a cluster of events that went through the maternity support advisors. Sadly, these are showing as exceptional circumstances and tragic events but nothing to be concerned about. Nothing is being picked up internally or externally regarding these through the PMRT processes.

Ellie brought to attention there has been a MRSA complex patient. Currently collating through the PIR process. This looks like cross contamination at line insertion. This is being picked up with the team and has been brought up to PRIM meetings around practice around care of lines etc.

Ellie noted the C difficile trajectory is 20 and reflects the Trust previous excellent record. This is challenging as on the Trust has had 4 cases already this year pre-winter. Nationally there are concerns of a general rise in C difficile. We have been approached regarding best practice. The Committee to be aware this is a tough ask but are regionally in a good position and the Trust compares well nationally and with peers. Fiona noted Richard had commented in the chat about the Trust C difficile rate performance was in the 93rd percentile on benchmark with peers up to March 2023.

It was noted that complaints have been responded to 100% on time meaning a great team effort. The Committee commended this result and the progress that had been made.

228/23 Nursing & Midwifery Assurance Report

The report was taken as read. Ellie updated that Grimsby stroke unit are currently under an enhanced surveillance process. The area has had an “intense support” 15 steps outcome which resulted in a quality surveillance approach. A deep dive is underway in staffing, dashboard and a retrospective look at what came back through from 15 steps previously. A concern is the area has had intense support previously, does better then drops back down suggesting best practice is not being adopted. Ellie advised the unit will have a 6-12 month surveillance to ensure the practice and culture is embedded. This will involve quality of care spot checks and audits throughout the week.

Ellie looking at the detail and length of the report with an aim to give a reduced version for the next meeting. The Committee welcomed this approach. Ellie advised that Chief Nurses in struggling organisations have been referred to look at what NLaG produce.

Fiona queried regarding the trend of the number of supportive care shifts falling. They are the lowest levels in 2 years without an increase in patient safety incident, and Fiona queried if the June levels can be expected going forward. Ellie advised it is seasonal. The processes to assess if a supportive shift is needed have been refreshed along with the short term staffing process. An overuse of supportive observation has been identified. The Afloat tool identifies and reduce the need for one to one supportive observation but allows various levels of observation to be in place. At the Safe Staffing meeting there is an open challenge around where supportive observation shifts have been asked for. A review of the Afloat and Safe Care Live gives a live update on patient acuity so only patients needing to be kept at arm’s length get the shift booked. Additional there is now the ability to safely flex and adapt the

staff around the organisation where there are higher acuity levels. There is assurance a robust process is now in place.

Fiona referred to the work Ellie had instigated to benchmark the Trust again the findings in the CQC report at HUTH and asked for Ellie to provide a brief update as from an assurance perspective this was an important piece of work. Ellie advised it was discussed in AOB at the Maternity Improvement Board. Jane Warner is providing support and is looking at themes and trends and reviewing internal processes. We need to be aware of the sensitivities of this exercise.

Fiona queried the midwife to birth ratio. In June the ratio was below what was expected and are we comfortable the service is safe? Response was yes, otherwise it would be closed, or beds would be reduced. There is a separate Opel levels of reporting and have adapted the National Maternity Opel safe staffing scores. This is used on a daily basis along with occupancy meaning staffing can be adjusted according to need.

229/23 Key SI update including Maternity

The report was taken as read. Richard clarified the information as the cover page mentions no new incidents for maternity services but refers to an incident as new within the body of the report although this had been reported in the previous month. The report illustrates a low level of harm reporting over the last few weeks meaning less SI Panel meetings have been needed. Open actions are now closed incidents with follow up actions. A never event report is due for sign off in September by Kate W. Kate W confirmed receipt of this.

Fiona queried the training schedule for staff of paediatric audiology timescale. Kate W updated the team are being supported to attend offsite training sessions. Training dates have been set. External providers are happy to provide support for the training. It was noted that staff have not recovered from the shock.

230/23 CLIP Report including Annual Report

The report was taken as read. Richard updated the report is a complicated read, noting the appendices give more oversight detail. Richard noted he was keen to change the report. The report give flavour for the rate of information received for complaints, PALS enquiries and litigation. There are almost 100 litigation cases currently being managed. There are 46 inquests for the last period. The run rate of inquests is growing along with the number of open cases also growing. This is due to the number of cases being concluded is slower than the rate of new ones coming in.

Fiona noted from an assurance point of view the main body of the report is a status report that doesn't give assurance. There needs to be a better way of reporting it as the details needed are in the appendices. It needs to be established what HUTH do regarding reporting to allow working together for a middle ground that works for all.

Ellie agreed a refresh is overdue as there is no context. There is a concern that sight of the report is quite late.

ACTION: Richard to work with HUTH equivalent to establish what is included in their CLIP report. If the information is ready prior to the next QSC meeting a small group to meet to look at it.

Richard noted another consideration is factoring in the cross over of work ie. legal. This needs to be done in a different way.

231/23 CQC Framework

The report was taken as read. Richard noted the summary paper shows an improvement towards full assurance. There are actions due, some have not progressed but are being prioritised by the team. It is being considered how support to the divisions and action leads can be taken to improve this. The body of the paper shows charts with progress over time. There are risks for delivery with capacity, operational pressures and financial restraints. Kate W noted that Belle is embarking on a piece of work with the divisions regarding finance. Conversations to then be had with commissioning colleagues as to what needs to be done differently.

Sue queried on page 5 the family services, the 22 MAT 10 spot check audit for 31st August, if this is on track. Response was that Belle has discussed with the team who have not prioritised addressing this problem yet, but the CQC found an issue with the checking process regarding stock rotation. This is not a complex task, and they are starting to explore how to build on this. There is a need to show there is progress even if actions aren't completed.

Kate T queried if the spot check audit is a regular thing or one off. Response was this type of action should progress to regular checks was being looked at.

Fiona queried regarding the MAT10 that the standard business process be that new stock goes to the back and when taking stock off the shelf that dates are checked. Richard confirmed that the CQC action was it is more about consumable items that are not included in this standard stock rotation management.

232/23 Potential Deviations from National Documentation

Richard noted there aren't any potential deviations.

233/23 PSIRF update

The report was taken as read. Richard noted this is a gradual progress. There is more engagement with people going on training. Steps have been taken going forward on risk profiling. An incident response plan is being worked on with people that have been involved. The next meeting is later this week, with the expectation of a draft incident response plan with policy to be taken there. Contribution from Maternity services and Neonates is needed to match the profile. It is hoped that documents line up ready for a system change in October. We are on track to do LFPSE switch over in September, NHS England to confirm. This is the automatic uploading of incidents which will replace NRLS.

Fiona queried the statement at the top of page 5 “time saved should be reutilised on quality improvement activities improving the patient safety risk profile”. Fiona asked given it is understood it will be clinicians doing the investigation, will the time saved from the report go back to clinical time rather than QI projects? Richard advised that this is realistic as it is guidance from NHS England. This releases time for investigation in more detailed ways, so staff are free to contribute towards the quality improvement work. This should reduce time needed for investigation over a longer period of time. This is distributed widely across all divisions. Fiona noted this will be difficult to deliver and will need to go through a process of change. Richard advised there will be more senior people doing these reports and will be more likely to contribute to QI initiatives.

234/23 Annual Patient Experience Report incorporating Annual Inpatient survey

The report was taken as read. Fiona asked the Committee to note this is the Annual Report being accepted on behalf of the Board and would go into the public domain rather than the detailed regular reports that we receive for timely assurance during the year.

Melanie Sharp noted the report is accurate and for wider viewing. The team are continuing with current strategy with a view to writing a new one next year with the new Patient Experience lead. The PALS position has greatly improved. Complaints continue to show an improved position. There was a decrease in July/August ’22 due to prolonged annual leave. This has been closely monitored. Compliments recording to be looked at. FFT have seen an increase in patient feedback due to the temporary Patient Experience manager whose secondment has been extended to the end of December. National surveys feed into the patient experience group and the surveys form part of the Trust improvement plan. There are a lot of positives in the surveys. Next year will focus on the patient voice and learning will continue to be developed from complaints.

Kate T queried, if this is going to general public, would they understand the abbreviations. Response was these to be corrected. Kate T also was noted this was much broader than 2022. Response was this is just when the results come through.

Sue noted the FFT was fabulous. Sue also noted that 4.54 out of 5 speaking positively, this is not seen with the Trust staff survey. Is there a way of correlating staff recommending family and friends? Mel advised there had been a change seen in clinical areas and how proud staff are of where they are working. Staff feedback from 15 steps is really positive, but it is still unclear how this will correlate. Mel and Ellie agreed this should be investigated how we can communicate, and drive positives achieved through the patient experience to staff.

Kate W noted we need to make a positive for the organisation so people can see what we can see.

Kate T noted we need to celebrate success from external patients but also we need to find out why are staff not recommending services in the Trust to family and friends.

Fiona suggested a referral be raised to the Workforce Committee to say we have a positive set of patient feedback and need to know how we can support uplifting the staff survey in the same way.

ACTION: Ellie/Mel to work up the statistics and data to support the patient experience. Through the action log this can then be checked if we are at the stage to make a referral to the Workforce Committee.

Fiona queried regarding the family liaison officers, if they have been employed in areas where their interpersonal skills can be fully utilised to directly support patients in the main. Mel advised they have gone into different roles and responsibilities now. The few who are now employed elsewhere in the Trust still champion the patient experience.

Fiona asked the Committee if the report can be recommended to the Board as recommended on their behalf with the acronyms changed. The Committee agreed.

235/23 Annual Organ Donation Report

Item deferred until November.

Highlight reports

236/23 Quality Governance Group (QGG)

The report was taken as read. Fiona asked for clarification of the highlight “medicine safety transcribing for discharge referral needs investigation with the Care Plus Group”. Richard advised that there is a situation that occurs at DPoW where a document is used to ensure there is continuity of medicines management when going home. This involves transcribing onto a document by staff in a ward then the information is then copied into another document at its destination. James Hargreaves raised this as a concern and action has been taken as a consequence with discharge. James is meeting with discharge process leads and Richard has contacted Care Plus Group to speak with their lead for discharge and together they will work through how to work through reducing the risk of transcribing error.

237/23 Mortality Improvement Group (MIG)

The report was taken as read. Fiona queried the reference to a deep dive into pneumonia and when this would be scheduled. Richard advised he would look into this as he didn’t attend the meeting. The Committee looks at themes in deaths and this data shows seasonal variation which needs some understanding. Richard also advised that coding management needs to be working as it should. Data access is also due from CHKS which will give better information.

ACTION: Richard to include when the deep dive into pneumonia will take place in the next learning from deaths report.

238/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

239/23 Quality Governance Group (QGG) minutes

Distributed for information.

240/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

241/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

242/23 Any Other Business

None raised.

243/23 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

The Committee agreed to add the following points to the highlight report to the Trust Board.

- **Sepsis** - Manual collation of data – to continue until an IT solution is in place although progress to ensure that it will be delivered in a sustainable manner is underway.
- **Patient experience report** – to be referred for approval to Board.
- Receive **End of Life quarterly report.**

244/23 Meeting review

- January onwards meetings to be face to face. Kate W noted the group structure needs to be confirmed. Ellie noted mileage is increasing and asked for a hybrid model be considered.
- Fiona queried with Ellie the referral from ARG and if there is anything that can be deferred? Response was it is not an issue for the team to produce what is needed.

245/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 26th September 2023
Time: 13:30-16:00
Venue: Virtual via MS Teams

The meeting closed at 16:00

QSC Annual attendance log

Name	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023
Michael Proctor	✓	✓												
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Maneesh Singh	✓	x	✓											
Dr Kate Wood	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	✓
Ellie Monkhouse	x	✓	x	✓	x	✓	✓	✓	x	✓	x	x	✓	✓
Dr Peter Reading	✓	x	x	x	x	✓	✓	x	x	x	x			
Shaun Stacey	x	x	✓	✓	x	x	x	✓	x	x	x	✓	✓	✓
Susan Liburd				✓	✓	✓	x	x	✓	✓	✓	✓	✓	✓
Kate Truscott				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

NLG(23)186

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 3 October 2023	
Director Lead	Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Jo Loughborough, Lead Nurse Patient Experience	
Title of the Report	**Annual Complaints Report**	
Purpose of the Report and Executive Summary (to include recommendations)	• Overview of complaints, concerns and compliment activity throughout financial year 2022 – 2023 • Progress made against Key Performance Indicators (KPIs) • Quality of complaints evidenced through timeliness and reopened activity • Themes	
Background Information and/or Supporting Document(s) (if applicable)	DCP071 Policy reviewed to reflect learning from process changes	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Feedback from complaints, concerns, and compliments

ANNUAL REPORT

FINANCIAL YEAR 2022/2023

Performance for Period 2022-2023

Contents –

Background

The complaint processes are divisionally led but supported by the central Complaints Team and PALS (Patient Advice & Liaison Service) Team at Northern Lincolnshire and Goole NHS Foundation Trust. The process is available for patients or their representatives who wish to make a formal complaint or raise concerns on a more informal basis. Anyone who expresses a view, verbally or in writing, with the appropriate consents, will have those views acknowledged via either of these processes.

Both the PALS and Complaints processes put the patient, or their representative, at the centre of their process to support a timely resolution. The Trust recognises the importance of listening to the experience and views of our patients about our services, particularly if they are unhappy, and the Trust strives to make it easy for anyone to do so.

Compliments are verbal or written expressions of praise, admiration or congratulations sent of a person's own volition and are currently recorded on a central database. Patients and their representatives leave some wonderful feedback and sharing these ensures that staff received the positive feedback to help build a strong culture of recognition.

This report will provide information on the representations made via the PALS concerns and complaints processes in addition to the compliments received between 1 April 2022 and the 31 March 2023.

It is a requirement of the National Health Service Complaints (Regulations) 2009 to produce an annual report. The purpose of this report is to inform the Trust Board and the public of the effectiveness management of the complaints processes within the Trust, ensuring that it remains sighted on the timeliness, quality, and learning.

Patient Advice and Liaison Service (PALS)

A concern is an expression of dissatisfaction where the patient or their representative does not wish to make a formal complaint but wishes for their incident or experience in service to be logged and/ or investigated on an informal basis.

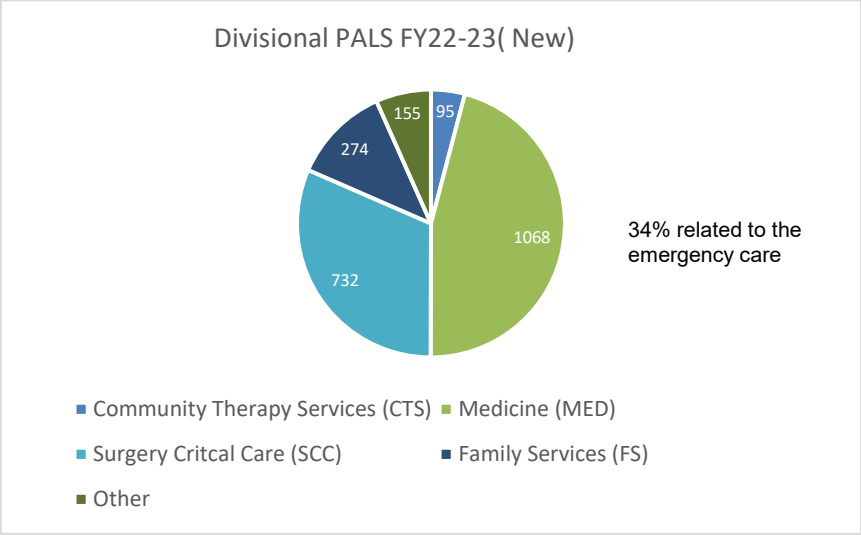
Between 1 April 2022 and 31 March 2023, the PALS Team received **2324** concerns. This is an increase of 9% from the previous year, and a 575 increase over the last 3 years, as seen in the table A:

Table A

Year	2019/20	2020/21	2021/22	**2022/2023**
Number of new PALs received	1338	1327	2134	**2324**

Table B highlights the divisional breakdown of new concerns: -

Table B



Response times indicated that 754, (32%) of the concerns were resolved within one working day, which is a 19% improvement in day one resolution since Financial Year 2021-22

1417 (61%) of overall concerns were closed within 5 working days, this is a 13% improvement from the previous annual reporting in 2021-22.

The KPI (Key Performance Indicator) target has been adjusted to a staged approach initially aiming for 60%, which was achieved as an average overall yearly total.

The central PALS team has experienced several staff changes which has caused disruption in the team however towards the latter end of the year this has stabilised. The introduction of a dedicated PALS Manager for 6 months (October 22 – March 23) had a significant impact on the reduction of the number of open PALS. The separation of PALS oversight from the Complaint Manager has seen open concern numbers at their lowest in recent reporting history.

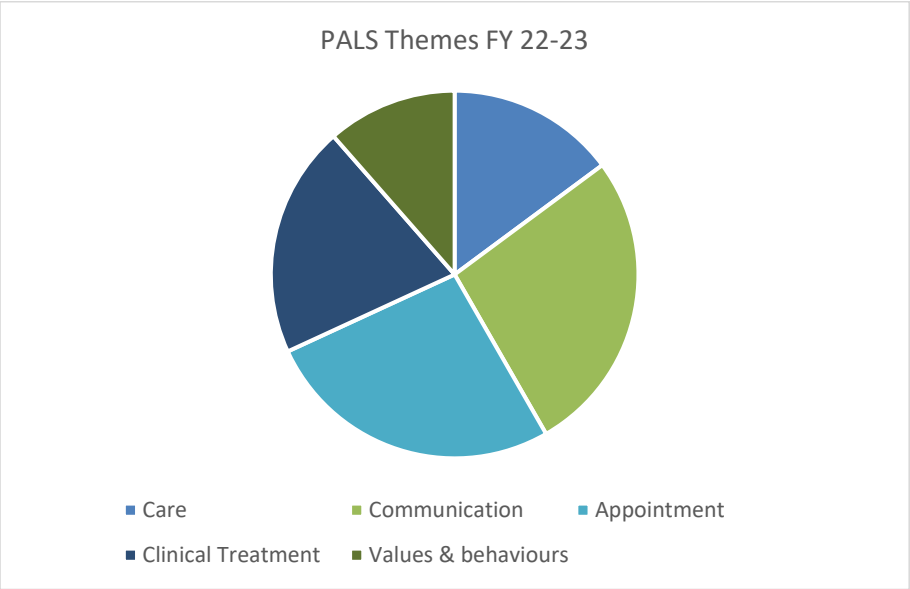
Through more reactive ways of working numbers of new concerns were reduced or resolved in in a timely manner. The PALS team have worked collaboratively to support Divisions, particularly with long standing PALS. Weekly reports are now sent to Divisions identifying how many PALS are open and highlighting those that are over the timescale for action, this is further supported by regular meetings.

There has been internal ongoing team development and improved supervision opportunities, which is essential as the role can be a challenging one. Working with the team to identify new ways of working has created a more engaged culture.

PALS Themes

The top theme from PALS concerns this year are shown in table C, with further detail around the sub themes which contribute to these detailed in the following narrative:

Table C



Communication → lack of communication between wards and families

Appointment → delays or communication about changes/cancellations

Care → various aspects of general care and lack of involvement from family perspective, this includes discharge planning.

Clinical treatment → various aspects of clinical care, including delays and misdiagnosis.

Values & behaviours → various aspects including attitude and manner of staff when speaking to patients, not listening to patients or families. This is a widespread issue and not specific to a particular staff group.

Themes arising are explored through Patient Experience Group but also through collaborative work with the 15 Step Assurance programme, National Survey programme, Friends and Family Test and the Trust's INSIGHT survey.

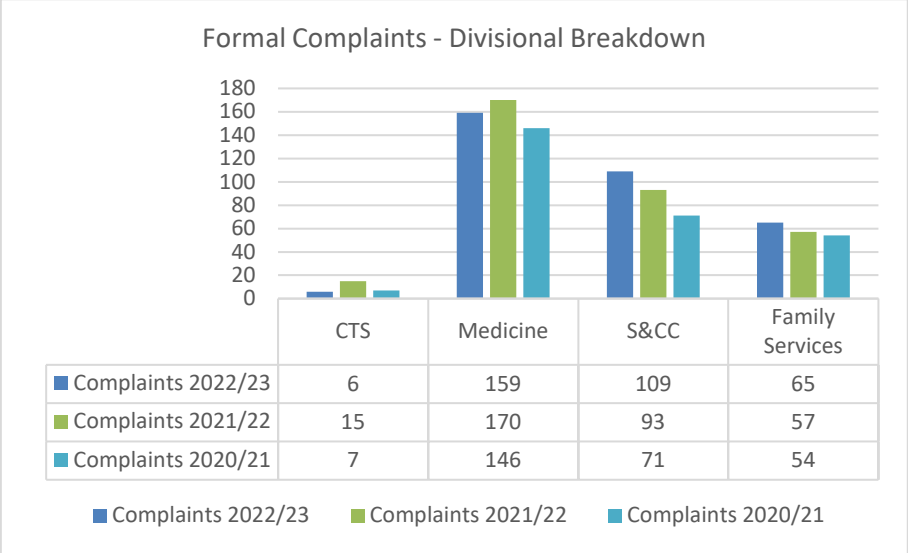
Communication remains a priority and continues to be challenging in high activity Wards/Departments. Increasing the involvement of patients and families in care and care planning will be a key message to explore during the coming year.

Formal Complaints

The Trust received **339** formal complaints throughout the year 2022/23, this is a 2% decrease from the previous year.

Table D displays the number of complaints received by the division directly providing patient care:

Table D



	CTS	Medicine	S&CC	Family Services
Complaints 2022/23	6	159	109	65
Complaints 2021/22	15	170	93	57
Complaints 2020/21	7	146	71	54

The central complaints team continues to work with Divisions to ensure that complaint timescales, quality of responses and learning are a priority. This is monitored through the central team weekly Support and Challenge meetings, where visual tracking tools monitor week by week progress in line with a 12-week framework. This meeting has been key to ensuring escalation and development.

The number of complaints closed during 1 April 2022 to 31 March 2023 was **369.** The number of complaints closed within timescale averaged 68% across the year.

Table E

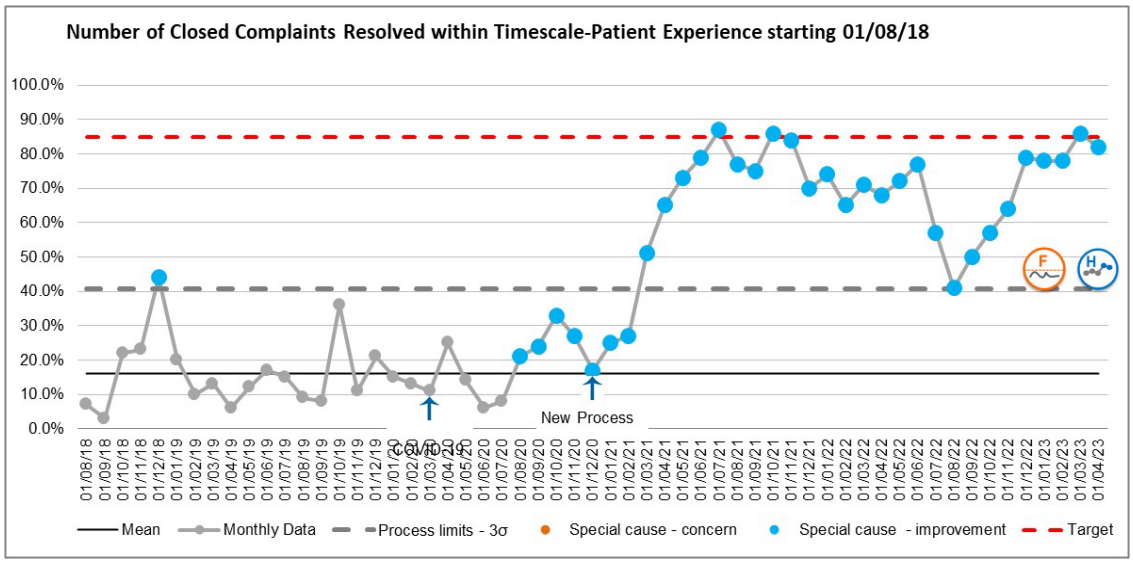
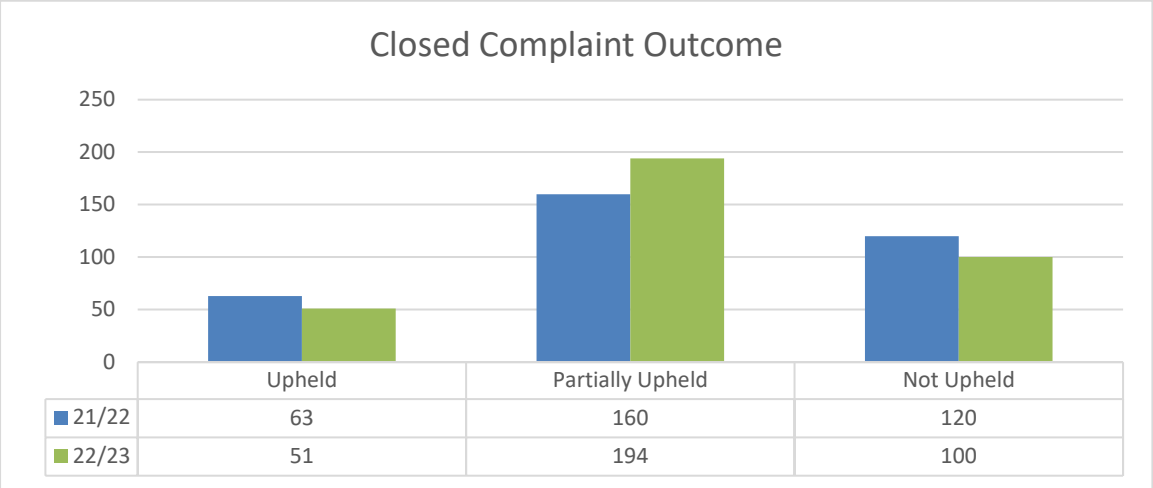


Table E, above, highlights a reduction in compliance during the summer period during 2022. This was primarily due to divisional lead investigator allocation and associated annual leave. The divisions have had feedback on this issue and have been asked to plan accordingly during the same period in 2023 to avoid repetition.

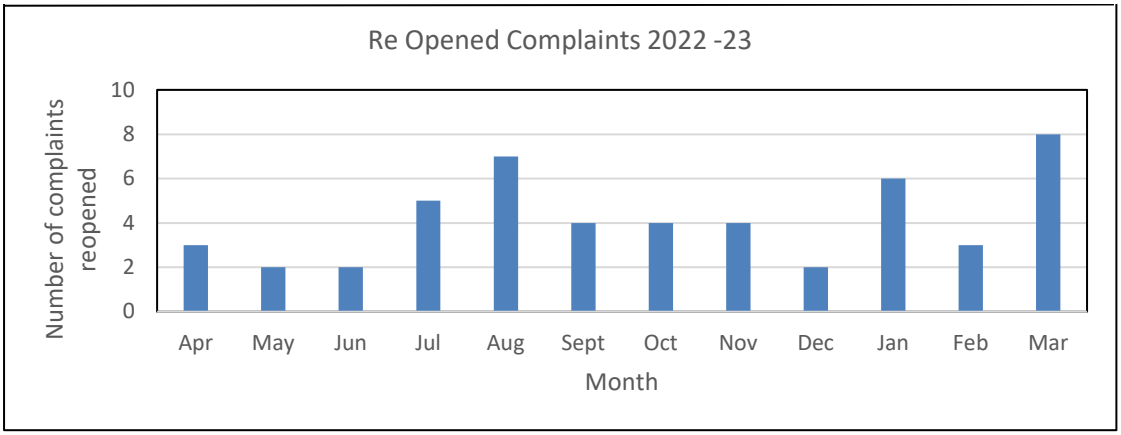
Of the formal complaints closed, the data below, in table F, demonstrates how many of those were deemed: upheld, partially upheld, and not upheld following investigation. There were 15 cases classed as not applicable due to various reasons, these include: progression to a serious incident or the complaint was withdrawn.

Table F



The Trust re-opened 50 complaints, highlighted in table G, which is a 25% increase on the previous year, when the number of re-opened complaints was 40.

Table G



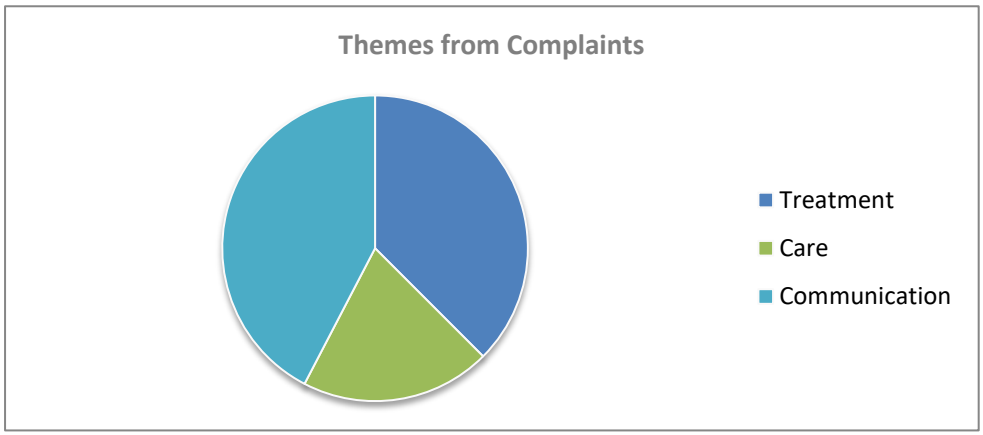
A monitoring process is in place which identifies whether a re-opened complaint could have been avoided. Of the 50 complaints reopened, 25 of these complaints were reviewed, which indicated that 16 (64%) were unavoidable. This criterion includes additional questions from the complainant on receiving their response. Avoidable complaint learning is shared back within teams for further improvements in the process and includes aspects such as inaccurate data.

Divisional teams are responsible for reviewing the re-opening requests and identifying if any further resolution can be reached through a further response or meeting.

Complaint Themes

The visual in table H demonstrates the headline themes for formal complaints during the period of 1 April 2022 to 31 March 2023:

Table H



Further subheadings which contribute to these are:

Treatment → diagnosis or treatment pathway not followed as expected, including missed opportunities to treat or delays

Care → various aspects of care – with no one specific theme identifiable

Communication → lack of communication with patients and their families, including updates/changes in treatment plans and discharge

Learning is a divisional responsibility with the central complaint team responsible for logging this data. Learning is captured in all upheld complaints.

The Round Table Meeting has been established and reviews patient experience data bimonthly and has undertaken a series of deep dives into headline themes. These include outpatient appointments and emergency department feedback. Complaints and PALS data forms part of this triangulation process and the data has been used either to feedback directly into services or as part of quality improvement work streams.

Learning Lessons

Learning lessons are detailed in every upheld, or partially upheld, complaint. The Lead Investigator role, within the complaints process, is responsible for identifying learning as part of each complaint investigation, this is then translated into “what we have learnt from your complaint” in each response. An audit of complaints closed during 2022 and 2023 showed that in complaints upheld or partially upheld, learning had been appropriately identified in responses. The Lead for Patient Experience has met with the Complaints Team individually to provide education of identifying learning and to ensure that learning and meaningful actions are entered appropriately onto Ulysses uniformly, to allow Divisions to identify themes and trends from complaints, for wider learning and sharing within the Trust.

The electronic learning log on Ulysses has been under development during the year, which allows for learning and actions to be added to Ulysses, unfortunately, this process has been lengthy due to each change request having to be managed by the provider. These reports are an improvement as they can now be monitored in relation to completion and evidence, allowing increased oversight. A monthly report will be sent to Divisions which identifies themes and further actions needed. Divisional Governance Leads will be supporting the pilot phases of this process during the coming year, and this will be a valuable step to enhancing divisional oversight of learning from complaints.

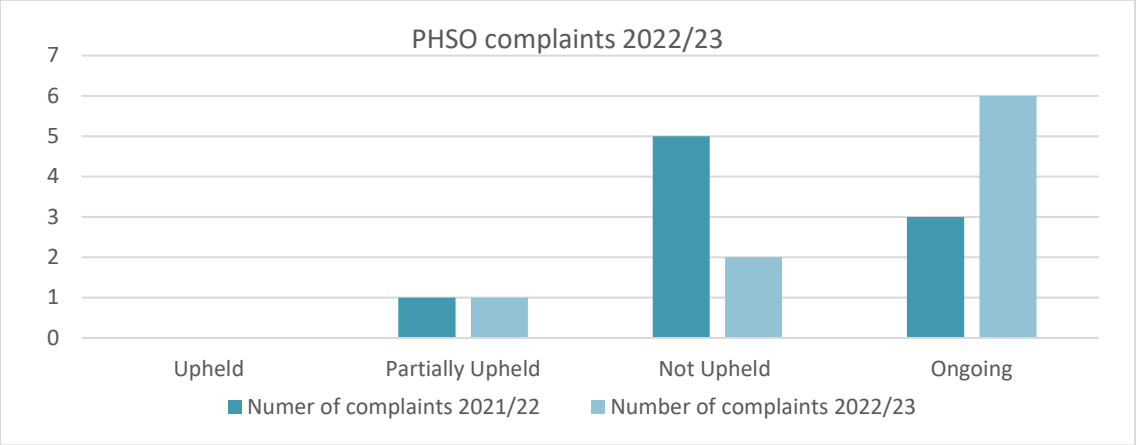
Within the central team any process and service feedback seriously and changed when required. This included ensuring any “failure to resolve” PALS which transitioned to a formal complaint were treated in a person-centred manner and elapsed days considered in process handover. All reopened complaints are now added to the central spreadsheet for monitoring and oversight during Divisional review processes. It is a service priority that complainants are aware of the commitment to listen and learn and this is always fed back to them.

To engage with our complainants and understand what we are doing well and what can be improved a survey link, from April 2023, is included at the bottom of the response from the Divisional Medical Director. This was previous sent directly to the complainant but only 4 responses were submitted during the year. This is thought to be related to complainants giving direct feedback to their facilitator or through the re-opened process, all feedback is reviewed for improvement.

Parliamentary and Health Service Ombudsman (PHSO)

The PHSO processes have seen several central changes, this has caused some lack of clarity to their management of cases from an internal basis. However, close working continues with the PHSO and Divisions, with the shared aim of obtaining the best possible outcome for the complainant. Table I shows the complaints investigated by the PHSO for the period 1 April 2022 to 31 March 2023. There were zero cases upheld during the year, with those numbers of partially upheld remaining unchanged from the previous year. Ongoing cases are remaining open for considerable periods and, at times, late decisions about progression to investigation are being made. There were an additional 5 complaints that the PHSO reviewed but did not investigate shown on the data table.

Table I



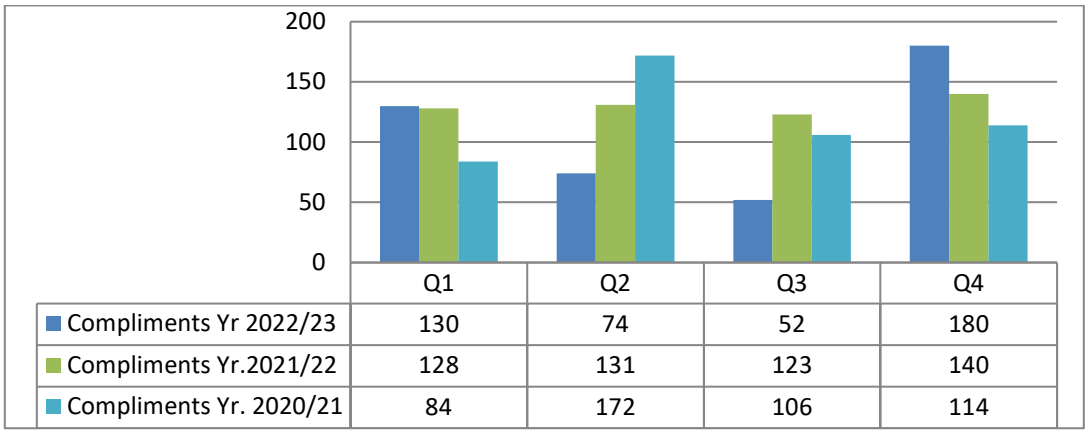
Compliments

Compliments are as central to the measurement of patient experience as are complaints and concerns and can be an under reported data element.

It is recognised that logged compliments only form part of the recognition of positive feedback received across the Trust. Staff are encouraged to keep a folder with their area for thank you cards and the compliments they receive directly. From March 2023, and as part of the quality improvement pathway with the service, all compliments received internally or externally are logged onto the Ulysses database. A monthly report is being developed to ensure this information is shared with Divisions on a regular basis.

The volume per quarter can be seen in table J, and whilst a slight decrease in logged numbers from the previous year is noted the ongoing work to raise the profile of recorded compliments will hopefully see this increase during Financial Year 23-24.

Table J



	Q1	Q2	Q3	Q4
Compliments Yr 2022/23	130	74	52	180
Compliments Yr.2021/22	128	131	123	140
Compliments Yr. 2020/21	84	172	106	114

Developments

The quality improvement work within complaints and PALS continues it is now central to the service thinking. Through use of the PDSA (Plan, Do Study, Act) quality improvement cycle we have revisited and update the existing policy, added elements to the Support and Challenge meetings around recognising safeguarding concerns and enhanced reporting.

Lead Investigators have been surveyed to understand their support requirements in the process. Approximately 70% of those who responded advised that further training was needed, and that the biggest barrier to undertaking a good complaints investigation was the time taken to investigate. The complaints training for Lead Investigators is to be reviewed, together with identifying the best options for delivery.

The following summarises some more of this year's internal complaints and PALS process improvements: -

- Weekly divisional PALS reporting
- Review of re-opened complaints for learning
- Creation of electronic Learning Log system
- Improved monthly reporting of Learning for Divisions
- Emergency Department collaborative PALS work
- Complaint delays monthly divisional feedback for learning
- End of Life reporting improvements to inform strategy group
- Revised policy
- Standardising triaging processes
- Review of the PALS processes

Conclusion

Collaboration with the Divisions to investigate and respond to complaints, to provide robust and compassionate responses to complainants, within the 60 working day timescale, has continued throughout the year. Any complaints that are responded to outside the agreed timescale and now considered to be the exception, with each complaint that goes over timescale to be accounted for and discussed at the Support and Challenge meeting and learning shared back to the Divisions. The increased complexity of complaints has become evident during this last year, with some of this related to the increased pressures within the whole health service footprint. It is therefore felt that to ensure a quality experience the 12-week process remains the right approach to formal complaint management.

Learning from feedback will be the priority for the year 2023-24, with not only progressing practical developments to support the processes but to fortify impartial and robust divisional learning outcomes.

These must be translated into meaningful and monitored actions which complainants can have assurance in. The implementation and embedding of the electronic learning log pilot will be pivotal in this, although further work around ensuring learning actions are robust, and importantly measurable, will be equally important. Training for both the central complaints team and Lead Investigators will be key to this change, alongside the continued partnership working with Divisional Triumvirates and their teams.

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 3 October 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 8.7 in July and benchmarks well. There were no wards with CHPPD below 6. The overall fill rate has been around 95% for the last five months. The midwife to birth ratio for the Trust in July was one to 23.1 (Grimsby – 1:24.2, Scunthorpe – 1:21.7) which is below the acceptable ratio of 1:28. There were 218.47 Whole Time Equivalent (WTE) (11.45%) Registered Nurse/Registered Midwife vacancies and 93.75 WTE (9.30%) unregistered vacancies across the Trust in July. Ninety conditional offers have been accepted by newly qualified nurses, seventeen by newly qualified midwives and fifteen by newly qualified paediatric nurses. Twenty-three internationally educated nurses joined the Trust in July. A total of 37 staffing red flags were reported which is comparable with previous months and there are no concerning trends. There has been a decrease in the total number of reported in-patient falls in July 2023. The number of pressure ulcer incidents in acute and community has increased slightly with all incidences reviewed at the weekly scrutiny meeting. No new root causes were identified during the review process and local actions are in place to share the learning. New formal complaint numbers were 39 equating to a 39% increase. A total of 92% of closed complaints managed in timescale; 156 new PALS (Patient Advice and Liaison Service) concerns were captured.129 PALS were closed, of which 71% were closed in timescale; 57 compliments were logged, a 39% increase from June. No mixed sex breaches were declared in July. Ten 15 Steps Challenge visits were completed; five visits within acute and five within community. Four visits were rescheduled due to doctors strikes. There is concern nationally regarding a national increase in cases of Cdiff (Clostridioides difficile) and MSSA (Methicillin-Susceptible Staphylococcus Aureus**)** Bacteraemia, thought to be associated to post pandemic. Whilst The Trust is currently managing well with

	Cdiff, there is a risk that the case threshold set may not be met this year. A total of 482 nurses, midwives and Associate AHPs (Allied Health Professions) have been trained at some level of Quality Improvement (QI); in addition 43 QI projects were initiated in the past 12 months.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Nursing and Midwifery Assurance Report September 2023 (July 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.

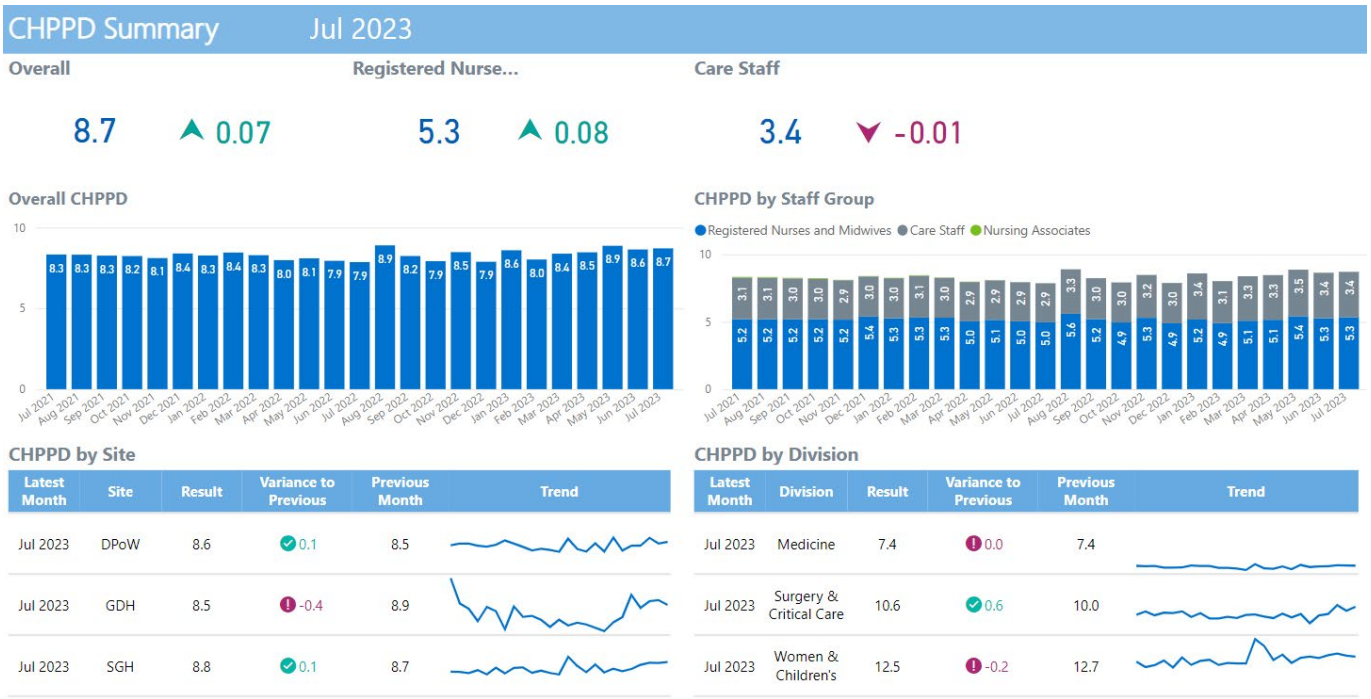
Oversight continues to be provided to the Quality and Safety Committee on nursing, midwifery, and safe staffing. The changes to ward configurations and use of escalation beds have made it challenging to make comparisons and benchmark, and for this reason we continue to review individual metrics and apply professional judgement. Quality impact assessments are undertaken with final sign-off by the Chief Nurse prior to additional wards being opened.

The Chief Nurse chairs the Nursing Metrics Review Panel which 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.



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2023	DPoW	8.6	0.1	8.5	
Jul 2023	GDH	8.5	-0.4	8.9	
Jul 2023	SGH	8.8	0.1	8.7	

CHPPD by Division

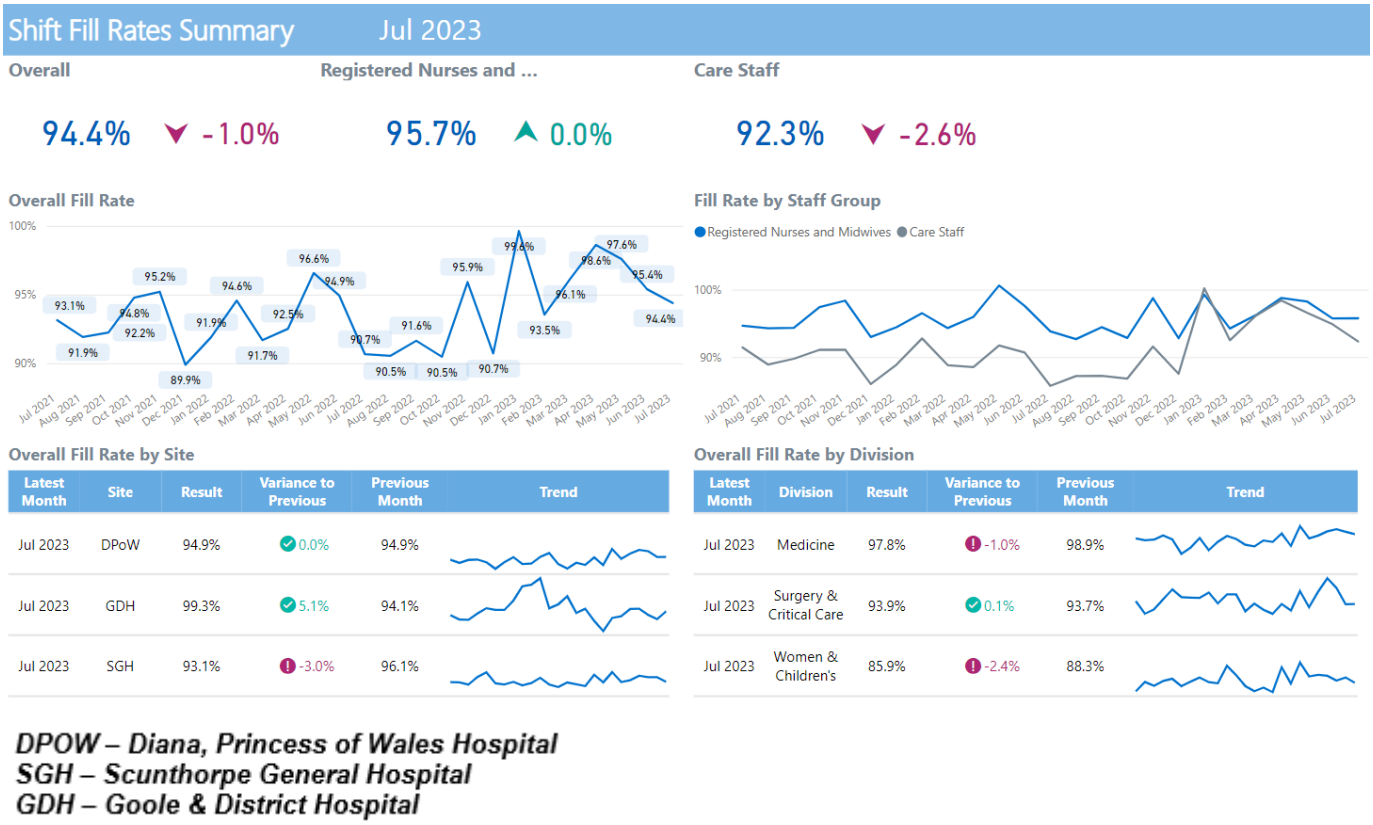
Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2023	Medicine	7.4	0.0	7.4	
Jul 2023	Surgery & Critical Care	10.6	0.6	10.0	
Jul 2023	Women & Children's	12.5	-0.2	12.7	

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.

DPOW – Diana, Princess of Wales Hospital
SGH – Scunthorpe General Hospital
GDH – Goole & District Hospital

There were no wards with CHPPD below 6 in July.

The latest model hospital data for June 2023 indicates a provider value of 8.6 (quartile 3 mid-high 25%) against a peer median of 8.4 and provider median of 8.5.



Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jul 2023	DPoW	94.9%	0.0%	94.9%	
Jul 2023	GDH	99.3%	5.1%	94.1%	
Jul 2023	SGH	93.1%	-3.0%	96.1%	

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jul 2023	Medicine	97.8%	-1.0%	98.9%	
Jul 2023	Surgery & Critical Care	93.9%	0.1%	93.7%	
Jul 2023	Women & Children's	85.9%	-2.4%	88.3%	

DPOW – Diana, Princess of Wales Hospital
SGH – Scunthorpe General Hospital
GDH – Goole & District Hospital

The overall fill rate has been at or about 95% for the last five months. Fill rates for individual wards vary from 111.1% to 68% (**Appendix 1**) and are outlined in ward dashboards (**Appendix 2**). Wards wilth fill rates over 100% are B2, 3, 28, C3, Amethyst, B7 and C6.

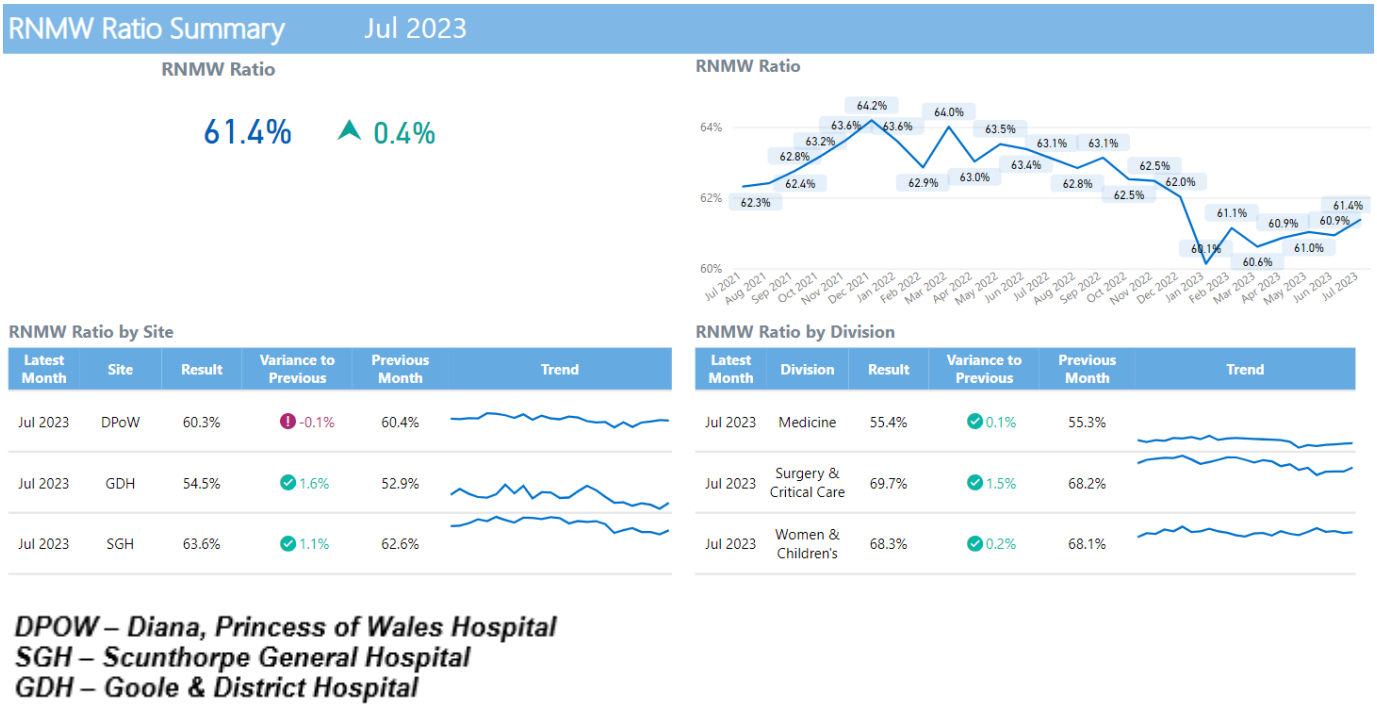
Within Medicine there were four areas with a fill rate above 100%. Two of these areas, C3 Short Stay and B2 (Integrated Acute Assessment Unit (IAAU)), have continued to have an increased number of beds open in line with the recent bed modelling increases, this has resulted in the requirement for additional staff to manage this increase.

Amethyst has seen an increased fill rate and duty requirement for two reasons: the first has been to support chemotherapy skills training, allowing staff to work within the Chemotherapy Day Case Unit on a supernumery basis enabling competency sign off in line with the required training; the second reason was a spike in the dependency, as shown in the SNCT data towards the end of the month, with patients requiring additional 1:1 supportive care which was in part related to the geography of the ward and the increased sideroom provision.

C6 had an increase in dependency, shown in the SNCT data, from the middle to end of the month and saw 1:1 supportive care shifts requested based on this need.

Ward 3 at Goole (GDH) and ward 28 at Scunthorpe General Hospital (SGH) also expereienced an increased requirement for 1:1 supportive care shifts.

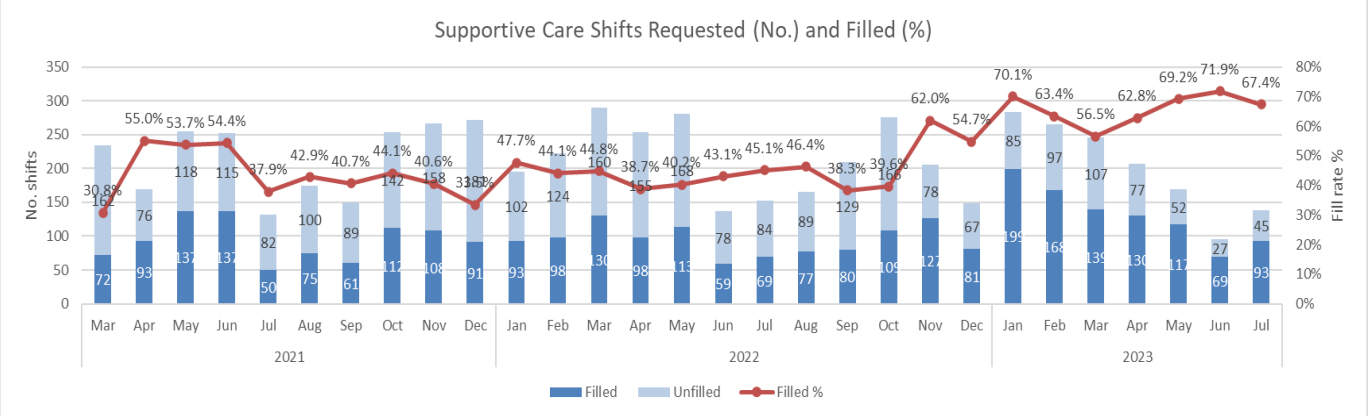
Wards with fill rates below 85% are Central Delivery Suite, Neonatal Intensive Care Unit (NICU) Diana Princess of Wales Hospital (DPOW), Laurel, Intensive Therapy Unit (ITU) DPOW and Disney. All areas have high vacancies however are areas where robust processes are in place to manage capacity and demand with senior oversight and timely escalation where required.



DPOW – Diana, Princess of Wales Hospital
SGH – Scunthorpe General Hospital
GDH – Goole & District Hospital

A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse (RN) and Registered Midwife (RMW) to Health Care Assistant (HCA) ratio for the Trust has been above 60% for the last two years. Medicine remains the lowest RN ratio in July at 55.4%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

2.2 Supportive Care – July 2023



1:1 supportive care requests increased in July. Robust process are in place with Matron oversight to ensure patient safetly can't be maintained without this additional resource. Ward fill rate data is included in the ward assurance dashboards (**Appendix 2**) and it is hoped to include number of duties requesed on the dashboards in the future.

Amethyst ward saw a spike in the dependency of patients towards the end of July with patients requiring additional 1:1 supportive care which was in part related to the geography of the ward and the increased sideroom provision.

C6 had an increase in dependency from the middle to end of the month and saw 1:1 supportive care shifts requested based on this need.

2.3 Escalation Beds

Bed modelling has been completed by the Operations Division has indicated that an additional 8 medical beds are required at Grimsby (ward C3 – 2 additional beds, ward B2 - 6 additional beds) and 4 extra beds at Scunthorpe (on ward 24). Surgery requires an additional 6 beds at Scunthorpe which will be accommodated on ward 27. Additional surgical beds at Grimsby are being reviewed. To date these beds have been used as escalation beds and staffed with bank and agency staff. Establishments will be adjusted from September 2023 to support the opening of beds and recruitment of substantive staff.

2.4 Overnight Patient Moves

Ward transfers between 22.00 and 06.00 hours are captured on the ward dashboards (**Appendix 2**) and continue to show high numbers of transfers during this period across all areas.

Within Medicine the number of out of hour patient moves continues to be monitored. It is noted that the Grimsby site undertakes more patient moves between 22:00 and 06:00 than the Scunthorpe site. These differences are more noticeable within the IAAUs (Integrated Acute Assessment Units) and Short Stay areas indicating that they are linked to bed availability and challenges in capacity. Due to these differences a Quality Improvement project is underway looking at short stay and the process linked to identification, management and placement of patients with an identified short stay need.

2.5 Staffing Indicators

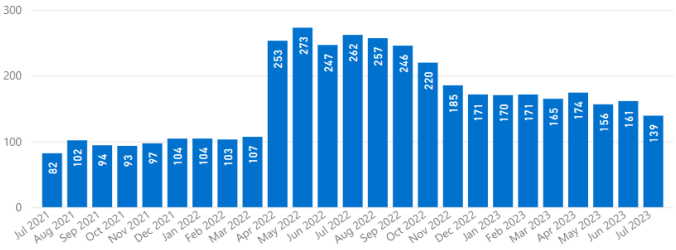
2.5.1 Vacancies

The information presented below shows data on **inpatient wards** only.

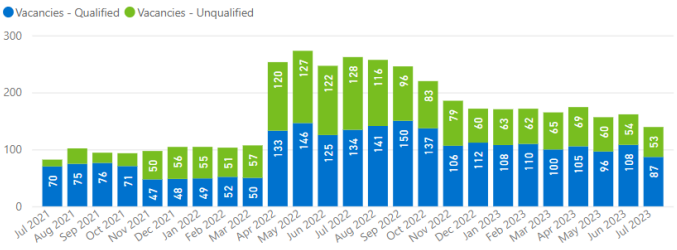
Vacancies Summary Jul 2023

Vacancies - Total	Vacancies - Qualified	Vacancies - Unqualified
139.2 ▼ -22.2	86.7 ▼ -21.2	52.5 ▼ -1.0

Vacancies



Vacancies by Staff Group



Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2023	DPOW	40.0	-8.3	48.3	
Jul 2023	GDH	7.6	-3.6	11.2	
Jul 2023	SGH	39.1	-9.3	48.4	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2023	Community & Therapies	7.6	-3.6	11.2	
Jul 2023	Family Services	3.9	-4.5	8.4	
Jul 2023	Medicine	49.9	-5.9	55.8	
Jul 2023	Surgery	25.3	-7.2	32.6	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2023	DPOW	16.4	-2.9	19.3	
Jul 2023	GDH	1.5	0.7	0.8	
Jul 2023	SGH	34.6	1.2	33.4	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jul 2023	Community & Therapies	1.5	0.7	0.8	
Jul 2023	Family Services	-1.3	-2.1	0.8	
Jul 2023	Medicine	43.5	0.6	42.9	
Jul 2023	Surgery	8.8	-0.2	9.0	

DPOW – Diana, Princess of Wales Hospital
SGH – Scunthorpe General Hospital
GDH – Goole & District Hospital

There is a total of 218.47 Whole Time Equivalent (WTE) (11.45%) RN/RMW (Registered Nurse/Registered Midwife) vacancies and 93.75 WTE (9.30%) unregistered vacancies across the Trust in July.

Ninety conditional offers have been accepted by newly qualified adult nurses (NQNs) which equates to 82.11 WTE. The majority will join the Trust in the autumn, however 16 NQNs (13.42 WTE) will not commence in post until Quarter 4 when they complete their training.

Seventeen conditional offers have been accepted by newly qualified midwives which equates to 15.16 WTE. Seven internationally educated midwives (IEMWs) have joined the Trust and have their NMC (Nursing & Midwifery Council) registration, an additional four IEMWs will join the Trust in Quarter 4.

Fifteen conditional offers have been accepted by newly qualified paediatric nurses which equates to 14.52 WTE.

Three newly qualified Operating Department Practitioners have accepted conditional offers of employment with the Trust.

2.5.2 International Recruitment

The Trust has a memorandum of agreement in place with NHS England to appoint 90 IENs (Internationally Educated Nurses) by November 2023, however has agreement to delay the last cohort until January 2024 due to our ability to safely support them in the clinical areas. IEN recruitment plans are as follows:

Month	Planned arrivals	Actual arrivals
May 2023	12	12
July 2023	23	23
September 2023	18	
November 2023	17	
January 2024	20	
Totals	90*	35

**An additional 2 IENs joined the Trust in May from the 2022/23 allocation and 4 of our HCAs (Health Care Assistants) who have been internationally registered nurses have been supported through the OSCE (Objective Structured Clinical Examination) process and have gained their NMC registration.*

The Trust agreed with the ICB (Integrated Care Board) to appoint 112 IENs in 2023/24 and it is hoped that an additional 20 IENs can be accommodated in March 2024.

The IENs who have joined the Trust continue to progress through their OSCE (Objective Structured Clinical Examination) preparation and induction programme with a 99.7% OSCE pass rate. One overseas pre-registration nurse failed their OSCE for the third time which resulted in the overall Trust pass rate falling from 100% in May to 99.7% in June. Nationally between January - March 2023, a total of 10613 applicants took the new OSCE and overall, 76% achieved a pass.

The Trust is continuing to participate in work with the ICB to develop links with educational institutions in Kerala and Karnataka to support our current and future pipelines for nurses and AHPs.

2.5.3 Nursing Apprenticeships

The Trust started to offer nursing apprenticeships from January 2023. The table below summarises progress to date:

Start date	Course	Starters	Break in learning/ left programme	Anticipated end date	Anticipated no. of registrants	Actual no. of registrants
Sep 2022	APIN (Assistant Practitioner Nursing) conversion to RN (Registered Nurse)	1	-	Sept 2024	1	
Jan 2023	Nursing Associate (NA) conversion to RN*	5	-	Aug 2024	5	
Jan 2023	Trainee NA (Nursing Associate) (15 places/year)	9	2 paediatric trainees (left programme)	Feb 2025	7	
Sep 2023	APiN conversion to RN*	5	1 (deferred)	Sept 2025	4	

Sep 2023	RNDA (Registered Nurse Degree Apprenticeship) (15 places/year)	10	-	Sept 2026	10	
Total		**30**	**3**	**-**	**27**	

**10 places per year total for conversion programme*

The number of offers made to date has been lower than anticipated and work has been undertaken to support future applicants to meet the apprenticeship entry requirements and with application and interview preparation. The advert for the next cohort of trainee Nursing Associates has closed with 48 applications received; 26 applications have been received for the conversion course.

2.5.4 Recruitment and retention work

Recruitment initiatives include:

- Working with workforce colleagues to diversify the IN pipeline and ensure adequate support for ambitions. Participating in the Integrated Care Board Project to develop links and recruit nurses from Kerala
- Widening Access Project (NHS England funding for 12 months) – to date 16 Healthcare Support Workers from diverse backgrounds have been offered posts, the target is 20 Healthcare Assistants by 31st March 2024
- Targeted divisional support worker recruitment along with Trust mass recruitment days
- Recruitment underway for the next cohorts of Nursing Apprenticeships

Retention initiatives includes:

- Ongoing delivery of career clinics and promotion of the internal transfer process, continued development of the nursing career framework to improve accessibility
- Flexible working team rostering pilot progressing with rollout to further wards
- 38 HCA (Health Care Assistant) buddies trained across 23 clinical areas with plans to rollout the programme further this year
- Development of Healthcare Assistant Council across sites. Proposal to develop this into Shared Decision-Making Council
- Development of legacy mentor role (supported by NHS England funding) to impart knowledge, skills and experience through coaching and supporting nurses, midwives and AHPs in the early stages of their career development to improve their experience and reduce attrition
- Continue to train Professional Nurse Advocates (PNAs) – trajectory of 91 qualified PNAs by March 2024 (1:20)
- Next cohort of trainee ACPs (Advanced Clinical Practitioners) commencing September 2023 & January 2024 (acute medicine – 3, urology – 1)
- International recruitment ‘stay and thrive’ work

2.5.4 Staffing incidents & Red Flags

Twenty-four nurse staffing incidents and 37 red flags incidents were reported in July. Nine of the staffing incidents were reported on maternity Grimsby and will be discussed in the separate Midwifery & Neonatal oversight report.

Twenty-three red flag incidents were raised because areas were ‘below safe staffing levels’, 7 of these were reported on ward C3, 3 on the stroke unit at Scunthorpe and 3 on ward 6 at Goole. Ward 25 reported 4 red flag incidents and 3 nurse staffing incidents. Incidents are linked to short notice sickness and failure to provide 1:1 supportive where need identified. Staffing shortfalls are reviewed and mitigated throughout the day where possible.

Safe staffing red flags are currently being reviewed to ensure they remain appropriate.

3 Non-Inpatient Ward Areas

The non-inpatient ward dashboard has been developed and can be found in **Appendix 3**. Safety and quality indicators are discussed in more detail later in the report.

Work is underway to improve hand hygiene compliance in Same Day Emergency Care DPOW which is at 90.8%.

4 Emergency Care Centres

The Emergency Centre dashboards can be found in **Appendix 4.** Vacancies remain high in both departments but particularly at Scunthorpe however the departments have an NQN (Newly Qualified Nurse), IEN (Internationally Educated Nurse) and new starter pipeline that leaves minimal band 5 RN (Registered Nurse) vacancy. The Division are working with the recruitment team to realise the pipeline as quickly as possible.

Work continues to improve hand hygiene compliance at Grimsby. Safety and quality indicators are discussed in more detail later in the report.

5 Maternity

5.1 Midwife to birth ratio

The Maternity dashboard can be found in **Appendix 5**. However, the July data should be viewed with caution as data quality issues have been identified and are being explored.

The midwife to birth ratio for the Trust in July was one to 23.1 (Grimsby – 1:24.2, Scunthorpe – 1:21.7) 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.

5.2 Maternity Fill Rates and Care Hours Per Patient Day (CHPPD)

Maternity Wards Fill Rates and CHPPD Jul 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.2%**	**▲ 1.0%**	**82.5%**	**▲ 1.0%**	**11.8**	**▲ 0.17**
Registered Nurses and Midwives	88.0%	▲ 1.6%	77.4%	▲ 0.7%	7.3	▲ 0.16
Care Staff	96.8%	▼ -0.1%	91.4%	▲ 1.6%	4.6	▲ 0.01
Central Delivery Suite	**84.4%**	**▼ -0.3%**	**55.3%**	**▲ 0.3%**	**25.7**	**▼ -5.48**
Registered Nurses and Midwives	85.7%	▲ 1.1%	51.8%	▼ -1.3%	20.9	▼ -4.05
Care Staff	79.4%	▼ -6.1%	69.7%	▲ 6.9%	4.7	▼ -1.42
Jasmine & Honeysuckle	**93.9%**	**▲ 3.5%**	**77.0%**	**▲ 0.4%**	**11.3**	**▼ -5.21**
Registered Nurses and Midwives	91.9%	▲ 4.9%	78.0%	▲ 7.9%	7.4	▼ -3.25
Care Staff	98.0%	▲ 0.5%	75.0%	▼ -15.2%	3.9	▼ -1.96
Ward 26 SGH	**87.6%**	**▼ -3.2%**	**59.7%**	**▲ 0.3%**	**6.7**	**▲ 0.14**
Registered Nurses and Midwives	84.9%	▼ -5.9%	53.2%	▼ -3.8%	4.8	▼ -0.05
Care Staff	95.0%	▲ 3.9%	77.4%	▲ 11.5%	2.0	▲ 0.18
Total	**89.6%**	**▲ 0.4%**	**69.9%**	**▲ 0.5%**	**11.2**	**▼ -1.04**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	61.5%	▲ 0.5%
Central Delivery Suite	81.6%	▲ 1.3%
Jasmine & Honeysuckle	65.9%	▲ 1.1%
Ward 26 SGH	70.8%	▼ -2.2%
Total	**69.0%**	**▲ 0.2%**

The shift fill rates in maternity remain below 95% in all areas with staffing shortfalls seen across both hospital sites and in the community. Escalation processes and plans are in place to manage capacity and demand with daily senior oversight and escalation of any risks that can't be mitigated.

Maternity and neonatal services are discussed in detail in the separate Maternity and Neonatal Oversight Report.

6 Community Nursing

The Community Nursing dashboard can be found in **Appendix 6**.

6.1 Community Nursing Workforce

The overall vacancy rate for nursing in Community and Therapies has increased slightly in July 2023 with the largest number of vacancies being Registered Nurse posts in the Community Nursing Networks.

There is ongoing work to recruit to vacancies and retain new and existing staff to improve staffing capacity. Once all the newly recruited band 5 nurses and the September cohort newly qualified nurses are in post, there will be minimal band 5 vacancy in the Community Nursing Networks.

The Macmillan Healthcare team vacancies are in the recruitment pipeline.

Vacancies by Team Jul 2023

Team	Vacancies - Qualified	Vacancies - Unqualified	Total
South Network	6.1	-0.8	5.3
East Network	3.4	1.0	4.4
Macmillan Health Care Team		3.1	3.1
West Network	3.3	-0.6	2.6
Single Point of Access (SPA)	2.3	0.1	2.4
Intermediate Care Services (ICS) + Core Therapy	1.7	-0.6	1.1
Palliative Care	1.0		1.0
Tissue Viability Team	0.0	1.0	1.0
Continence Team	0.0	0.2	0.2
Unscheduled Care Team (UCT) (incl rapid response)	1.3E-15	0.2	0.2
Evening / Night Service	-0.3	0.5	0.1
Specialist Palliative Care Nurses (SPC)	0.0		0.0
DN Students	0.0		0.0
Locality Co-ordinators	-0.2	0.0	-0.2
Long Term Conditions / Complex Care Matrons (Comm Matrons)	-0.3		-0.3
Chronic Wound Team	0.2	-0.7	-0.5
Discharge Liaison Team		-1.0	-1.0
Total	**17.2**	**2.5**	**19.7**

6.2 Community Red Flag Incidents

The total red flag incidents for July 2023 were three, one of these relate to shortages in staffing reported by West Network. Staff are being reminded in team meetings to report red flags as this number does not reflect current staffing challenges.

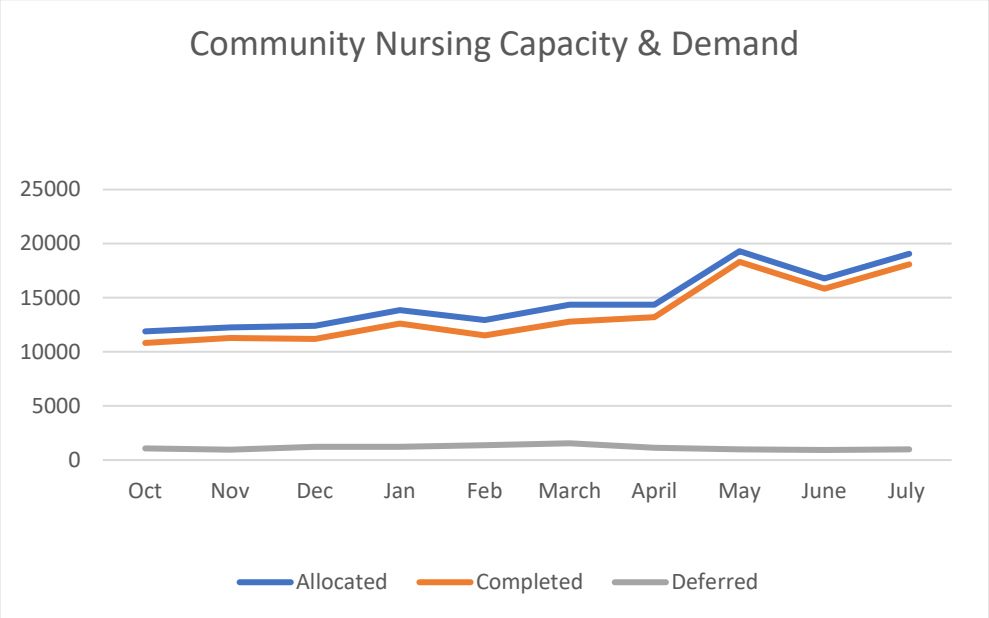
Red flags are currently being reviewed.

6.3 Community Nursing Activity

There is limited activity information for July 2023 due to the ongoing issues with the data warehousing, this is evident in our Community Nursing dashboard.

The following data has been pulled manually from Civica the electronic scheduling system used in Community Nursing.

Visits Allocated July 23 (Completed + Deferred)	Visits Completed July 23 (Visits Activity Report)	Visits Deferred/Cancelled Moved to July 23 (Moved Visits Report)
19078	18096 (average 583.7 per day) 95%	982 moved



6.3.1 Activity delivered/not delivered

- The data shows that the activity continues to be higher in month than was seen in 2022-2023 and there has been a further increase seen in July 2023
- Further work is being undertaken to understand this increase in demand and what kind of activity it is
- Despite the increase in the total number of visits, 95% of visits were completed and only 5% were deferred, this has remained consistent for the past 2 months
- Capacity and demand are reviewed at a weekly safe staffing meeting, visits are looked at proactively and staffing moved between networks to cover any shortfalls
- Capacity and demand are also reviewed on a daily basis and any visits that need to be deferred because of capacity are prioritised using the Essential Visit Guidance for Community Network Teams
- Patients who are receiving care that is considered essential are ticked on the Civica electronic allocation system as requiring a ‘critical intervention’ so these visits are not deferred
- The caseload holders (District Nurses) have oversight of deferred visits for their patients

7 Non-Medical Education Tariff (NMET)

Successful work continues to support the growing number of undergraduate students through expansion of student placements.

The DHSC (Department of Health and Social Care) introduced tariffs for clinical placements on 1st April 2013. The clinical tariff payment is intended to provide an annual contribution to the funding of placement coordination and practice-based learning for all eligible clinical professions. The tariff funding should be used to support all professions for which it has been allocated.

The placement tariffs cover funding for all direct costs involved in delivering education and training by the placement provider, and the DHSC state that:

"Placement providers must demonstrate that such funding for clinical placements is being utilised for the delivery of such learning" (DHSC 2022).

Tariff payments are calculated as follows:

> Pre- September 2022: £3,993 per WTE (Whole Time Equivalent)*
> As of 01/09/22: £5,193 per WTE*
> ** 1.0 WTE for the purpose of tariff calculations and payments is 40.8 weeks/year, a week of placement activity should be reflective of 37.5 hours of placement activity*

Placement capacity has increased by 70% since 2018 and submissions for 2023 are as follows:

Submission Date	Hours	Income
03/04/23	75,942	£257,756
21/08/23	111,449	£364,214
Total	**187,391**	**£636,027**

The next data submission will be made in mid-December 2023. Work is being progressed to determine where this additional tariff income is required to support clinical placements.

8 Advanced Level Practice

The ACP (Advanced Clinical Practice) Programme continues with an additional two trainees starting in September, one in acute medicine and one in urology, with the University of Hull. It is hoped that a further two acute medicine trainees will start the apprenticeship programme in January with Sheffield Hallam University.

Governance processes continue to be strengthened with specialty national curriculums used where available and collaborative work is underway with the Corporate Lead ACP in Hull University Teaching Hospitals to align curriculum use.

A strategic advanced level practice meeting is being established at the request of the Chief Nurse and Chief Medical Officer to provide strategic direction and support development of a co-ordinated consistent approach to identifying needs and developing advanced level practice and MAP (Medical Associate Professions) roles (physician associates, anaesthesia associates, surgical care practitioners and advanced critical care practitioners) within the Trust with the first meeting planned for 21st September 2023.

9.0 Quality

9.1 Reported Falls Incidents (In-patient Wards)

There has been a decrease in the total number of reported in-patient falls in July 2023. There has been an increase in the number of falls reported at the Grimsby site and a decrease in the number of falls reported at the Scunthorpe site.

There were three in-patient falls reported with major harm in July 2023. All three incidents resulted in the patients sustaining femoral fractures.

No lapses in care were identified in two incidents which occurred on Ward B3 at the Grimsby site and the Integrated Acute Assessment Unit (IAAU) at the Scunthorpe site. The huddles for each incident were completed within three working days.

Lapses in care were identified in the incident which occurred on Ward 22 at the Scunthorpe site. A full investigation is being completed to identify the learning. The huddle was completed within two working days of the incident.

Emergency Departments

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

There was one fall with moderate harm reported at Scunthorpe Emergency Department. The patient sustained a fractured vertebra. The incident was reviewed by the Deputy Chief Nurse and no lapses in care were identified.

9.2 Wards with Highest Incidence of Fall

Highest Reporting Wards with Falls Incidents Jul 2023

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - A1	8	▲ 4	2	▲ 2	0	0	0	0	10	▲ 6
DPOW - C3 Short Stay	5	▲ 3	3	▲ 1	0	0	0	0	8	▲ 4
DPOW - Amethyst	5	▲ 1	2	▲ 1	0	0	0	0	7	▲ 2
SGH - Ward 27	4	▲ 2	3	▲ 2	0	0	0	0	7	▲ 4
DPOW - B3	4	▲ 4	0	0	0	0	1	▲ 1	5	▲ 5
DPOW - B6	1	▼ -4	4	▲ 1	0	0	0	0	5	▼ -3
DPOW - C2	5	▲ 4	0	0	0	0	0	0	5	▲ 4
DPOW - C6	2	▲ 2	3	0	0	0	0	0	5	▲ 2
SGH - Ward 16	4	▲ 1	1	▼ -3	0	0	0	▼ -1	5	▼ -3
SGH - Ward 25	5	▼ -1	0	▼ -1	0	0	0	0	5	▼ -2

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

None of the higher reporting wards are demonstrating any concerning trends at present.

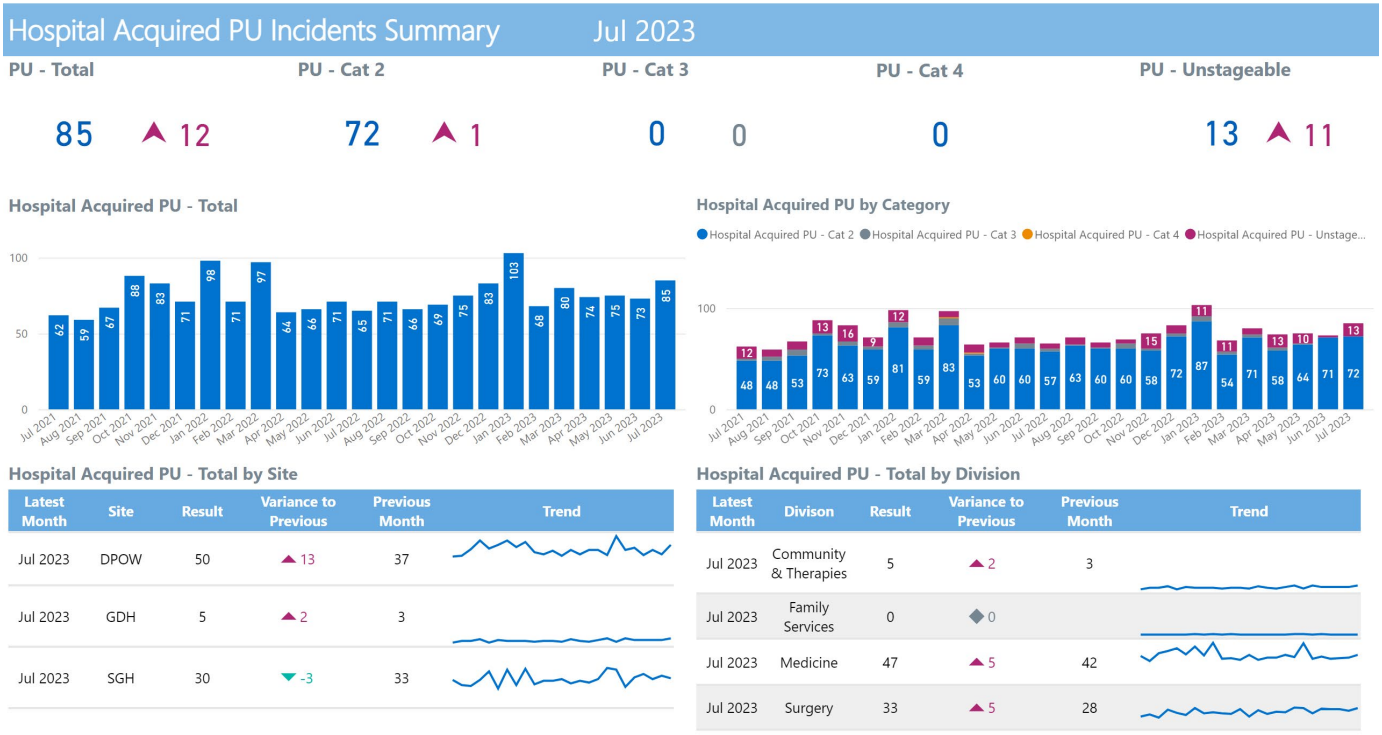
No staffing concerns have been highlighted on any of the higher reporting areas. The areas detailed above have all been reviewed alongside other metrics at the Nursing Metrics Panel with no areas of immediate concern.

9.3 Pressure Ulcers

9.4 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.



The number of pressure ulcer incidents reported in July 2023 has increased. There has been an increase in the number of reported unstageable pressure ulcers. There have been no Category 3 pressure ulcers reported.

All moderate harm incidents reported in July 2023 have been reviewed at the weekly scrutiny meeting.

Lapses in care were identified in three of the incidents reviewed. These were reported by Ward B3 and the Stroke Unit at Grimsby and the Integrated Acute Assessment Unit at Scunthorpe.

No new root causes were identified during the review process and local actions are in place to share the learning.

9.5 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents **Jul 2023**

Indicator	Hospital Acquired PU - Cat 2		Hospital Acquired PU - Cat 3		Hospital Acquired PU - Cat 4		Hospital Acquired PU - Unstageable		Hospital Acquired PU - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - A1	5	▲ 2	0	0	0	0	2	▲ 2	7	▲ 4
DPOW - C3 Short Stay	5	0	0	0	0	0	2	▲ 2	7	▲ 2
DPOW - B3	5	▼ -1	0	0	0	0	1	▲ 1	6	0
DPOW - B7	6	▲ 3	0	0	0	0	0	0	6	▲ 3
DPOW - B6	4	▲ 1	0	0	0	0	1	▲ 1	5	▲ 2

DPOW – Diana, Princess of Wales Hospital

Ward C3 Short Stay has triggered as higher reporting ward for the third consecutive month. No lapses in care were identified when the unstageable pressure ulcers were reviewed.

Ward B3 has triggered as a higher reporting ward for the second consecutive month. A robust education plan is being implemented on the ward following the learning identified when the unstageable pressure ulcer was reviewed.

None of the other higher reporting wards are currently demonstrating any concerning trends.

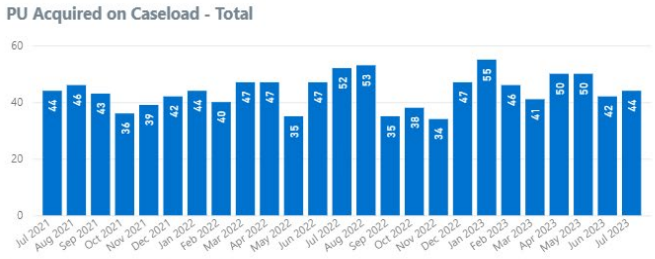
No staffing concerns have been highlighted on any of the higher reporting areas. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

9.6 Community (Acquired on Caseload) Pressure Ulcer Incidents

The data includes pressure ulcers acquired on community caseload at North Lincs, this includes category 2,3,4 and unstageable pressure ulcers. 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 **Jul 2023**

PU - Total		PU - Cat 2	PU - Cat 3		PU - Cat 4	PU - Unstageable	
44	▲ 2	31	5	▲ 1	0	8	▲ 1



PU Acquired on Caseload by Team **Jul 2023**

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
South Network	15	3	0	2	**20**
West Network	11	1	0	2	**14**
East Network	4	0	0	1	**5**
Intermediate Care Services (ICS) + Core Therapy	0	1	0	3	**4**
Tissue Viability Team	1	0	0	0	**1**
Total	**31**	**5**	**0**	**8**	**44**

The number of pressure ulcer incidents in July 2023 has increased slightly. South Network have reported the highest number of incidents followed by West Network and then East Network. This is reflective of the caseload sizes.

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.

There has been a slight increase in the number of unstageable and category 3 pressure ulcers. There have been no category 4 pressure ulcers.

All moderate harm incidents reported in July 2023 have been reviewed at the Community and Therapy Weekly Pressure Ulcer Scrutiny Meeting.

Lapses in care were identified in 2 of the incidents reviewed. These were both reported by South Network. No new root causes were identified during the review process and learning is being shared across the teams.

A review of the networks and place of residence for patients who developed a category 2,3,4 or unstageable pressure ulcer for July is as below. 28 of the incidents occurred in care homes and 16 in patients' own homes. The information will be used to guide the ongoing education and training provided by the React to Red team to care homes.

Pressure Ulcer	**Developed in patients own home/network**	**Developed in residential/care home setting (name if known)**
Category 2	**5 South Network** **4 West Network (1 reported as Tissue Viability Team)** **3 East Network**	**10 South Network** 1 Gresham Lodge Residential Home 1 Cherry Tree House Residential Home 3 Sycamore Lodge Care Home 1 Sunningdale Court Care Home 1 The Valleys Residential Home 1 Carisbrooke Manor Care Home 1 Balmoral House Residential Home 1 Richeden Park Residential Home **8 West Network** 2 Cumberworth Lodge Residential Home 2 Sandhills Residential Home 1 Overfields Care Home 1 Ascot House Residential Home 1 Greenacre Residential Home 1 St Mary's Nursing Home **1 East Network** 1 Abbey Village Care Home
Category 3	**1 South Network** **1 West Network**	**2 South Network** 1 Carisbrooke Manor Care Home 1 Sycamore Lodge Care Home **1 Intermediate Care** 1 Sir John Mason House
Category 4	**0**	**0**
Unstageable	**1 South Network** **1 East Network**	**1 South Network** 1 Balmoral House Care Home **2 West Network** 1 Nicholas House Care Home 1 Greenacres Residential Home **3 Intermediate Care** 3 Sir John Mason House (2 the same patient)
Totals	**16**	**28**

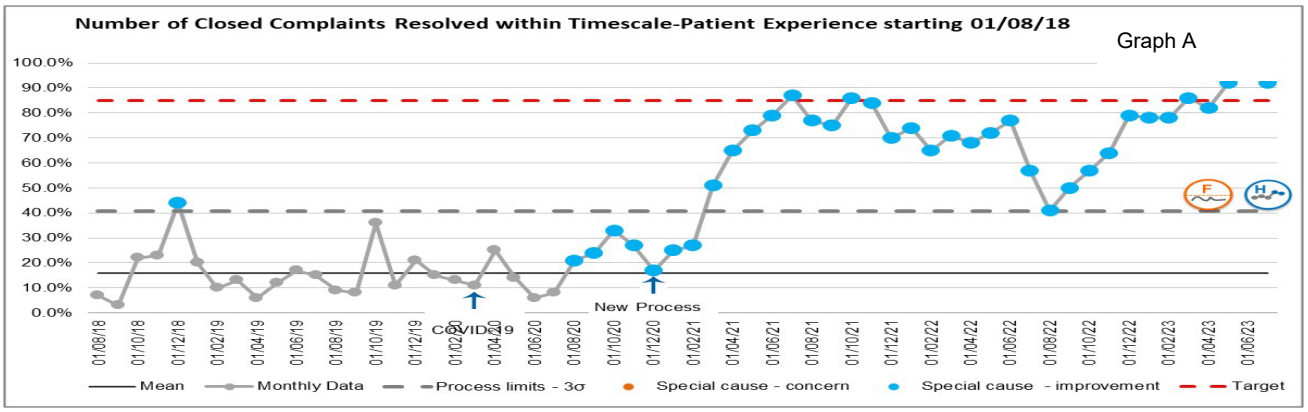
Improvement plan

Areas for Improvement	Actions
Education and training	• Education and training with dates scheduled for 2023 • Tissue Viability training to be made mandatory every 2 years- to be approved • Weekly review of all moderate harm pressure ulcers leading to immediate actions being undertaken to reduce risk to patients • Tissue Viability education programme to be included in care home programme of training organised by Head of Nursing from the Integrated Care Board (ICB)
Staffing	• Weekly safe staffing, capacity, and demand review
Equipment	• Updated algorithm for equipment choice
Risk assessments	• Introduce Primary Ulcer Risk Primary or Secondary Evaluation Tool (Purpose T) across acute and community

10 Patient Experience

New formal complaint numbers for July were 39, which equates to a 39% increase. These are: 20 Medicine, 13 Surgery and Critical Care, 4 Family Services and 2 Community and Therapies. Complexity remains high and this is having a direct impact on the ability of Lead Investigators to manage multiple investigations, this is especially evident in surgery and Critical Care. This has been escalated within the divisions for review of their processes as at the time of reporting, the Trust had 6 complaints open over timescale, which is the highest number seen this year, 4 of these resided with Surgery and Critical Care division. In conjunction with the escalation to the triumvirate, the Complaint Manager continues to have meetings with division, with weekly divisional complaint reporting for increased awareness.

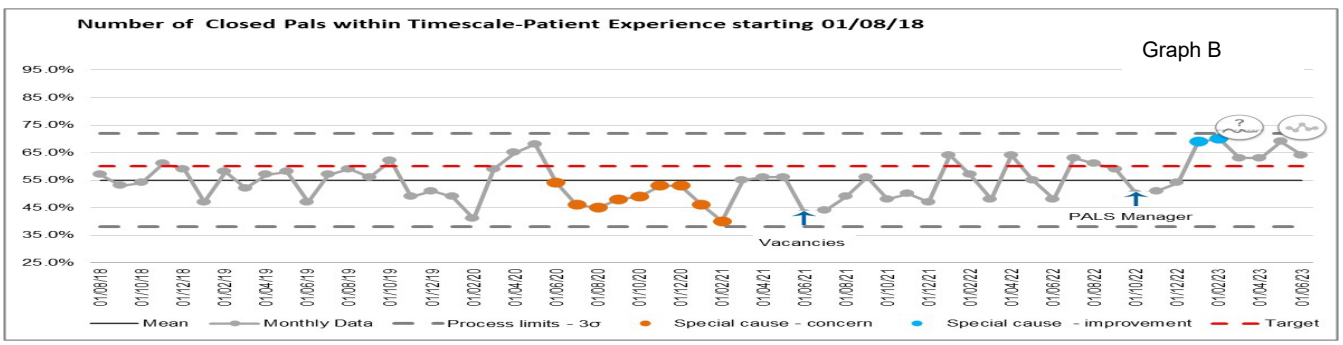
July saw 92% of closed complaints managed in timescale, as seen in graph A. This achievement continues to provide patients and families with timely, robust, and compassionate complaint investigation responses.



The learning log pilot, which will see learning captured electronically via Ulysses and will support divisions to identify themes , completed and ongoing actions, continues. The central team continue to receive in house training to ensure learning actions are meaningful however a wider conversation will need to be undertaken with divisions on how they can best equip their lead investigators to identify this. This will be part of the pilot evaluation and findings from a Learning from Complaints Audit by Audit Yorkshire will be finalised and contribute to those discussions.

A noted increase in the theme around End of Life care has been identified in formal complaints, with RESPECT form completion being one key area. This information is shared monthly at the the End of Life Strategy Group.

156 new Patient Advice and Liaison Service (PALS) concerns were logged in July, which is similar to June's data; 129 concerns were closed, of which 71% were closed in timescale. The consistency in improvement, since separating out the management of PALS from formal complaints can be seen in graph B below. The risk regarding the temporary Patient Experience Manager post loss remains on the Chief Nurse Risk Register.



July saw 57 compliments logged across the Trust, through Ulysses, a 39% increase from June. Three positive messages were logged via the national platform, Care Opinion.

A Visiting Framework workshop is planned for September following divisional discussions related to visiting survey findings. “Vicki’s Plea”, a moving patient story about the impact of restricting visiting has been shared with the Trust from the Patient Experience leads NHS England as it has been pivotal in shaping the national visiting agenda, which will become more apparent in November as it is finalised. The Trust remains linked into the national review work.

The Volunteering Team continue to work to increase volunteers, especially those in wayfinding positions. The challenges of patients and visitors navigating the Trust’s current signage, outpatient letter instructions and movement of areas has been highlighted numerous times to the Patient Experience Group and escalated via Quality Governance Group. A small working group is now focusing on creating a cascade pathway for changes to improve the experience for patients and visitors. This forms part of a layered longer-term project which is being developed for proposal. Volunteers are central to this, and their voice will be part of the working group. The youth volunteer programme outline is being refined following first formal iteration of the proposal will be available by September. There were 109 core volunteers registered on the data base in July, and a further 46 providing services such as hospital radio or pet therapy.

The North Yorkshire and Humber Integrated Care System (ICS), NHSE and the Kings Fund patient experience project, which the Trust is part of continues to progress. Alongside Humber, Hull University Teaching Hospitals, City Health Care Partnership and York and Scarborough Teaching Hospitals NHS Foundation Trust a communication charter is being developed through engagement processes. The project has required ICB leadership involvement, following posts being recently changed, this has now been confirmed and should provide additional resource and support to add pace to the project. The next planned exercise is how the wider engagement workshops will look, and this will take place in September. The Kings Fund continue to explore how working across the ICS is practically, including challenges and benefits.

July Friends and Family Test (FFT) data submission saw the expected dramatic decrease in Trust feedback responses via this route, with a 59% reduction in recorded patient feedback.

As highlighted in last month’s report the Trust digital priorities have resulted in a delayed implementation plan with the Trust’s new provider Healthcare Communications (HCC). To mitigate this the Patient Experience Team are now extending the temporary paper solution to all areas. This will have continued implications to the team’s ability to progress any new work due to the manual inputting of data, it is hoped that HCC will have the Trust platform built in the next 2 months which will allow the paper submissions to be managed by them and therefore release the Patient Experience Team once again. The risk is highlighted on the Chief Nurse Risk Register and regular meetings with the Trust’s digital team are ensuring communications and timelines are updated.

11 Mixed Sex Breaches

No mixed sex breaches were reported in July.

12 15 Steps Challenge

Ten 15 Steps Challenge visits were completed during July 2023, 5 visits within the acute schedule at Diana Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH), 5 visits within the community schedule. Four visits were rescheduled due to doctor strikes and/ or clinical team member cancellation. Themes reported through the acute schedule are shown in **Appendix 7**.

Acute 15 Steps Challenge Visits				
Date	**Area**	**Rating**	**Rating**	**Most Recent Rating**
04/07/2023	Fracture Clinic, SGH	N/A	14/07/2022	04/07/2023
06/07/2023	Same Day Emergency Care, SGH **Revisit**	28/04/2022	06/10/2022	06/07/2023
12/07/2023	Neonatal Intensive Care Unit, DPOW	08/07/2021	28/07/2023	12/07/2023
19/07/2023	Antenatal Outpatients, SGH **Revisit**	N/A	12/01/2023	19/07/2023
25/07/2023	Cardiology Outpatients, SGH	N/A	N/A	25/07/2023

Community 15 Steps Challenge Visits			
Date	**Area**	**Rating**	**Most Recent Rating**
11/07/2023	Community Dental, Beacon Medical, Cleethorpes	13/05/2023	11/07/2023
12/07/2023	Macmillan Healthcare Team, Global House, Scunthorpe	04/03/2023	13/07/2023
13/07/2023	East Nursing Network, Global House, Scunthorpe	14/02/2022	13/07/2023
13/07/2023	South Nursing Network, Global House, Scunthorpe	05/07/2022	13/07/2023
13/07/2023	West Nursing Network, Global House, Scunthorpe	24/08/2022	13/07/2023

*Rating guidance

Outstanding	Good	Requires Improvement	Intensive Support

Mandatory alert organism

Overview 2023/24 YTD
Healthcare-associated cases

	PHE Trust-level Targets	Trust	April – July 2023 DPOW	SGH	GDH	2022/23 2022/23 Targets	2022/23 Actuals
C. difficile	20	6	2	4	0	21	24
MRSA	No Target	0	0	0	0	0	1
MSSA	No Target	5	2	3	0	No Target	20
E. coli	46	19	12	4	3	65	65
Klebsiella spp.	22	7	3	4	0	25	23
P. aeruginosa	7	2	1	1	0	7	15

Targets 2023/24

Healthcare-associated cases (HOHA and COHA) Hospital Onset Healthcare Associated/Community Onset Healthcare Associated
Baseline dataset 12 months ending November 2022
C. difficile – Trusts with greater than 10 cases – target 1 less than count
Gram-negative bloodstream infections - Trusts with greater than 10 cases – target 5% less than count
https://www.england.nhs.uk/publication/minimising-clostridioidesdifficile-and-gram-negative-bloodstream-infections/

Current Highlights

Alert Organisms

There is concern nationally regarding a national increase in cases of Cdiff (Clostridioides difficile) and MSSA (Methicillin-Susceptible Staphylococcus Aureus) Bacteraemia. A national working group is looking at this and it is thought to be associated to post pandemic.

Whilst the Trust is currently managing well with Cdiff, an in-depth Post Infection Review (PIR) continues to take place for each case. It needs to be recognised that the case threshold set may not be met this year. There is no threshold set for MSSA BC's, however a PIR is held for each case.

There is a PIR in process with appropriate action plan regarding an MRSA BC case in August at SGH. The source of the BC is deemed to be associated with a peripheral cannula.

The Trust is performing within acceptable levels with the other alert organisms.

The Trust is participating in a National Point Prevalence Survey 2023: Healthcare Associated Infections (HAI), Antimicrobial Use and Antimicrobial Stewardship in England. To commence 19th September 2023 over 4 weeks on the Grimsby and Scunthorpe sites on all inpatient wards.

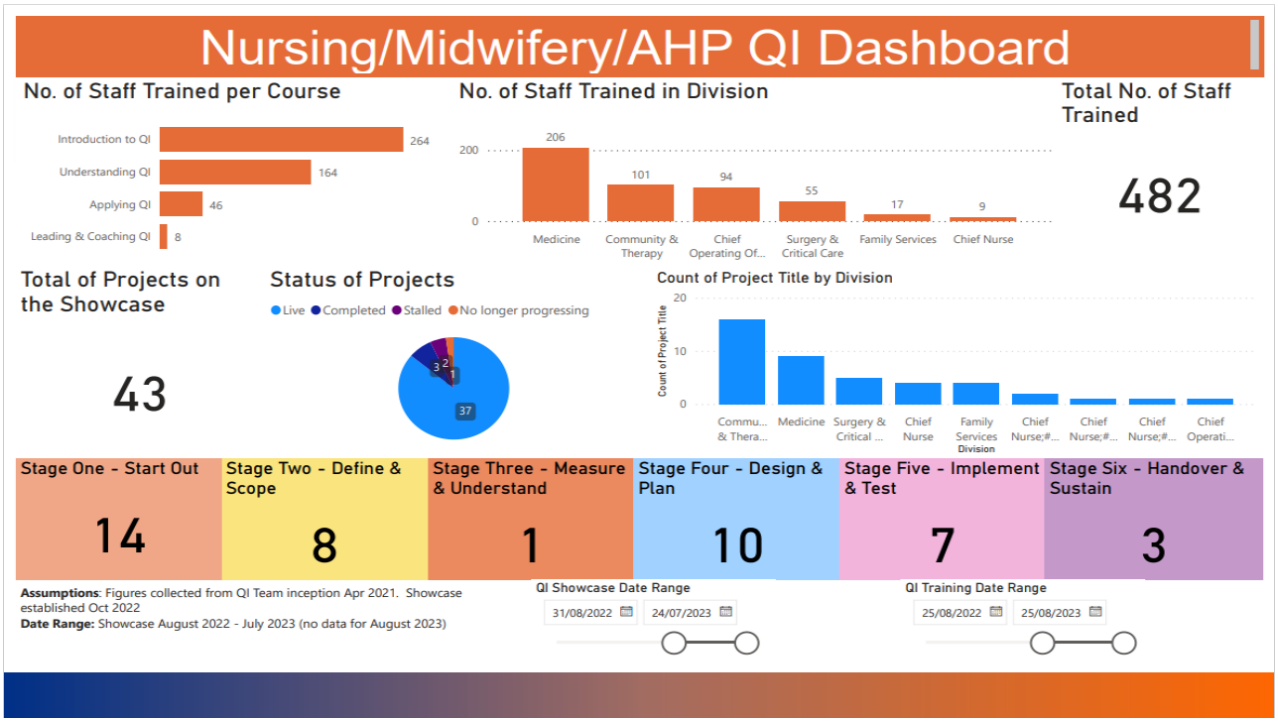
Objectives:

- To estimate the total burden (prevalence) of Healthcare Associated Infections (HAIs) and Antimicrobial Use (AMU) in acute-care hospitals, community trust sites and mental health sites
- To describe patients, invasive procedures, infections and antimicrobials prescribed

- To describe key structures and processes for the prevention of HAIs and antimicrobial resistance at the hospital and ward level
- To disseminate results to those who need to know locally, regionally and nationally
- To provide a standardised tool for hospitals to identify targets for quality improvement
- The team are finalising the Bugs R Us study day on 24th October. The day has guest speakers and product stands. There is key focus on antimicrobial resistance and also Gram-negative bacteria
- Infection Prevention & Control (IPC) Link Champions: Study sessions planned for November
- IPC Nurse vacancies: x1 IPC Nurse Band 7 retired August and further IPC Nurse Band 7 to retire in December. Plan to put out advert for Band 7 Whole Time Equivalent. Team Winter Plan including 'On Call' to be revisited

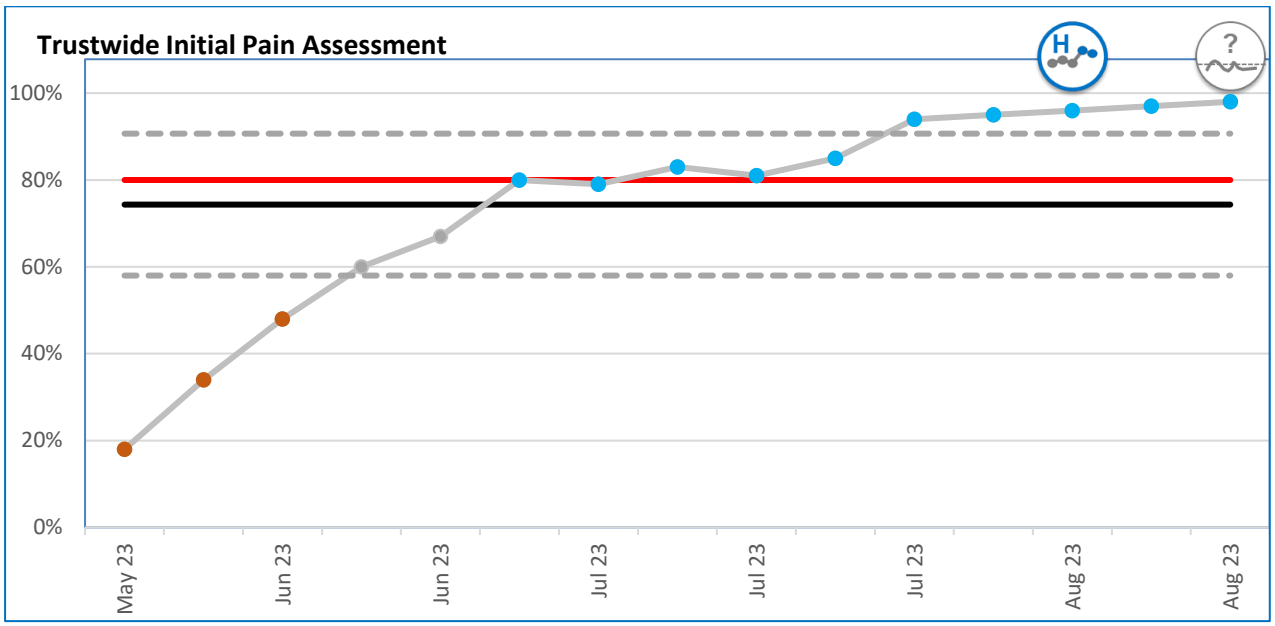
14 Quality Improvement (QI)

As part of the Trust QI strategy to build QI capacity and capability across all levels of the organisation, the below charts capture the number of Nurses, Midwives and AHPs (Allied Health Professions) that have accessed QI training to date, split by division and the different levels of QI training completed in accordance with the QI educational dosing model levels of training. To date 482 of this workforce have been trained at some level of QI, in addition 43 QI projects have been initiated in the past 12 months.

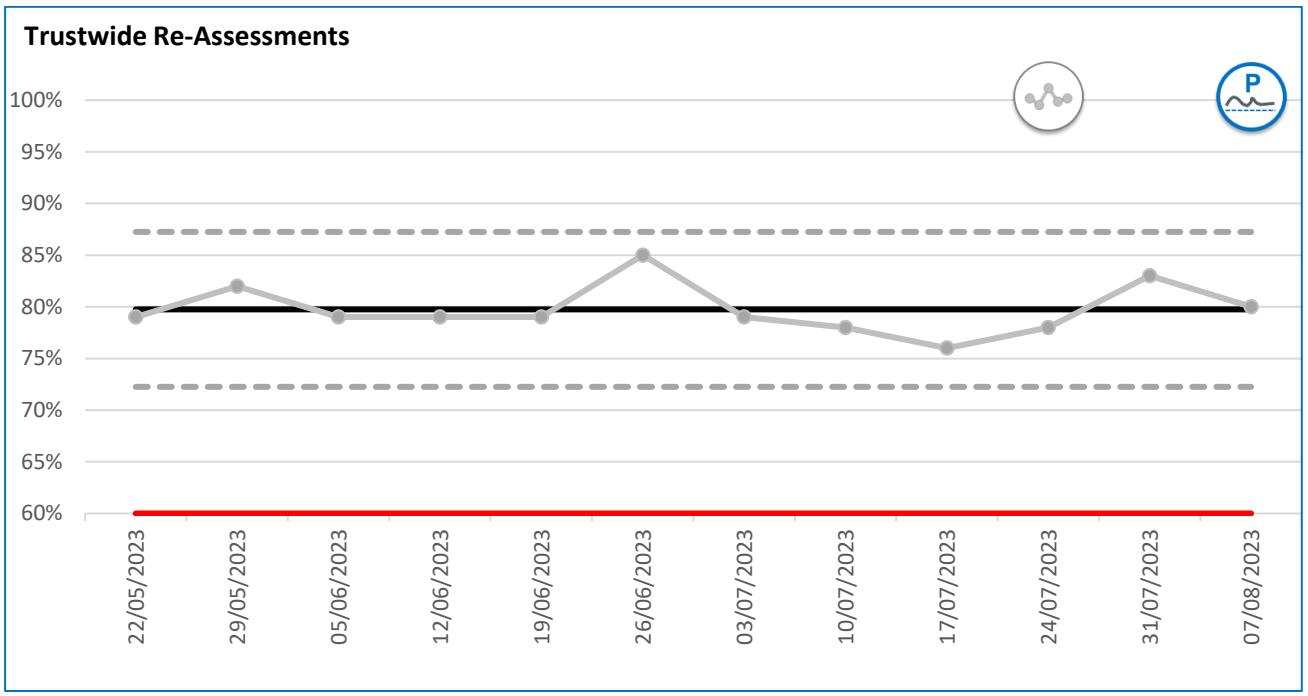


Work continues with the QI collaborative to improve pain assessment and reassessment on inpatient wards. The WebV electronic pain assessment is currently the most used electronics form in the trust with the below SPC chart demonstrating measurable improvement achieving the aim of the QI Collaborative for both Assessment & Reassessment.

Aim statements: to achieve a completion rate of two pain assessments per patient per day of 80% (based on the fill rate of 85% of the core bed numbers) by 30th September 2023.



To achieve a completion rate of 60% of re-assessments for patients that trigger a re-assessment by 30th September 2023.



Work continues to engage those wards that are not yet demonstrating measurable improvement whilst monitoring all ward to ensure the improvement has been sustained.

15 Conclusion

CHPPD (Care Hours per Patient Day) was 8.7 in July. There were no wards with CHPPD below 6. The overall fill rate has been around 95% for the last five months. Higher fill rates on some wards are a result of an increased number of beds open in line with the recent bed modelling increases resulting in the requirement for additional staff to manage this increase, and additional 1:1 supportive care requirements which couldn't be safely managed within some establishments. Establishments will be adjusted from September 2023 to support the opening of beds and recruitment of substantive staff.

The midwife to birth ratio for the Trust in July was one to 23.1 (Grimsby – 1:24.2, Scunthorpe – 1:21.7) which is below the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios.

There is a total of 218.47 WTE (Whole Time Equivalent) (11.45%) RN/RMW (Registered Nurse/Registered Midwife) vacancies and 93.75 WTE (9.30%) unregistered vacancies across the Trust in July. Ninety conditional offers have been accepted by NQNs (Newly Qualified adult Nurses) which equates to 82.11 WTE. Seventeen conditional offers have been accepted by newly qualified midwives (15.16 WTE). Fifteen conditional offers have been accepted by newly qualified paediatric nurses (14.52 WTE), and three newly qualified Operating Department Practitioners have accepted conditional offers of employment.

International recruitment continues with 23 IENs (Internationally Educated Nurses) joining the Trust in July. Recruitment is underway for the next cohorts of nursing apprentices. Work has been undertaken to support future applicants to meet the apprenticeship entry requirements and with application and interview preparation, and this has resulted in a high number of applicants.

A total of 37 staffing red flags were reported which is comparable with previous months and there are no concerning trends.

Community nursing activity continues to be higher in month than was seen in 2022-2023 and there has been a further increase seen in July 2023. Work is being undertaken to understand this increase in demand and the type of activity. Despite the increase in the total number of visits, 95% of visits were completed and only 5% were deferred following prioritisation.

Whilst there has been a decrease in the total number of reported in-patient falls, there were three in-patient falls reported with major harm with all 3 incidences receiving a comprehensive multi-disciplinary huddle which identified no new learning for 2 of the areas.

The number of pressure ulcer incidents has increased however there were no Category 3 pressure ulcers reported. The weekly Pressure Ulcer meetings continue to see robust rapid reviews being undertaken and presented, and where any new learning has been captured are able to offer support in a very timely manner and ensure the Duty of Candour is achieved. No new root causes were identified, and local actions are in place to share the learning.

Complexity with our complaints remains high which is similar to the national picture and is thought to be linked to post covid expectations. Themes form formal complaints remain communication and end of life care and this has been shared monthly at the the End of Life Strategy Group. Consistent improvement is being maintained with high percentages of complaints closed within timescales which continues to offer patients and families a response that is timely and thorough with captured learning.

The number of logged PALS (Patient Advice and Liaison Service) remain at similar numbers however we are seeing a consistent high number of PALS being closed in timescale which offers confidence in our services to the public. This improvement is

attributed to the temporary Patient Experience Manager post which is funded until end December 2023.

There is concern nationally regarding a national increase in cases of Cdiff (Clostridioides difficile) and MSSA (Methicillin-Susceptible Staphylococcus Aureus) Bacteraemia. A national working group is looking at this and it is thought to be associated to post pandemic. Whilst the Trust is currently managing well with Cdiff, an in-depth Post Infection Review (PIR) continues to take place for each case. It needs to be recognised that the case threshold set may not be met this year.

A total of 482 nurses, midwives and AHPs (Allied Health Professions) have been trained at some level of Quality Improvement (QI), in addition 43 QI projects were initiated in the past 12 months.

Appendix 1


Fill Rate Wards Chart
Jul 2023
Site
All
Division
All
NHS
Northern Lincolnshire and Goole
NHS Foundation Trust
Fill Rate %
100%
80%
60%
40%
20%
0%
B2 111.1%
WARD 3 GDH 109.3%
WARD 28 SGH 107.3%
Ward C3 107.0%
Amethyst 102.2%
WARD B7 DPoW 102.1%
WARD C6 DPoW 101.2%
Clinical Decisions Unit 99.1%
Stroke Unit SGH 98.7%
WARD 25 SGH 98.5%
NICU SGH 97.6%
WARD B6 DPoW 97.3%
WARD B3 DPoW 96.4%
WARD 16 SGH 95.6%
WARD C5 DPoW 95.6%
Ward C1 Glover 95.3%
WARD 6/7 GDH 95.0%
NRC Nursing Team GDH 95.0%
STROKE UNIT DPoW 94.7%
WARD 17 SGH 94.3%
WARD 24 SGH 94.3%
WARD C2 94.1%
Ward A1 93.9%
Jasmine & Honeysuckle 93.9%
29 SGH 93.8%
WARD 22 SGH 93.7%
Rainforest DPoW 93.5%
HDU DPoW 92.5%
Blueberry/Holly DPoW 91.2%
Gynae Assessment Unit 90.3%
WARD 23 SGH 89.8%
ICU SGH 87.7%
Ward 26 SGH 87.6%
Central Delivery Suite 84.4%
NICU DPoW 76.9%
LAUREL WARD DPoW 76.4%
ITU DPoW 75.4%
Disney SGH 68.0%

Appendix 2 In-patient Ward Dashboards

DPOW Ward Assurance Dashboard Jul 2023

Division: All | Ward: All

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Occupancy		Staffing						Safety & Quality						Infection Control	Friends & Family	NEWS
Site - Ward	Occupied Bed Days %	Ward Transfers 22:00 to 06:00	Fill Rate %	CHPPD - Total	Staffing Incidents	Red Flags	Vacancies - Total	1:1 Supportive Care Shifts Filled %	Falls - Total	Falls per 1000 Bed Days	Hospital Acquired PU - Total	Hospital Acquired PU per 1000 Bed Days	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
DPOW - A1	105.1	26.0	93.9	10.0	0.0	1.0	6.9		10.0	18.1	7.0	12.6	1.0	0.0	82.6	100.0	86.1
DPOW - Amethyst	98.9	26.0	102.2	6.3	0.0	0.0	5.9	95.0	7.0	9.9	0.0	0.0	2.0	1.0	92.9	100.0	85.0
DPOW - B2 Assessment Unit	78.1	547.0	111.1	9.7	0.0	0.0	5.1		1.0	1.3	2.0	2.6	1.0	2.0	92.2	92.3	86.4
DPOW - B3	96.2	76.0	96.4	7.4	0.0	0.0	3.7		5.0	6.5	6.0	7.7	1.0	0.0	97.2	96.2	82.0
DPOW - B4		1.0			0.0	0.0			0.0		0.0		1.0	0.0			
DPOW - B6	97.2	70.0	97.3	7.7	0.0	1.0	3.4		5.0	7.5	5.0	7.5	1.0	0.0	92.1	100.0	94.6
DPOW - B7	89.4	21.0	102.1	8.9	0.0	0.0	3.7	100.0	0.0	0.0	6.0	12.0	0.0	0.0	89.6	100.0	97.5
DPOW - C1 Glover	98.0	38.0	95.3	6.3	0.0	0.0	2.9	100.0	4.0	5.1	2.0	2.5	0.0	1.0	78.4	100.0	88.3
DPOW - C2	99.2	27.0	94.1	6.0	0.0	3.0	5.4		5.0	6.0	3.0	3.6	1.0	1.0	94.0	100.0	82.9
DPOW - C3 Short Stay	111.2	122.0	107.0	7.0	0.0	7.0	6.0	75.0	8.0	8.6	7.0	7.5	3.0	1.0	93.3	100.0	85.4
DPOW - C5	158.3	29.0	95.6	6.8	1.0	2.0	5.4	100.0	3.0	4.1	3.0	4.1	2.0	0.0	97.7	100.0	81.9
DPOW - C6	99.7	16.0	101.2	7.8	1.0	0.0	2.1	82.4	5.0	7.7	3.0	4.6	0.0	1.0	71.9	100.0	85.4
DPOW - C8		0.0															
DPOW - HDU	80.2	22.0	92.5	20.9	0.0	0.0	1.7		0.0	0.0	2.0	11.5	0.0	1.0	82.7		
DPOW - HOBS DPW														0.0	85.0		
DPOW - ITU	68.8	15.0	75.4	32.1	0.0	1.0	7.6		0.0	0.0	3.0	23.4	0.0	1.0	93.3		
DPOW - Laurel	47.3	23.0	76.4	12.4	0.0	2.0	2.2		1.0	5.7	0.0	0.0	0.0	0.0	100.0	100.0	96.4
DPOW - Maternity	42.5	80.0	92.5	11.6	9.0	0.0	-15.3		0.0	0.0	0.0	0.0	2.0	1.0	0.0		
DPOW - NICU DPW	73.9	41.0	76.9	13.9	1.0	0.0	4.9		0.0	0.0	0.0	0.0	0.0	1.0	100.0	100.0	
DPOW - Rainforest	52.8	207.0	93.5	14.0	2.0	1.0	2.9		0.0	0.0	0.0	0.0	0.0	0.0	82.1	100.0	
DPOW - Stroke DPW	98.8	34.0	94.7	6.2	0.0	2.0	2.2		3.0	3.9	1.0	1.3	2.0	0.0	100.0		93.5

SGH Ward Assurance Dashboard

Jul 2023

Division: All | Ward: All

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Occupancy		Staffing						Safety & Quality						Infection Control	Friends & Family	NEWS
Site - Ward	Occupied Bed Days %	Ward Transfers 22:00 to 06:00	Fill Rate %	CHPPD - Total	Staffing Incidents	Red Flags	Vacancies - Total	1:1 Supportive Care Shifts Filled %	Falls - Total	Falls per 1000 Bed Days	Hospital Acquired PU - Total	Hospital Acquired PU per 1000 Bed Days	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
SGH - CDS	47.9	116.0	84.4	25.7	1.0	0.0	-0.6		0.0	0.0	0.0	0.0	1.0	0.0			
SGH - Disney	48.9	70.0	68.0	14.2	2.0	1.0	2.3	50.0	0.0	0.0	0.0	0.0	0.0	0.0			
SGH - Gynae Assessment	54.8	15.0	90.3	16.7	0.0	0.0	0.2		0.0	0.0	0.0	0.0	0.0	0.0		100.0	97.5
SGH - ICU	66.3	20.0	87.7	28.8	0.0	0.0	3.3		0.0	0.0	2.0	10.8	1.0	0.0	85.8		
SGH - NICU SGH	83.6	28.0	97.6	13.4	1.0	0.0	0.1		0.0	0.0	0.0	0.0	0.0	0.0	100.0		
SGH - Stroke SGH	71.3	38.0	98.7	10.0	0.0	3.0	5.6		3.0	5.9	2.0	3.9	0.0	0.0	100.0	93.8	96.2
SGH - Ward 16	97.9	17.0	95.6	7.2	0.0	1.0	4.9		5.0	7.2	4.0	5.7	1.0	1.0	100.0	100.0	90.3
SGH - Ward 17	171.2	20.0	94.3	8.2	1.0	0.0	9.2		1.0	1.5	2.0	2.9	0.0	0.0	78.9	100.0	88.2
SGH - Ward 18		1.0			0.0	0.0			0.0		0.0		0.0	0.0		100.0	96.2
SGH - Ward 19					0.0	0.0	-1.0		0.0		0.0		0.0	0.0			
SGH - Ward 22	99.2	21.0	93.7	6.0	0.0	2.0	4.9	75.0	2.0	2.4	4.0	4.8	0.0	1.0	100.0	91.9	91.2
SGH - Ward 23 Short Stay	96.9	35.0	89.8	7.6	1.0	1.0	9.1		1.0	1.3	0.0	0.0	0.0	2.0	100.0	94.4	95.3
SGH - Ward 24 Assessment Unit	94.1	301.0	94.3	7.5	0.0	0.0	10.4		3.0	3.6	4.0	4.7	0.0	1.0	79.8	88.0	94.2
SGH - Ward 25	98.6	15.0	98.5	7.1	3.0	4.0	4.0		5.0	11.7	2.0	4.7	0.0	0.0	100.0	100.0	91.6
SGH - Ward 26	73.7	157.0	87.6	6.7	0.0	0.0	5.9		0.0	0.0	0.0	0.0	0.0	4.0	100.0		
SGH - Ward 27		45.0			1.0	0.0		65.4	7.0	10.8	3.0	4.6	1.0	1.0	97.9		93.8
SGH - Ward 28	72.5	36.0	107.3	9.7	0.0	0.0	4.3	100.0	1.0	1.6	3.0	4.8	0.0	0.0	82.5	100.0	93.3
SGH - Ward 29	91.6	71.0	93.8	7.1	0.0	0.0	7.5	66.7	1.0	1.4	3.0	4.2	0.0	0.0	92.6	100.0	92.2
SGH - Ward 5	99.6	23.0	99.1	7.2	0.0	0.0	3.5		2.0	3.0	1.0	1.5	0.0	1.0	89.2	100.0	98.1

GDH Ward Assurance Dashboard

Jul 2023

Division: All | Ward: All

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Occupancy		Staffing						Safety & Quality						Infection Control	Friends & Family	NEWS
Site - Ward	Occupied Bed Days %	Ward Transfers 22:00 to 06:00	Fill Rate %	CHPPD - Total	Staffing Incidents	Red Flags	Vacancies - Total	1:1 Supportive Care Shifts Filled %	Falls - Total	Falls per 1000 Bed Days	Hospital Acquired PU - Total	Hospital Acquired PU per 1000 Bed Days	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
GDH - GNRC	102.3 ↗	1.0 ↗	95.0 ↗	7.9 ↘	0.0	2.0 ↗	6.4	42.9	1.0 ↘	2.3 ↘	0.0 ↘	0.0 ↘	0.0	1.0 ↗	95.8 ↗		84.6 ↘
GDH - Ward 3	83.7 ↘	5.0 ↘	109.3 ↘	7.1 ↗	0.0	0.0	3.7 ↗	15.0 ↘	1.0 ↘	2.3 ↘	2.0	4.5 ↗	0.0	0.0	97.1 ↘	100.0 ↗	85.3 ↗
GDH - Ward 6	49.5 ↗	4.0 ↗	95.0 ↗	12.5 ↘	0.0	3.0 ↗	-1.0 ↘		1.0	4.4 ↘	3.0 ↗	13.0 ↗	0.0	2.0 ↗	95.3 ↗	100.0	97.2 ↘

Appendix 3

Non-Inpatient Ward Assurance Dashboard

Showing Data: Jul 2023 Available Data: Apr 2019 to Jul 2023

A summary of some key staffing and quality indicators for the non-inpatient wards in the latest month.

	Indicator Category	Occupancy	Staffing					Safety & Quality					Infection Control	Friends & Family	NEWS
Site	Ward	Ward Transfers 22:00 to 06:00	Staffing Incidents	Red Flags	Vacancies - Qualified	Vacancies - Unqualified	Vacancies - Total	Falls - Total	Serious Incidents	Hospital Acquired PU - Total	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
DPOW	Amethyst Day Case Unit		0.0	0.0	0.2	0.7	0.9	1.0 ↗	0.0	0.0	0.0	1.0 ↗	100.0		
	CDCU		0.0	0.0	0.6	0.2	0.8	0.0	0.0	0.0	1.0 ↗	0.0	100.0	100.0	
	Discharge Lounge DPW	0.0 ↘	0.0	0.0				1.0 ↗	0.0	0.0	0.0	0.0			194.1 ↗
	DIU		0.0	0.0	0.5 ↗	0.7	1.3 ↗	0.0	0.0	0.0	0.0	0.0	100.0		
	DSU DPW		0.0	0.0	0.1 ↗	1.2	1.2 ↗	0.0	0.0	0.0	1.0 ↗	0.0	100.0		
	ECC DPW		1.0	0.0 ↘	12.1 ↗	2.5 ↗	14.6 ↗	5.0	0.0	1.0 ↗	2.0 ↗	2.0	68.0	100.0 ↗	99.4 ↗
	SDEC DPW	105.0 ↘	0.0	0.0	3.1	0.1 ↘	3.1 ↘	1.0	0.0	0.0	2.0 ↗	0.0	90.8	0.0 ↘	96.9 ↘
	UCS DPW		0.0	0.0				0.0	0.0	0.0	0.0	0.0			
SGH	Discharge Lounge SGH	2.0 ↗	0.0	0.0	2.3	-0.1	2.2	0.0	0.0	0.0	0.0	0.0			75.0 ↘
	DSU SGH		0.0	0.0	0.2	2.4	2.6	0.0	0.0	0.0	0.0	0.0	100.0	100.0	
	ECC SGH		0.0 ↘	0.0	27.5 ↗	8.9 ↘	36.4 ↘	1.0 ↘	0.0	0.0 ↘	1.0 ↘	0.0 ↘	94.4 ↗	63.6 ↘	99.5 ↗
	PIU		1.0 ↗	1.0 ↗	1.8	0.3	2.1	0.0	0.0	0.0	0.0	3.0 ↗			99.6 ↘
	SDEC SGH	25.0 ↘	0.0	0.0	2.1 ↘	0.9	3.1 ↘	0.0	0.0	0.0	0.0 ↘	0.0	93.1 ↘		
	UCS SGH		0.0	0.0				0.0	0.0	0.0	1.0 ↗	0.0			
	Stroke Assessment Area														

Appendix 4 ECC Assurance Dashboards

DPOW ECC Assurance Dashboard

Showing Data: Jul 2022 to Jul 2023 Available Data: Apr 2019 to Jul 2023

A summary of some key staffing and quality indicators for ECC.

Indicator Category	Indicator	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
Staffing	Fill Rate %	109.2	119.0	123.9	151.3	94.1	100.9	148.7	106.2	103.2	106.9	106.3	104.6	103.3
	Staffing Incidents	2.0	1.0	0.0	0.0	2.0	2.0	1.0	0.0	1.0	1.0	0.0	1.0	1.0
	Red Flags	1.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
	Vacancies - Qualified	12.5	7.8	8.5	15.1	12.9	24.9	17.8	15.2	13.2	14.6	13.2	11.1	12.1
	Vacancies - Unqualified	4.4	-0.4	-0.6	9.1	9.1	7.1	9.9	9.3	6.9	4.3	3.9	1.9	2.5
	Vacancies - Total	16.8	7.4	7.9	24.2	22.1	32.0	27.7	24.5	20.1	18.9	17.0	13.0	14.6
	ED Paediatric Emergency Fill Rate %													
Safety & Quality	Falls - Total	0.0	3.0	3.0	4.0	4.0	5.0	5.0	3.0	3.0	5.0	1.0	5.0	5.0
	Serious Incidents	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0
	Hospital Acquired PU - Total	0.0	1.0	0.0	2.0	0.0	2.0	5.0	0.0	0.0	1.0	3.0	0.0	1.0
	Complaints	2.0	2.0	0.0	4.0	3.0	3.0	3.0	3.0	2.0	2.0	3.0	1.0	2.0
	Administration Errors - Total	0.0	0.0	5.0	1.0	1.0	6.0	9.0	2.0	4.0	2.0	5.0	2.0	2.0
	ED 12hr Trolley Waits	223.0	227.0	351.0	361.0	346.0	559.0	457.0	451.0	439.0	210.0	360.0	387.0	290.0
	ED Mental Health Incidents	0.0	6.0	2.0	3.0	4.0	4.0	8.0	6.0	3.0	6.0	7.0	2.0	5.0
	ED Paediatric Incidents	5.0	9.0	10.0	10.0	13.0	12.0	10.0	9.0	13.0	15.0	13.0	8.0	6.0
	ED Red Flags	8.0	1.0	4.0	2.0	2.0	7.0	6.0	3.0	7.0	3.0	1.0	4.0	3.0
Infection Control	Hand Hygiene %	69.2		100.0			52.9	77.7	74.7	70.6	72.4	70.9		68.0
Friends & Family	Recommendation rate %	64.7	70.1	68.1	74.5	76.0	66.9	78.4	76.6	60.8	71.1	82.7	82.3	100.0
NEWS	Observations completed in time %	98.9	99.1	98.0	98.9	97.8	98.9	98.9	99.0	98.5	98.7	98.9	98.4	99.4

SGH ECC Assurance Dashboard

Showing Data: Jul 2022 to Jul 2023 Available Data: Apr 2019 to Jul 2023

A summary of some key staffing and quality indicators for ECC.

Indicator Category	Indicator	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
Staffing	Fill Rate %	103.9	107.6	109.6	108.6	73.0								
	Staffing Incidents	2.0	1.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0
	Red Flags	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Vacancies - Qualified	16.9	14.9	16.1	16.5	12.8	13.0	8.8	7.7	7.8	28.0	28.3	27.3	27.5
	Vacancies - Unqualified	6.2	6.2	6.9	2.4	2.6	3.6	1.6	-2.4	-6.5	13.6	13.6	10.5	8.9
	Vacancies - Total	23.1	21.2	23.0	18.9	15.3	16.6	10.4	5.4	1.3	41.5	41.9	37.8	36.4
	ED Paediatric Emergency Fill Rate %													
Safety & Quality	Falls - Total	3.0	0.0	4.0	6.0	3.0	2.0	7.0	4.0	1.0	4.0	7.0	2.0	1.0
	Serious Incidents	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	0.0	0.0
	Hospital Acquired PU - Total	0.0	2.0	1.0	0.0	1.0	1.0	0.0	0.0	0.0	3.0	0.0	1.0	0.0
	Complaints	3.0	2.0	1.0	1.0	2.0	2.0	1.0	4.0	2.0	3.0	3.0	4.0	1.0
	Administration Errors - Total	1.0	3.0	5.0	0.0	0.0	0.0	2.0	2.0	2.0	1.0	2.0	1.0	0.0
	ED 12hr Trolley Waits	309.0	336.0	357.0	257.0	190.0	401.0	345.0	329.0	415.0	244.0	313.0	241.0	252.0
	ED Mental Health Incidents	14.0	7.0	0.0	2.0	5.0	4.0	6.0	6.0	2.0	8.0	13.0	1.0	4.0
	ED Paediatric Incidents	6.0	3.0	4.0	7.0	9.0	12.0	5.0	5.0	7.0	13.0	8.0	15.0	5.0
	ED Red Flags	6.0	2.0	9.0	1.0	1.0	8.0	2.0	1.0	3.0	3.0	2.0	6.0	3.0
Infection Control	Hand Hygiene %	83.6	75.0	100.0	100.0	93.8	100.0	78.3	80.4	87.5	77.5	77.3	82.6	94.4
Friends & Family	Recommendation rate %	55.1	71.6	68.4	71.1	72.0	60.5	74.5	75.0	63.2	77.6	71.6	80.1	63.6
NEWS	Observations completed in time %	99.3	99.5	99.5	99.7	99.5	99.7	99.2	99.4	99.7	99.7	99.6	99.4	99.5

Appendix 5

Trustwide Maternity Dashboard

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
Midwife to Birth Ratio	26.2	25.8 ↘	24.8 ↘	22.9 ↘	24.2 ↗	23.7 ↘	23.4 ↘	22.2 ↘	22.4 ↗	22.3 ↘	23.0 ↗	23.1 ↗
Red Flags	16.0 ↘	9.0 ↘	17.0 ↗	9.0 ↘	19.0 ↗	3.0 ↘	1.0 ↘	3.0 ↗	6.0 ↗	14.0 ↗	24.0 ↗	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	2.0 ↗	2.0	0.0 ↘
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	2.0	1.0 ↘	1.0	0.0 ↘	3.0 ↗	1.0 ↘	0.0 ↘	2.0 ↗	2.0	2.0	0.0 ↘	0.0
(c) Missed medication during an admission to hospital	0.0 ↘	0.0	0.0	3.0 ↗	0.0 ↘	0.0	0.0	0.0	2.0 ↗	0.0 ↘	2.0 ↗	0.0 ↘
(d) Delay of more than 30 minutes in providing pain relief	2.0	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	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	5.0 ↘	4.0 ↘	5.0 ↗	3.0 ↘	9.0 ↗	1.0 ↘	1.0	1.0	1.0	3.0 ↗	5.0 ↗	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	1.0 ↗	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.	6.0 ↘	3.0 ↘	11.0 ↗	3.0 ↘	5.0 ↗	1.0 ↘	0.0 ↘	0.0	0.0	6.0 ↗	15.0 ↗	1.0 ↘
Continuity of Carer %	12.0	12.0	14.0 ↗									
In Receipt of %	8.0 ↘	9.0 ↗	8.0 ↘									
CoC In Receipt of %	72.0 ↗	68.0 ↘	66.0 ↘									
Continuity Team Caseload	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 %	84.1	85.5 ↗	89.0 ↗	96.2 ↗	91.0 ↘	93.1 ↗	92.3 ↘	97.2 ↗	97.8 ↗	98.2 ↗	94.8 ↘	94.2 ↘
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	99.5 ↘	100.0 ↗	100.0	100.0	100.0	100.0
Vacancies	45.2 ↗	51.8 ↗	41.6 ↘	41.1 ↘	40.4 ↘	42.2 ↗	41.7 ↘	34.4 ↘	16.0 ↘	10.5 ↘	14.5 ↗	14.9 ↗
Vacancies - Registered	40.6 ↗	42.2 ↗	39.8 ↘	34.4 ↘	34.4 ↗	36.0 ↗	37.3 ↗	30.5 ↘	17.6 ↘	13.9 ↘	18.0 ↗	17.6 ↘
Vacancies - Unregistered	4.6 ↘	9.6 ↗	1.8 ↘	6.7 ↗	6.0 ↘	6.1 ↗	4.4 ↘	3.9 ↘	-1.6 ↘	-3.4 ↘	-3.5 ↘	-2.7 ↗
Serious Incidents	2.0 ↗	1.0 ↘	0.0 ↘	0.0	2.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0	1.0	1.0
Complaints	3.0 ↗	1.0 ↘	3.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	2.0 ↗	1.0 ↘	1.0	1.0	2.0 ↗	3.0 ↗
PALS	6.0 ↗	5.0 ↘	6.0 ↗	4.0 ↘	3.0 ↘	3.0	3.0	3.0	1.0 ↘	6.0 ↗	6.0	6.0
Sickness Absence (Division) %	6.4 ↘	6.0 ↘	6.5 ↗	5.0 ↘	6.7 ↗	5.6 ↘	5.5 ↘	5.9 ↗	6.0 ↗	5.7 ↘	5.2 ↘	

Appendix 6

Community Nursing Assurance Dashboard Jul 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					0.0	14.0 ↗					2.6 ↘			
East Network					0.0	5.0 ↘					4.4 ↘			
South Network					0.0	20.0 ↗					5.3 ↗			
Unscheduled Care Team (UCT) (incl rapid response)					0.0	0.0					0.2			
Macmillan Health Care Team					0.0	0.0					3.1 ↘	100.0		
Specialist Palliative Care Nurses (SPC)					0.0	0.0					0.0			
Palliative Care					0.0	0.0					1.0			
Single Point of Access (SPA)					0.0	0.0					2.4			
Continence Team					0.0 ↘	0.0					0.2			
Tissue Viability Team					0.0	1.0 ↘					1.0			
Long Term Conditions / Complex Care Matrons (Comm Matrons)					0.0	0.0					-0.3 ↗			
Intermediate Care Services (ICS) + Core Therapy					0.0	4.0					1.1 ↗			
Discharge Liaison Team					0.0	0.0					-1.0			
Locality Co-ordinators					0.0	0.0					-0.2			
Evening / Night Service					0.0	0.0					0.1			
Chronic Wound Team					0.0	0.0					-0.5 ↗			
DN Students					0.0	0.0					0.0			
Community Nursing														13.6 ↗

Activity data not currently available for the dashboard

Appendix 7 - Themes reported through the acute 15 Steps Challenge

Standards	Themes	Actions
Standard 1: Observation	• Lack of 'I am clean' tape or observed cleaning of equipment between patient use • Dusty Equipment	• Lead Nurse – Quality Assurance liaison with facilities monitoring officers • Staff communication re: cleaning of stored equipment and waste management • 'I am clean' tape ordered, and appropriate use shared with staff – assurance gained during spot checks and Ward Assurance Tool (WAT) completion by Manager and Matron
	• Non-compliance with uniform policy	• Expected standards for safe and secure storage of confidential information communicated with staff • New processes for managing theatre and clinic list identified and communicated out to staff • Continued monitoring through WAT
	• Out of date stock in storerooms (e.g., syringes, gloves, blood bottles)	• Email themes regarding stock rotation out to Ward Manager, Matrons and Associate Chief Nurse' • Quality Times and Senior Leadership meeting focusing on stock rotation • New processes in place to manage stock including a review of 'top up' and quantity of stock required
Standard 2: Documentation	**Outpatient areas do not require standard 2 to be completed - No themes to report**	
Standard 3: Patient Feedback	Minimal Areas for consideration noted within patient feedback	
Standard 4: Staff Feedback	• Staff not aware of Learning Lessons from within their area • Support staff not aware of how to report incidents on Ulysses	• New processes in place for sharing learning lessons on staff notice boards as well as at staff huddles and meetings, for those who cannot attend • Assurance gained staff escalate concerns/ incidents to senior colleagues, however staff encouraged to use the incident reporting process themselves or seek support/ training where required

NLG(23)188

Name of the Meeting	**Trust Board of Directors – Public Board**	
Date of the Meeting	03 October 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 - July 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday 18 July 2023, and approved at its meeting on Tuesday 19 September 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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday, 18 July 2023 at 14:00 hours via Microsoft Teams

Present:

Susan Liburd	Non-Executive Director (Chair)
Kate Truscott	Non-Executive Director

In Attendance:

Gillian Ponder	Non-Executive Director (rep for Linda Jackson)
Abolfazl Abdi	Deputy Chief Operating Officer
Paul Bunyan	Interim Deputy Director of People
Jenny Hinchliffe	Deputy Chief Nurse
Ashy Shanker	Deputy Director of Planning & Performance
Shaun Stacey	Interim Chief Executive
Victoria-Jade Hordon	Organisational Development (OD) Business Partner (agenda item 6)
Liz Houchin	Freedom to Speak Up (FTSU) Guardian (agenda item 7)
Annabelle Baron-Medlam	Head of Compliance and Assurance (agenda item 9)
Jane Heaton	Associate Director of Strategic Medical Workforce (agenda items 10 and 11)
Dave Sprawka	Head of Recruitment and Employment Services (agenda item 14)
Wendy Stokes	Executive Personal Assistant to Director of People (taking minutes)

Governor Observer:

Robert Pickersgill	Governor, Membership Office

1 Welcome and Apologies for absence

Apologies received from Valerie Almira-Smith, Linda Jackson, Simon Nearney and Kate Wood

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 Monday, 22 May 2023

The minutes from the previous meeting held on Tuesday, 22 May 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 07 - Equality, Diversity, and Inclusion from a patient perspective – discuss with NEDs
The Chair reported this is a specific action in relation to Linda Jackson's request. A further discussion is required and that will take place at the next NEDs meeting.

Action 08 – Progress Report on Occupational Health and DBS Clearances
To be discussed as part of the agenda. It was agreed to remove this item from the action log.

Action 09 – Trust Accommodation for Training – Speak to Jug Johal
Paul Bunyan reported that Simon Nearney did speak with Jug Johal regarding delays in mandatory training due to a shortage of training rooms and one being out of action. The stakeholder group are looking at allocation of additional rooms and the boardroom at SGH has been made available. The group is working hard to ensure more rooms are available and will continue to monitor the situation. It was agreed to remove this item from the action log.

5 People Strategy Annual Delivery Plan 2023-2024 – Quarter 1 Report

Paul Bunyan presented highlights from the People Strategy Annual Delivery Plan 2023/2024, available on SharePoint. There are three overarching themes broken down by subcategory and actions given for each subcategory. The report will be more concise going forward to make it more summary based.

The Chair stated that Gillian Ponder and Kate Truscott were aware of requests from both the Audit, Risk and Governance Committee, and the Finance and Performance Committee regarding use of the apprenticeship levy and they may seek further assurance from this section of the agenda.

Kate Truscott commented the report is very comprehensive. Regarding the Flexible Working Policy and it being piloted in non-clinical areas, Kate asked when the first pilot would take place in clinical areas because she felt that would help improve retention issues. Paul Bunyan reported this is being piloted in corporate areas first to test the system and then will be rolled out further. The clinical staff group are already rolling out team-based rostering and are designing their own rosters. Kate went on to ask if this would include medical staff and Paul confirmed the Flexible Working Policy is for all staff groups.

Kate Truscott went on to ask if the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data will be incorporated into the report, rather than having a separate report. Paul Bunyan confirmed they want to incorporate Equality, Diversity, and Inclusion (EDI) data in the Quarter 3 report, from October.

Gillian Ponder felt the report is really helpful to see what is planned for the apprenticeship levy and when that will start to take effect. She felt it important that the trust does not lose any opportunities it may have. Gillian Ponder stated although the plan is very detailed, she didn't feel it included any measures, milestones and outcomes that would give assurance. She asked how the trust knows they are doing the right things and whether they are having the envisaged impact. Paul Bunyan reported there is a detailed plan for the apprenticeship levy for nursing, AHPs and leadership as well as future plans. If the levy is not fully utilised the remainder will go into the Government's central pot and be offered to other health areas. Paul added that further metrics could be built into

the report if that would be helpful. The Chair added this was discussed at Board Development as part of the committees in common discussion and there are some focus areas and priorities to give measures going forward.

Regarding training and education and the risks around funding, Shaun Stacey added there have recently been conversations with North Lindsay College about the benefits of becoming an employment partner with them and the report does not reflect that. Shaun felt that the trust needs to develop partnerships in both Grimsby and Scunthorpe in the medium to long term and should be talking about nurses, AHPs, management, culture, and service options. Shaun asked it that could be included in the plan if his observations were correct. Paul Bunyan confirmed those conversations took place after the report submission date. Shaun felt this is a good opportunity, it would reduce some of the fiscal pressures and the quality and effectiveness of that education would be better. Kate Truscott agreed and felt there may be other opportunities with the Grimsby Institute, North Lindsay College, Hull University and Lincoln University. Kate stated that further updates on this would be really helpful for the committee.

The Chair stated that NHS England had published the NHS Long Term Plan which detailed how the NHS will address existing workforce challenges. Apprenticeships are a key action in the plan stating its ambitions for 2031-2032 is for 22% of all training of clinical staff will be delivered via apprenticeships. The Chair asked what the current percentage is. Paul Bunyan reported the analysis has not yet started, there is a meeting next week to bring all the elements of the workforce plan together and undertake a gap analysis. It is a high ambition and depends on availability of providers to deliver the scope and scale of training. A lot of the plan is for medical staff and there is no national training at present, this may take two to three years to develop. It was agreed that Paul Bunyan will present the Apprenticeship Report to the next meeting, giving appropriate analysis as in a deep dive.
Action: Paul Bunyan

The Chair asked when the Flexible Working Policy will be ratified. Paul Bunyan felt that may be October as there is a national consultation and information on one element of home working around what expenses can be claimed is awaited.

The Chair highlighted that the trust had received the NHS Pastoral Care Quality Award which recognises the quality and delivery of pastoral care for NLaGs internationally educated nurses and midwives. Jenny Hinchliffe added this is a great achievement and recognises all of the hard work undertaken over the last two years by the Corporate Nursing Team, Workforce Team, and Divisions. A lot of time was spend evidencing that the trust meets the standards for best practice pastoral care at every stage of recruitment and beyond.

Robert Pickersgill stated that the Long Term Plan does not say a lot about international recruitment, and he asked if the trust is going to follow directions in the plan and does that signal a change in policy. Paul Bunyan reported that international recruitment will be a factor for the next five years while the trust moves towards a more sustainable local provision. Sheffield Hallam University are behind Lindsay College and developing services in the middle of the patch. The Chair highlighted this is not binary, the trust will continue with international recruitment whilst it home grows its own staff, then the two streams will run together.

Shaun Stacey stated that a lot of work is underway to look at how the trust uses the right people in the right way, but this is very dependent on registered staff. Career pathways are also part of the early conversations with North Lindsay College and Kate Woods conversation with Lincoln University. The apprenticeship levy will help with this, as some older people have not previously had the opportunity to work in health care and enter into medical practice.

6 People Strategy Focus / Deep Dive – Leadership Development

Victoria Hordon presented highlights from the Leadership Development Deep Dive, available on SharePoint.

Paul Bunyan added that in January this year there was no provision for Values Based Leadership and Leadership Individual Development Assessment. The Summer Leadership Events commence shortly to help leaders engage, inspire, and develop their teams and help them to do the basics of leadership well. When Jonathan Lofthouse arrives, he will also have his own winter plan.

The Leadership Individual Development Analysis ((LIDA) is completed by all delegates. It assesses them against a set of People Leader core skills. Kate Truscott stated that the initial part of the leadership development approach is self-assessment, and she asked has consideration been given to any other type of assessment such as 360. Victoria Hordon felt that in certain areas trust needs to be gained, and they are now looking at 180 feedback. Kate Truscott felt that was a concern if Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) did not have separate NLaG specific strands. If the assessment is profession specific, how does the trust make sure it has that corporate approach. Victoria stated that if people have been through the Royal College of Nursing (RCN) and Faculty of Medical Leadership and Management (FMLM) development programmes it is about gathering feedback from them to make sure it is not the same as the programme. Kate added that the emphasis should be on NLaG with added approaches from the RCN and FMLM.

Robert Pickersgill stated it was good to have more information and he referred to the NHS Academy Leadership Model on strategic working, and he asked if that was emphasised in the programme. Victoria Hordon confirmed the programme includes strategic working through to objectives as well as quality improvement and doing what is right for the patient. It is about being compassionate with everything and making sure strategic objectives are met.

The Chair asked how the funding for this was going to be ring fenced. Paul Bunyan stated that future funding is being sought from next year and finances totaling £159k has been secured for nine cohorts, one cohort each month. If Sheffield Hallam University and Doncaster Colleges want to develop a School of Nursing the trust should be able to ask for further leadership training in the future.

The Chair felt there should be some consideration to Patient Led Assessment of the Care Environment (PLACE) based partners, they are crying out for innovation and should not allow funding to delay the programme.

7 Freedom to Speak Up (FTSU) Guardian – Quarter 1 Report 2023-2024

Liz Houchin presented highlights from the Freedom to Speak Up (FTSU) Guardian Quarter 1 Report available on SharePoint.

Kate Truscott asked if the number of formal grievances had reduced and were staff working with Liz. Liz Houchin confirmed everyone is going through the Just and Learning process and if people say they have a personal grievance she does not get involved in that. Some people are not sure where to go, and it is about signposting them to Human Resources (HR) colleagues. Paul Bunyan added that Just and Learning is less of a process and more about having an open, honest, and transparent conversation with a manager, who then responds to staff concerns.

The Chair asked Liz if there was a particular type of bullying and harassment. Liz stated that she does not put a case down as being bullying and harassment unless a person specifically says that is what it is. Usually, it is about how a person has been spoken to, their relationship with their manager, and sometimes the manager having a conversation around performance. It is about supporting managers and each other to have those open, honest, and transparent conversations around behaviours and how we speak to each other which some people perceive as bullying.

8 BAF 2023-2024 - Quarter 1 Report

Paul Bunyan presented highlights from the BAF 2023-2024 Quarter 1 Report available on SharePoint. The focus was Strategic Objective (SO) 2, to be a good employer and SO4, to work more collaboratively. Blue text will be added to update the BAF, and the red text has been improved.

The information has been broken down into trust people themes to align that to a more detailed conversation at this meeting. The main risks are the Humber Acute Services Review (HASR) and the Group structure. These are two big workforce changes which will have a huge impact; what does the change programme need to look like and how does the trust start pulling this together to limit disruption. HASR has entered a formative consultative stage and will probably continue at pace. The committee will be updated when more information is known.

The Chair thanked Paul Bunyan for the improvements, the report was previously out of date, and is now fit for purpose.

Gillian Ponder asked the following questions:

- Regarding SO2 - why was the target risk score 12 in 2023, going up to 15 in 2024.
- Regarding SO5 – puzzled why deleting mentoring, reversed mentoring, and talent and succession planning.
- Strategic risk 2976 – what is being done to address the accommodation issues for international recruitment.

Regarding SO2, the Chair stated there had been a robust discussion about risk scores. The committee felt they were not accurate, and they have been reset. The figure had not gone up, it was not correct.

Regarding SO3, Paul Bunyan stated this is in relation to being encompassed in the Leadership Strategy and being captured elsewhere.

Regarding Strategic risk 2976, a lot of work is being done around travel and accommodation. Paul Bunyan agreed to include information on the NHS Pastoral Care Quality Award.

9 CQC Progress Report

Annabelle Baron-Medlam presented highlights from the CQC Progress Report available on SharePoint.

Regarding mandatory training trajectories Kate Truscott felt they needed to be meaningful. Targets are set by NLaG and she questioned is there anything further the trust can do to enable staff to meet those requirements. With revalidation and appraisal for medical staff, they are not required to report on role specific and mandatory training but there is still an obligation trust wide.

Kate asked if the committee needed to watch this because the figures speak for themselves.

Gillian Ponder was shocked that only 34.6% of Safeguarding Leads had completed level 3 safeguarding for children training and she asked if that should be prioritised. Gillian was also nervous about trajectories and people feeling they do not want to be held to account. On the other hand, it is easy to keep deferring things when under pressure. Jenny Hinchliffe added that level 3 safeguarding for children is for diagnostic staff, and she felt a trajectory would be useful, but realistically she asked how they are going to get there. Some of the level 3 training was revamped and that may be the case for diagnostic staff.

Regarding trajectories Shaun Stacey asked if it would be worth getting Ashy Shanker and Maria Wingham involved, looking at capacity to provide training and that needs to show a work towards, rather than trying to achieve 100%. The trajectory will go beyond the year and show capacity against training demand which is meaningful data which will help. Month to month training will change and the trajectory can affect the tip over rate. The divisions will not be able to do that, but Maria and Ashy will. Abolfazl Abdi and John Awuah can do that through planning for operational divisions and that could be built in excel to change the tip over rate for the trajectory as a long term solution. It would be worth spending time building that to get such a rich data set.

The Chair stated that she is not comfortable that trajectories are taken off the table and she asked Annabelle Baron-Medlam to take that back. The committee cannot ignore level 3 safeguarding for children training for Safeguarding Leads at 34.6%. The Chair agreed that planning should be involved rather than them working in silo.
Action: Annabelle Baron-Medlam

10 Medical Revalidation – Annual Report

Jane Heaton presented highlights from the Medical Revalidation Annual Report available on SharePoint.

Kate Truscott referred to the table on page 18 regarding Specialty Doctors, Associate Specialist, and Specialists (SAS) and agreed exceptions. A total of 51 SAS doctors have not undertaken appraisals between 01 April 2022 and 31 March 2023. Jane Heaton explained that some are international medical graduates and do not have a full appraisal, they have a mini appraisal in their first few weeks. After that they will move into the normal cycle. Jane agreed to find out what percentage of the fifty-one are International Medical Graduates (IMT).

Regarding exception reporting, the Chair commented that one third of doctors are on extended leave (maternity, long term sickness and caring responsibilities). Jane Heaton agreed to break that down into percentages.

Kate Truscott referred to page 26 and the Trust Board being sighted on suspensions, and she asked who is made aware and how. Jane Heaton confirmed that the Trust Board is advised of any suspensions via the Director of People.

Post meeting note:
All fifty-one doctors are IMT, and they do have a delay to their first appraisal which range up to 12 months from their start date. The reason for this is because a doctor has to bring a significant amount of supporting information and evidence which matches their scope of work, demonstrates that they are safe, demonstrates engagement with professional standards, demonstrates continued improvement within their service area (e.g. participating in audits) and ultimately the supporting information and the discussions around it will contribute to lifelong professional

development. These doctors are engaged by the appraisal and revalidation coordinator to have a 1:1 medical appraisal support session which aims to induct the doctors into the medical appraisal process and therefore can begin work on their portfolio. Out of the 51:

- Forty-five were recruited directly from abroad within the first yar of the appraisal year and the above applied,
- were on long term sickness, all of which were established SAS doctors who have been in the trust longer than the initial first year,
- Two were on maternity leave, two of which were established SAS doctors who have been in the trust longer than the initial first year and one commenced with the trust in December 2022.

11 Guardian of Safe Working – Quarter 4 Report – January to March 2023 and Annual Report 2022-2023

Jane Heaton presented highlights from the Guardian of Safe Working – Quarter 4 Report and Annual Report available on SharePoint. Jane Heaton advised that the Quarter 4 report also goes to Trust Management Board (TMB) and is shared with the Junior Doctors Forum. The report is presented today for information and assurance that a well-established reporting route is in place to report any concerns.

Regarding exception reporting Gillian Ponder commented that the table on page 4 does not give the number of junior doctors in each department and whether the same doctor reported more than once. Jane Heaton agreed that would be helpful to understand particularly in acute medicine and she felt that the data should be available and suggested redrafting the report before it goes to Trust Board.

The Chair stated the same pattern has been followed for much of the year regarding excess hours and she questioned what mitigation is being put in place to utilise the provision of safe staffing and medical staff wellbeing planning going forward.

Post meeting note:
The exception reporting table shows the number of exception reports submitted from all departments by month, broken down to show the reasons reports were submitted. As is usual the vast majority of the reports received concerns excess hours worked. The reason for this is likely to be that it is an easily recognisable incident which can be quantified, and thus is more likely to be reported. There appears to be a large increase in the number of reports submitted in August, which is to be anticipated owing to the Junior Doctors rotating jobs. This usually settles down as the doctors, in particular the foundation year one doctors, become more familiar with their roles and therefore more efficient and less likely to need to stay after hours. There was a high level of reporting for excess hours during what was a very difficult winter. There is also a high level of reporting for lack of service support during clinical commitments during November and December. This reflects an issue which was escalated by the Doctors in training from Gastroenterology and Cardiology in Diana Princess of Wales Hospital (DPOWH), concerning a lack of support at registrar level. This issue was escalated to the Medical Director, and a meeting was organized with the clinical leads for medicine. During this meeting, a plan was agreed upon which reenforced staffing in the affected departments, and an establishment review has been planned, in addition to work to manage and reduce sickness in the department. An additional doctor was added to each department in the interim to support the foundation year one doctors until the establishment review has been completed. This work is ongoing, but at the time of writing the level of reporting has markedly decreased, and anecdotal feedback from the doctors in training shows that the situation

has improved. Postgraduate Medical Education (PGME) and the Guardian of Safe Working have proactively sought feedback from the doctors in these departments to ensure that the situation is not recurring, and that the support provided is adequate.

In addition to this the committee asked about what sat behind the numbers below, for example what was the number of trainees in the department and was this one t6rainee putting in, for example ten reports or was it a number of trainees putting in reports. The table below, from the Allocate software, provides a breakdown by specialty of the total number of exception reports received during the period April 2022 to March 2023.

Department	Total number of exceptions submitted	Number of trainees per area	Number of people reporting per area
Accident and emergency	1	31	1
Acute Medicine	10	24	5
Anaesthetics	1	18	1
Cardiology	12	7	2
Gastroenterology	29	12	2
General Medicine	136	20	20
General Surgery	30	22	11
Geriatric Medicine	5	11	3
Obstetrics and Gynaecology	10	25	4
Paediatrics	4	28	2
Respiratory Medicine	1	11	1
Trauma & Orthopaedic Surgery	10	17	3
Urology	3	5	1
Total	252		

The Guardian of Safe Working is updating the Annual Report prior to submission to Trust Board.

12 Quality and Safety Actions

12.1 Occupational Health Progress Report

Paul Bunyan presented highlights from the Occupational Health Progress Report available on SharePoint.

For the past twelve months there have been delays with recruitment processes and accessing occupational health services. There has been a change in leadership and the service remains fragile. The department has a new IT system, an increased volume of sickness management cases and four new staff members in the team. Paul Bunyan feels that IT processes can be reduced further to give a new level of clearance and triage. Staff wait six weeks to attend an appointment and Peter O'Sullivan is challenging customer practice because in some cases a two-minute conversation is all that is needed. There is a problem reporting in TRAC, the electronic recruitment system, and it is difficult to pull out the right type of information from the NHSEI occupational health delivery system. Occupational health is working with the informatics team to manage this and improve the metrics. There is an incredible amount of good will in the team, especially nursing, and they want to do things differently. Working with HUTH will also give more resilience with resources.

Kate Truscott stated that in March 2023 the clearance timescale stood at 21 days, and she asked about the figures for April to June. Paul Bunyan reported that timescales do fluctuate and there has been an increase in the volume of recruitment in the last couple of months due to the August rotation.

Regarding assessment when health needs are identified, and prior to clearance being given, Kate Truscott asked about the narrative when people are moving post internally. Paul Bunyan reported as part of the change clearance will not be needed unless that is required for exposure prone procedures.

The Chair highlighted occupational health is a fragile and evolving scenario, and she asked if there will be any significant change by the next committee meeting in September. Paul Bunyan reported a band 7 starts in post soon and he could give a brief milestone update in September.
Action: Paul Bunyan

12.2 Disclosure and Barring Service Check Timescales

Paul Bunyan reported there is a slight increase in timescales nationally with the DBS scheme. The average time is just over six days and overall is just over twenty-one days, so there is no impact.

13 Workforce Integrated Performance Report (IPR) – Trust and Directorate

Paul Bunyan reported the unregistered nursing vacancy rate had reduced and registered medical and nursing rates are on a downward trend. The trust is now at pre-Covid levels. Sickness rates are also at a two-year low. PADR rates are on an upward trend and within target. The trend is also positive for role specific mandatory training. Safety weeks have been held for resuscitation training and for medics to access training in different ways. Core mandatory training is also above target.

Shaun Stacey thanked Paul Bunyan for the comprehensive report which showed some good points and raises some real concerns.

14 Recruitment KPIs/Dashboard

David Sprawka presented highlights from the Recruitment KPIs/Dashboard available on SharePoint. Applications remain high and there is some concern with starters in month being slightly lower than recruitment would like.

The recruitment plans tab shows a downward trajectory with the exception of the AHP position, which will evolve with the Community Diagnostic Centres (CDCs). Pipelines are fairly conservative and there is an improving turnover picture. The Medical and Non-medical performance tab has decreased, which is expected at this time of year. There have been increased vacancies due to an increase of 128-130 in establishment in April.

Regarding the recruitment plan, Kate Truscott stated that numbers appear to be going in the right direction. Dave Sprawka agreed and stated that figures do fluctuate month on month. The same trends can be seen in quarter 3 because of newly qualified nurses coming in. He added that registered nursing is done on a cohort basis.

Kate Truscott had struggled with the overview dashboard and David Sprawka agreed to go through that with her outside of the meeting. Shaun Stacey asked if the increase in vacancy rates was relating to the emergency department or an approved business case. Shaun felt that

information would be useful when reporting externally, and where there is an increase in headcount relating to an approved business case. Jenny Hinchcliffe reported that the increase was from business cases at the end of last year and approved prior to April 2023. Jenny added that there is a risk with the number of vacancies in the emergency departments and therefore the number of newly qualified and international nurses they will be supporting. She had hoped to get some additional funding for supervisory time for the clinical sisters to support emergency departments and wards with high numbers, but the funding expected with exiting special measures has not been received and work is ongoing with the finance division. Detailed work is taking place with departments to get newly qualified and international nurses up to speed. Jenny added she has spoken to finance and a lot of work is ongoing to offset agency spend. Divisions are doing some work on priority wards around releasing staff two days a week for six months. Tighter principals are being looked at for last minute sickness absence and putting in robust checks to look at acuity of patients which should be completed in next couple of weeks. Regarding funding, Shaun Stacey felt this is a national issue and perhaps a discussion at Exec Team is needed to make sure Jenny can deliver what she needs to.

15 Industrial Action

Paul Bunyan reported that the longest ever period of junior doctor industrial action concluded yesterday. It has been very difficult and managed incredibly well through the emergency response prepared and planning teams. They have engaged with divisions to cover services to maintain safe patient care. This is the first-time that industrial action has taken place over a weekend and evaluation is taking place to see how, or if, this can be done better next time. The BMA has balloted junior doctors again, results are likely to be positive and they will set out daters for the next six months of industrial action.

On 20 July consultants commence industrial action and junior doctors cannot cover consultants. Emergency care and on call needs to be covered and the BMA have agreed department by department what safe care needs to look like. The trust is currently working with consultants and the Joint Local Negotiating Committee (JLNC) to confirm what that looks like. The BMA have announced further industrial action for consultants on 24 and 25 August.

The RCN balloted their staff and did not achieve the ballot they required. Paul Bunyan is not currently aware of any AHP industrial action for physiologists and radiographers.

The Chair asked what morale is currently like across the trust. Jenny Hinchcliffe stated that from a nursing perspective morale is quite good. It has been challenging in emergency departments and that has impacted at times, although generally morale is not too bad. Shaun Stacey agreed, morale is generally very good, people feel supported. The cost associated with industrial action is phenomenal and Shaun is not as confident as Paul around derogation and finding doctors to cover on call. Other doctors will tend do their own work as instructed but will not cover on call which is a risk for managers on the day. Nurses are carrying the strain due to the lack of senior cover, which can be difficult by the lack of medical staff present. Shaun is worried about future morale and the situation being generated through the continuum of industrial action as well as the cost of recovery and delivery. The workforce will tire out and they are already incredibly tired. Shaun is worried about morale and the social impact in the way people function and work. Paul Bunyan and his team are doing everything they can do to relieve stress and there is good access to services but there are real challenges around industrial action. This is a massive risk for health leaders, even with additional funding for someone to pick up the on call, the loss of decision making from senior experienced staff is high. HUTH struggled to fill their shifts and at one point and they were asking for mutual aid.

The Chair was also deeply concerned, in eleven weeks' time the trust will be into winter pressures. Shaun Stacey added there has been a 12% increase in emergency activity this year alone without winter pressures and that will add another layer for front line staff.

Jane Heaton agreed, and another dimension is that the SAS grades seem to be in the middle of both the junior doctors and consultant's industrial action. There is the potential they will strike and burn out; we need to keep our ears and eyes open to be able to provide support to them.

16 Annual Workplan

The Chair confirmed the committee is still working to the existing workplan until it moves into the Group structure. The workplan will be revised in regard to Committees in Common although the Chair has flexibility to bring items forward if required.

17 Trust Board Highlight Report

The Chair confirmed the following items to be put into the Trust Board Highlight Report:

- Apprenticeship Levy
- Disclosure and Barring Service (DBS)
- Occupational Health Service – gained further assurance and will continue to receive regular updates
- Leadership Deep Dive
- Safeguarding Leads Training – Level 3 Safeguarding for Children
- Freedom to Speak Up (FTSU) Guardian Quarter 1 Report 2023-2024
- Guardian of Safe Working Quarter 4 and Annual Report 2022-2023
- Medical Revalidation Annual Report 2022-2023
- Expectation that Shaun Stacey will mention industrial action

18 Items for information* (please refer to Appendix A)

Item 18.5 - Workforce Systems Steering Group Action Log

The Chair commented that Christine Brereton and Nico Batinica were listed as leads for some of the actions. Paul Bunyan agreed to look at that and amend the action log.
Action: Paul Bunyan

19 Any other urgent business

No other urgent business discussed.

22 Date, time, and venue of next meeting:

Date: Tuesday, 19 September 2023
Time: 14:00 hours
Venue: Via Microsoft Teams

The Chair highlighted that the next meeting may need to be moved to the morning, or the date may change. The committee will be notified accordingly of any changes.

The meeting closed at 16:29 hours

Cumulative Record of Workforce Committee Attendance (2023/2024)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Sue Liburd	2	2	Jenny Hinchcliffe *	2	2
Kate Truscott	2	2	John Awuah *	1	1
Linda Jackson	2	1	Gillian Ponder *	1	1
Simon Nearney	2	1			
Shaun Stacey	2	1			
Ellie Monkhouse	2	0			

NLG(23) 189

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	3rd October 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 Minutes**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance and Performance Committee Minutes from the meeting held on Wednesday 21st June 2023 and approved at the meeting on Wednesday 19th July 2023; and the Minutes from the meeting held on Wednesday 19th July 2023 and approved at the meeting on Wednesday 22nd September 2023; and the Minutes from the meeting held on Wednesday 23rd August 2023 and approved at the meeting on Wednesday 22nd September 2023	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: **Wednesday 21 June 2023, TEAMS**

Present:

Fiona Osborne	Non-Executive Director (Chair)
Shaun Stacey	Interim Chief Executive/Chief Operating Officer
Brian Shipley	Deputy Director of Finance
Simon Parkes	Non-Executive Director
Linda Jackson	Vice Chair, Trust Board
Craig Hodgson	Assistant Director of Commercial Services

In Attendance:

Ian Reekie	Lead Governor
Annabelle Baron-Medlam	Compliance & Assurance
Richard Peasgood	Executive Assistant to COO
Ashy Shanker	Associate Director of Planning
Allison Clover	Divisional Administrator (for the notes)

ITEM

1. Apologies

Apologies were noted from the Director of Estates & Facilities, Jug Johal (represented by Craig Hodgson), the Director of Finance, Lee Bond, and the Chair, Gill Ponder (represented by Fiona Osborne)

2. Quoracy

It was noted that the Committee was quorate.

3. Declarations of Interest

There were no Declarations of Interest declared.

4. To Approve the Minutes of the Meeting held on 24 May 2023

The minutes of the meeting held on the 24 May 2023 were reviewed. It was noted that there were no amendments to be made to the previous meeting and the minutes were accepted as a true record of the meeting.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

22.03.23

5.2 The changes to the Terms of Reference had been completed. Action closed

19.04.23

8.3 The Health Inequalities paper was due to be presented in this meeting. Action closed

6.1 The action required an update on action plans in the CQC report. Fiona Osborne noted that some areas had improved but the actions has not been updated by Geriatric Medicine and Gastroenterology. It was agreed the due date would be updated to July.
7.1 Unplanned Care: Updates to the Committee are provided for outstanding risks covering the ED QI project and the lead discharge nurse appointment however an update on the extra shifts to cover increased acuity is still outstanding. The delivery date is extended to July 23.
8.1 Fiona Osborne reported that a Board level meeting had been arranged for 1st August to discuss agency staff usage. The Committee agree the action could be closed.

Fiona Osborne reported two actions had been missed from the May minutes:

- 7.4 Matthew Overton to provide assurance on an action plan from the recent electrical failures (due date September)
- 8.1 Lee Bond to look into the increase in the use of agency nursing. This action could be closed as a Board level discussion had been arranged for the 1st of August.

5.2 Terms of Reference

The Terms of Reference (ToR) has been agreed at a previous meeting and the suggested updates have been made. The ToR was presented at today's meeting for information only, as no objections were raised the ToR was marked as accepted.

ACTION: Richard Peasgood to contact Helen Harris to confirm that the Terms of Reference have been accepted

5.3 2023 – 24 Finance & Performance Committee Workplan V2

The Committee received and noted the Workplan. Fiona advised that at the last meeting she had requested that Benefits realisation be added to row 23, this relates to the Business Case review. Fiona noted that this has now been added.

5.4 Action Plan

Fiona asked if there were any additional actions which needed to be included in the action Plan, or amended. There were no further additions or amendments requested.

6. Presentations for Assurance

6.1 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 ratings have remained stable. There has been some progress with several actions moving from limited assurance and the quarterly monitoring assurance has been completed, additionally the quarter 4 updates have been included in section 9.

Fiona Osborne advised that in previous months it had been noted that on action Med-18 Endocrinology and Geriatric Services had included performance numbers but did not have any actions listed. Endocrinology now has actions listed; however, Gastroenterology and Geriatric Services are only reporting their performance numbers and are not providing any information on future plans or actions. Annabelle Baron-Medlam advised that she has been in conversation with the Medicine Team. The Team have produced an updated appendix which will be shared with the Committee.
Further information has been added regarding Gastroenterology and a COW model has been adopted which will allow more control of referrals into the department. They have also continued the use of an Independent Sector (IS) provider with an insourcing model which is offering face to face and virtual appointments. Annabelle Baron-Medlam gave an update on

the Geriatric Services and mitigations. Waiting list reductions are expected to be realised by the General Internal Medicine Geriatric Frailty Service Transformation model.

ACTION: Annabelle Baron-Medlam to share the updated appendix with the Committee

Shaun Stacey suggested that Annabelle Baron-Medlam attend the Operational Management Group to raise the profile of the CQC reporting and underline the importance of swift feedback.

ACTION: Richard Peasgood to arrange for Annabelle Baron-Medlam to come to the Operational Management Group (OMG) meeting to raise awareness of the CQC Progress report with the Operational Divisions

7. Review of NLAG Monthly Financial Position (Finance Report SO3.1/SO3.2b)

7.1 Finance Report Month 2

Brian Shipley presented the Month 2 Finance Report and went on to note that the Trust had a £1.2 million in month deficit which was £0.8m ahead of plan. The key pressures have been identified as escalation beds, additional duties within the Emergency Department (ED) and a continued reliance on Agency Spending and vacancies. This has been slightly offset by slippage on the Trusts IS and Diagnostic capacity reserves.

Brian Shipley then went on and informed the Committee that the Trust is ahead of the programme for the year to date regarding CIP however many of the schemes were phased to deliver later in the year. Brian Shipley reported that there is a forecast £1.3 million deficit on the core programme, mainly around the continuation of pressure areas identified to date and the lack of mitigation provided by other schemes. The overperformance on corporate areas is being supported by some of the slippage on the core schemes. Brian Shipley reported the largest area of concern is the £10 million unidentified stretch target that was included in the plan. The divisions are working on action plans to deliver the stretch target, but a deficit is still forecast.

Elective recovery is performing well against the plan; however, the plan is heavily back ended in terms of increasing activity requirements. There have been no Elective Recovery Fund (ERF) penalties.

Brian Shipley drew the Committee's attention to Page 17 of the report where the forecast cashflow is projecting a cash deficit position by Month 12. Brian confirmed that addressing this is a priority.

Brain Shipley advised that the key risks are:

- The projected cash deficit by the year end
- The £10 million unidentified CIP
- ERF non-delivery and potential penalties
- Continued reliance on Escalation Beds
- Community Schemes outstanding causing pressure to Acute beds and OPAT
- On-going strike action
- Diagnostic capacity

Simon Parkes asked if there was a timescale for the actions relating to the £10 million for unidentified schemed within the CIP as the Trust was coming to the end of the first quarter and time is of the essence. Brian Shipley advised that the recovery plan would need to be produced by the next Finance & Performance (F&P) meeting.

ACTION: Brian Shipley to produce a recovery plan for the £10m unidentified CIP shortfall

Simon Parkes asked what the consequence of the diagnostic capacity issues for our patients was. Brain Shipley confirmed there would be a slippage in income but there would be a

negative impact on the DM01 waiting list performance target. Shaun Stacey reported that diagnostic machines are being pushed hard due to demand and there was a risk of not delivering to the plan trajectory however from September he is working with his team to deliver additional capacity from September. Risk stratification is being applied to ensure patients are kept safe.

Linda Jackson asked about what was different about the recruitment plans for this year compared to previous years to deliver the reduction in temporary staffing spend. Brian Shipley reported that in Nursing the successful recruitment, alongside their onboarding, of staff from India as very positive. Brian Shipley expressed some concern about the medical staffing Groups HR and Finance are working closely together. Linda Jackson requested that the plans to recruit will not deliver the required reduction in temporary staffing should be highlighted to Board. The Committee agreed.

Linda Jackson asked when the escalation beds are likely to be stepped down. Shaun Stacey confirmed that activity is being shifted out to the Community to assist with reducing the escalation beds. By the middle September it is expected that all escalation beds will be closed in a stepped programme and there is no plan to re-open the beds in winter. In a change to the plans if beds are required 20 will be available in one ward rather than a small number of beds across many wards. Shaun Stacey advised this would give greater visibility and control.

Fiona Osborne asked how consolidated escalation beds might impact the staffing compliment and plans. Shaun Stacey confirmed that the plans means that these beds should be covered by the existing planned shift compliment. There will be an element of agency spend but Brian Shipley confirmed this should be covered by the existing financial plan.

7.2 Recovery Support Programme (RSPf)

Brian Shipley advised that NLaG has now been removed from Special Measures. The Committee members congratulated the Trust on this achievement.

Brian Shipley reported that work is progressing on the format of the next Oversight Meetings; the previous meetings will be replaced with something which allows for more regional oversight. The first meeting will be in July and will be a joint meeting with HUTH.

7.3 Business Case Assurance

There were no business cases to be presented to the Committee. Brian Shipley advised that he is waiting on the Community Diagnostics Centre (CDC) papers to be finalised, although there has been official feedback to say the CDC has been approved some of the modalities have been amended and the business case needs to be reworked to reflect this.

7.4 Bed Base Review and Nursing Establishment Financial Risks – Response to referral from Quality & Safety Committee

Fiona Osborne read the referral from the Quality and Safety Meeting held on the 22nd of May. The Annual Safer Staffing Nursing Establishment Review was presented at that meeting. The report reviews that establishment for 2022/23 but also proposes changes for 2023/24. A query was raised at the Committee regarding the front sheet as under Financial Implications it reads 'to be confirmed pending bed base review.' Fiona Osborne added that as the Operational and Financial plans have already been signed off by the Board, including the outcome of the bed base review, it did not seem to correlate. Following discussion at the Committee meeting it was determined that this was not focused on the bed base review but was instead focused on the bed base configuration following the bed base review.

The Quality & Safety Committee had raised the question, if any increases to nursing staffing levels are required to ensure that safe staffing levels for the patients, how will these be funded given the financial envelope for the year has already been signed off both by the Trust and the Integrated Care Board (ICB).

Brian Shipley advised that the bed configuration is not to increase the bed base and therefore staffing levels but configuring them differently to save money. It would configure the current bed stock in the most appropriate financial and workforce reliant way using economies of scale through opening not just one or two beds but instead opening a whole ward.

Fiona Osborne asked if additional shifts were being used to cover existing pockets of escalation beds and if not, would we see extra costs through opening an entirely new ward for escalation beds under the proposed structure. Brian Shipley confirmed that existing escalation beds are being staffed by additional shifts many of which are staffed by temporary staffing. By consolidating the beds economies of scale can be achieved.

Shaun Stacey confirmed that the bed plans have been agreed across the estate although it possible that the bed numbers could decrease as the internal LoS for General Internal Medicine is 5.5 days although it should eb 3.5 days for NLaG due to the Acute model that the Trust works on. Work is underway to ensure that the Acute model is delivered to plan reduces the bed days waste. The target for 2023/24 is to deliver a Los in Medicine to 4.5 days which will free up beds while delivering quality care to patients. Consolidation of hobs beds across the estate will benefit patients and reduce costs.

Fiona Osborne queried if in the 2024/25 planning process that bed configuration will eb brought forward prior to Board and ICB approval. Shaun Stacey advised that the late delivery of national guidance, typically late December, it is extremely difficult to deliver all aspects of the plan within the timescale. There will eb a further challenge in 2024/25 that NLaG will plan as a Group with HUTH which will add a complexity to the planning process. The intention is to plan bed configurations in 2024/25 but this will be subject to national constraints.

7.5 Assurance Confirmation & Board Highlights

It was agreed that matters to be highlighted to the Board would be:

- The Trust are forecasting a cash deficit by the year end.
- The Committee have concerned over the medical staffing pipeline to meet the financial plan for the year
- The Committee have concerns about the level of unidentified CIP Stretch Target of £10million.
- The Trust has exited Financial Special Measures.

8. Estates & Facilities (SO 1.4)

8.1 Medical Gases

Craig Hodgson took the paper as read. Attention was drawn to the improvements to infrastructure and planning since 2020/21. There has been significant progress on the DPoW site but less progress at SGH which is reflected within the key risks contained in the Highlight Report.

Linda Jackson noted that a new ring-main for medical gases was needed in Scunthorpe, that the maximum flow exceeded designated flow by 200% at Scunthorpe and the HSE were expected to visit. Craig Hodgson advised that the HSE visit was expected to focus on water in ED rather than focussed on medical gasses. He advised that the use of medical gases is agreed with clinicians across the site and that is the designated flow but in reality, not every tap is turned on exceeding the flow, therefore the risks are mitigated.

Simon Parkes queried the risk rating of 20 and asked if the action plan in the paper moves the Trust to a target rating of 10 or whether they only mitigated the current risk. Craig Hodgson advised the risk level was dependent of the funding available and current funding is being directed higher priority items including fire. Simon Parkes asked for clarity on the level of assurance around when the target risk can be achieved as the conversation suggested adequate mitigations are in place. Shaun Stacey commented that the operational mitigations are in place to manage the oxygen flow so that flow was managed carefully according to need, but this does not remove the risk created by the pipework being insufficient to deliver the maximum flow requirement if all taps were turned on hence the high-risk rating.

Fiona Osborne challenged that under risk management principles if an unmitigated risk is scored highly once mitigations are introduced to manage risk it is common practise to reassess the likelihood of a risk so that attention can be directed areas where there are no or less effective mitigations. The lack of a reduction in the likelihood on this risk is indicating that the mitigations are not effective and the ring-main at Scunthorpe will still fail. Craig Hodgson agreed to take the challenge back to the Estates & Facilities Group for discussion.

ACTION: Craig Hodgson to take the Medical Gases risk rating challenge back to E&F for discussion.

Fiona Osborne asked about the reporting structure on page 5.

The structure shows the Quality Governance Group going into the Quality and Safety Committee reporting to the Finance and Performance Committee. Fiona advised that the Quality and Safety Committee do not report to Finance and Performance, and Finance and

Performance do not receive a Medical Gasses report as it has been agreed that the oversight is with the Audit Risk and Governance Committee.

Craig Hodgson advised that the reporting structure will be amended.

8.2 Assurance Confirmation & Board Highlights

The Committee will highlight Mitigations to manage the risk are in place to manage the demand and flow of oxygen in the Scunthorpe site, however this does not remove the risk.

9. Review of NLaG Monthly Performance and Activity Delivery IPR

9.1 Unplanned Care

Shaun Stacey took the paper as read. The key points are the continued challenge to ED in part due to the increase in attendance numbers and the impact of poor flow on Ambulance Handovers, however, there has been an improvement in the 60-minute handover position in the month against the April position. The twelve-hour bed waits continue to be a concern remaining below the 2022 peak but is still higher than it should be.

Shaun Stacey spoke to the group regarding the Lincolnshire and East Riding significant concerns around their long length of stay that are often for non-health reasons.

Shaun Stacey further advised that Staffing concerns remain a pressure for NLaG, including a large Agency, Nursing and Medical spend in this area, in both unfunded beds and vacancy cover in almost all areas who are supporting Emergency Care. Actions to address vacancies and recruitment are being discussed, however, progress is slow.

In April there was a temporary decrease in the percentage of shifts filled by bank staff and an increase in the percentage of shifts undertaken by agency staff when compared with March. This accounts for the increasing cost in the April and the improvement in May.

9.2 Planned Care

Shaun Stacey advised that the approach to Planned Care is being sustained this can be seen in the limited assurance, including the IPR. There are risks around the growing waiting list size this has been further affected by the Industrial actions which has taken place.

Shaun Stacey further advised that there has been a slight improvement in DM01. There are some concerns around the number of streams that go into Diagnostics, it is hoped that the CDC programme will help with this.

The Cancer Position is unvalidated, however it is still not showing significant improvement in performance. There is expected to be an improvement in June/July following the actions that have been taken.

Shaun Stacey warned that there was a major challenge regarding Oncology and Tertiary Diagnostics, this is creating the largest part of the Cancer Performance challenge. Histopathology is still in the planning process and the Workforce provision is still to be decided to allow for 7-day access to Histopathology.
Work has been completed with the GIRFT Team regarding Anaesthetic pre-assessment, however, this is still in the development phase, it is hoped that some improvement will be seen by early September.

Shaun Stacey advised that Theatres 7 and 8 are still closed, Theatre A will be open shortly.

Linda Jackson referred to the Cancer performance and that work has been carried out over a long period of time but he underlying challenge remains the same. Shaun Stacey advised it

was flagged at the Humber Cancer Board and the Cancer Alliance. Shaun Stacey advised that there is a regional review underway to meet the challenge. Despite a small amount of recruitment, it is not significant enough the release capacity. A regional strategy is needed to support pathways and the regional paper is taking some time.

Fiona Osborne asked for assurance that the regional review paper would tackle all the issues outlined. Shaun Stacey advised under the Terms of Reference of the paper that this would cover all of the areas of concern. However, every area in the region and nationally has an oncology workforce challenge and this means he could not provide confidence to the Committee.

9.3 Patient Flow Improvement Group Updates

Anne-Marie Hall took the paper as read. The Trust attendance and admission rates have increased significantly from last year. Anne-Marie Hall advised that it is not one thing which will help the Trust manage this situation, it is a combination of actions. The admission rate in June is the lowest in 24 months.

In ED there is a QI project that includes a focussed on DtA, patients flowing through SDEC, supporting consultants and staff to keep flow maximised. Each of these areas, together will improve the pathway.

Linda Jackson queried why the Senior Decision Maker Model (SDM) was making such a difference. Anne-Marie Hall explained that having senior decision makers at the front door rather than further down the patient journey means the patients can be routed to SDEC if appropriate rather than being admitted.

Linda Jackson referred to the number of patients being readmitted in 30 days in the IPR which has a seven-month upward trend and asked what the underlying cause was. Anne-Marie Hall advised this had been picked up and the team had been looking at patients with multiple admissions. There are weekly meetings to address these patients and work with community partners, social care and the voluntary sector to better support them.

Linda Jackson queried what actions were taking place regarding Lincolnshire and East Riding and their length of stay. Anne-Marie Hall advised that the team had been working system wide to improve processes by sharing changed practise and how the teams can do things differently. As it is system wide changes it is slow but making progress.

Simon Parkes congratulated Anne-Marie on the improvement in ambulance hand hovers and the 4 hour waits. He noted that these improvements were significant.

Fiona Osborne referred to the improvement in 4 hour wait in ED. The SPC chart indicated an element of seasonality as in the same period last year there was an improvement albeit not to the extent delivered this current year. She queried if the improvements may plateau as indicated in the season pattern last year as the Trust enters the winter period. Anne-Marie Hall advised that she expected the improvements in performance to continue given the activity and work that was underway. The risk to this is the number of attendances in ED although there are other projects planned to manage this. Shaun Stacey advised that the focus in managing demand and pursuing alternative pathways in the community.
This is a challenge for medical staff who have been asked for many years to deliver a hospital-based model and are being asked to deliver a community model. This what takes the time to support changes in practise. Shaun Stacey reported that the changes that are being delivered and delivering improvements are sustainable.

Fiona Osborne asked about the lack of Diagnostic Capacity and if there was anything that the Committee could do to support the team. Anne Marie Hall advised SDEC is a pinch point for diagnostics. The issues are not just equipment but people. MRI is another pinch-point as stroke requirements diagnostics have gone up as had demand on CT.

Anne-Marie Hall advised there is a Site Team consultation which is not only focuses on the front door but also the back door flow and it is emphasising close working together of the various teams.
The Committee thanks Anne-Marie for the presentation and the developments so far.

9.4 Health Inequalities

Shaun Stacey reminded the group that at a previous meeting the Committee asked for assurance that from a planning and delivery perspective, Health Inequalities were being considered for patients in all aspects of care.

Ashy Shanker took the paper as read. In the ICS there was very little development until a few weeks ago, when Learning Disabilities was highlighted as a priority area. Ashy advised since the paper had been written additional opportunities had arisen and she was hoping to utilise RAIDR which is utilised by NECS as links Primary and Secondary Care data. It allows the Trust to triangulate with primary care data and better support patients impacted by health inequalities. Ashy Shanker was pursuing RAIDR honorary contracts to allow this to progress.

Fiona Osborne queried if this new data would change the way patients were waitlisted, currently this is a strict chronological order. Ashy Shanker advised that instead it may be that the data highlight a more appropriate intervention such as a primary care led approach rather than being added to the Trust Wait List. Shaun Stacey clarified that it would not affect the way elective care is managed and this would still be based on chronological order. What is would do is change the way a patient with specific needs may be treated when they arrive, for example, a patient with LD would be provided with an appropriate environment for their appointment rather than having an initial appointment where it's discovered that their condition requires a quiet room and low numbers of staff leading them to have another visit.

Fiona Osborne asked if the ICS strategy as mature as the Trust strategy with regard to Health Inequalities. Ashy Shanker confirmed that the ICS is progressing and has picked up in pace to define a strategy.

Fiona Osborne asked about GDPR barriers in triangulating with primary care data.
Ashy Shanker confirmed that there was not between Primary and Secondary Care but there is between Primary Care and RIADR.

The Committee complemented Ashy Shanker on her work to address Health Inequalities and reiterated the excellent work in evolving the Business Planning process discussed earlier in the meeting.

9.5 Elective Care 2023/24 Priorities Letter

Shaun Stacey took the document as read.

Fiona Osborne referred to the question "Do Diagnostic Services meet the National optimal utilisation standards set to CT, MRI, Ultrasound, Echocardiogram and Endoscopy?' where the answer is, 'We are unclear what the minimal optimal utilisation standards set by NHS England are'. Fiona Osborne notes that she had searched for the National Standards and was unable to find any either. Shaun Stacey confirmed that there is no information from NHS England which shows what the minimal optimal utilisation standards are. This has been flagged to the Regional Performance Director.

9.6 Assurance Confirmation & Board Highlights

The Committee agreed that the Highlights to Board should include:
<u>Planned Care</u>

- The nationwide workforce challenges in the availability of suitably qualified skill sets for Cancer.

- The importance of the regional cancer review paper to support improvements in Cancer performance
- The rising demand for cancer diagnostic tests which remains a risk until the CDC is open.

Patient Flow Improvement Group Updates

- The improved ambulance wait times, lowest in the system
- The success of the Senior Decision-Making model resulting in the improvement in the four hour wait performance
- The increased number of attendances in ED making it difficult to manage flow
- Concerns relating to the Diagnostic Capacity

Health Inequalities

- The Committee are assured on the processes and work surrounding Health Inequalities

Elective Care 2023/24 Priorities Letter

- The Committee recommend the letter and responses to the Trust Board

10 BAF

10.1 SO1-1.6 Business Continuity and EPRR Deep dive

The report was taken as read. Shaun Stacey advised that there was no new or additional information to be added to the previous discussion.

Fiona Osborne raised the previous position when the Q1 risk was increased to 12 from 8, Fiona Osborne advised that most of the actions and planned actions have now been completed and the review of the evacuation plan is down twice and asked whether there were further actions to be added.

Shaun Stacey advised that there were no further actions to be added. Richard Peasgood advised that the duplication of the evacuation plan is an error that will be picked up in the Q1 action plan and removed.

11 Items for Information

11.1 Performance Letters to Divisions following PRIMS Meetings

There were no concerns or amendments made to the Performance Letters. Shaun Advised that the structure of the meetings and layout of the letters was under review and will be changing in August, an action review and tracker will be added to the letter format.

11.2 CIB Minutes

There were no concerns or amendments made to the CIB Minutes.

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.

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.

14 DATE & TIME OF NEXT MEETING:

WEDNESDAY 19th July 2023 1.30pm to 4.40pm, Executive Meeting Room, SGH

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	√	√	√	√	√	x						
Fiona Osborne	√	√	√	√	√	√						
Lee Bond	√	√	√	x	√	x						
Jug Johal	√	√	√	√	√	x						
Shaun Stacey	√	√	√	√	√	√						
Ian Reekie	x	√	√	√	x	√						
Richard Peasgood	√	√	√	√	√	√						
Simon Parkes	x	x	√	√	√	√						
Brian Shipley	√	√	x	√	x	√						
Annabelle Baron	√	√	√	√	√	√						
Abdi Abolfazl	√	x	x	√	x	x						
Ashy Shanker	x	√	√	x	x	√						
Shiv Nand	√	x	x	x	x	x						
Dr Peter Reading	x	√	√	x	x	x						
Linda Jackson	x	x	x	x	x	√						
Craig Hodgson	x	x	x	x	x	√						

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: **Wednesday 19 July 2023, Exec Meeting Room, SGH and MS TEAMS**

Present:

Gill Ponder	Non-Executive Director (Chair)
Shaun Stacey	Interim Chief Executive
Ashy Shanker	Interim Chief Operating Officer (COO)
Lee Bond	Director of Finance
Brian Shipley	Deputy Director of Finance
Craig Hodgson	Assistant Director of Commercial Services
Simon Parkes	Non-Executive Director
Kate Truscott	Associate Non-Executive Director

In Attendance:

Ian Reekie	Lead Governor
Annabelle Baron-Medlam	Acting Head of Compliance & Assurance (section 6.1)
Ab Abdi	Deputy Chief Operating Officer (section 8.3)
Richard Peasgood	Executive Assistant to COO
Georgina Birley	Executive Personal Assistant to COO (for the minutes)
Mike Robson	Non-Executive Director (Hull University Teaching Hospitals (HUTH) Observer)

ITEM

2. Apologies

Apologies were noted from the Director of Estates & Facilities, Jug Johal (represented by Craig Hodgson) and Non-Executive Director, Fiona Osborne (represented by Kate Truscott).

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 21 June 2023

The minutes of the meeting held on the 21 June 2023 were reviewed.

The following points were reviewed by the committee:

1. Page 4, paragraph 4, line 4 – Gill Ponder requested to remove 'There is in the on-boarding of those staff.' Shaun Stacey explained this shouldn't be a new sentence and to change to 'Brian Shipley reported that in Nursing the successful recruitment, alongside their onboarding, of staff from India was very positive.'
2. Lee Bond advised that he had given his apologies for the meeting.
3. Page 5 – Gill Ponder stated there are numerous spelling errors and these have now been rectified.

Subject to the agreed amendments, the Committee approved the minutes of the previous meeting.

10. Matters Arising

No matters that were not on the agenda or action log were raised.

11. Action Log

5.1 The action log was reviewed and updated as follows:

19.04.23

5.4 – Shaun Stacey confirmed that theatre data was now included and action to be closed.

24.05.23

5.3 – Carried forward to August.

6.1 – Annabelle Baron-Medlam to confirm that the appendix had been circulated after last month's meeting. (Post meeting note – the appendix was circulated after the meeting and the action was closed.)

6.1 – Annabelle Baron-Medlam to investigate if the discrepancies with the divisions and report request is still outstanding. Extend action to August.

7.1 – Date should have been changed to September on action log.

12 – Shaun Stacey stated that due to the Industrial Action (IA) strikes, the review by the Integrated Care Board (ICB) of Urgent and Emergency Care (UEC) was delayed until 12th July and the recovery plan had not yet been published. It should hopefully be available by August and it was agreed to carry forward the action to the next meeting.

21.06.23

5.2 – Confirmed action complete and to be closed.

6.1 – Confirmed action complete and to be closed.

7 – Confirmed action complete and to be closed.

8.1 – Craig Hodgson stated that this was discussed at the Estates and Facilities Group (E&F Group) meeting and the risk score remained justified. It was agreed that the action could be closed.

5.2 **Terms of Reference (TOR)**

Gill Ponder stated that the TOR were on the agenda for information, but that she had spotted a further amendment required on page 4, point 5.2.4 where the word 'like' should be removed and a full stop be inserted to read, 'To receive annual update on Electronic & Biomedical Engineering (EBME) Services including capital investment and equipment'. There was also a formatting error on page 7 of a blank page to be removed.

With those amendments, the Committee agreed the ToR which would be sent to the Trust Board in August for approval.

ACTION: Richard Peasgood to update the TOR and forward a copy to Helen Harris

5.3 **2023-24 F&P Committee Workplan V2**

Gill Ponder stated that the Workplan needed to reflect the amended TOR and she would meet with Richard Peasgood to update the Workplan.

Brian Shipley requested removal of the amount of £60m from row 20 of the Workplan.

ACTION: Gill Ponder and Richard Peasgood to meet to update the workplan.

5.4 **Action Plan**

Gill Ponder stated that a number of actions were marked as not yet started and some were on track. Gill Ponder and Richard Peasgood to update the Action Plan when they meet to update the Workplan.

ACTION: Gill Ponder and Richard Peasgood to update the Action Plan.

12. 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. She noted that there had been no movement on assurance ratings and she was expecting to have meetings with each division in the next month regarding their cancer position and actions needed. She hoped that would result in improvement across the Trust in the ratings next month.

Annabelle Baron-Medlam stated that she was due to attend the Operational Management Group (OMG) meeting in June 2023, but due to industrial action (IA) the meeting was stood down. She wass now due to attend and present at the next meeting on 27 July 2023.

8. Estates & Facilities (S01.4)

8.1 Fire Report

Craig Hodgson took the assurance paper as read and stated that the Annual Fire report was due to be presented at Trust Board.

He highlighted section 3 of the report where it stated that the fire alarm system replacement at Scunthorpe Hospital was progressing well and due to be completed by March 2024, along with risks relating to the Fire Ring Main. The Fire Safety Technical Group (FSTG) met on a regular basis and an Authorising Engineer (AE) for Fire had been appointed with their first report completed in January 2023 with an action plan produced in response.

A comprehensive review of all fire doors had been undertaken and a repair and replacement programme was underway. Craig Hodgson stated in terms of risk assurance, Risk ID 2038 related to the risk of a fire alarm failing to detect a fire, which currently had a score of 20, which would reduce significantly once damaged doors had been repaired or replaced. Risk ID 3015 related to insufficient resources to manage fire doors, which also had a risk score of 20. The Trust were working as a priority to replace those that needed replacing. Risk 2952 related to the Fire Ring Main, which currently had a rating of 16.Once the work was completed in March 2024 that risk would reduce significantly. He stated the Board Assurance Framework (BAF) was currently being updated and that routine inspections and walkarounds were being re-introduced and would increase as more fire wardens were trained.

Simon Parkes stated that if the fire door maintenance is a high risk at 20, the Trust knew that there was a significant risk and he queried the impact of that if there was a fire and the fire door did not protect in the way it was intended to. He also questioned why there was insufficient resource to complete the replacements immediately and whether other activities should be stopped to enable the replacement work to be completed as a priority.

Craig Hodgson responded by stating an accredited fire door inspection of around 3,500 doors had been carried out and, following the report of the inspection, 32 doors had already been replaced at Scunthorpe General Hospital (SGH). He stated that the Estates and Facilities team were working as a priority to identify and replace any 60-minute fire doors that needed to be replaced, as those were the highest risk and that work would be completed by the end of August 2023.

Simon Parkes responded by asking how the Trust got into this position with something as significant as fire doors. Shaun Stacey acknowledged Simon Parkes' concerns but stated the 60-minute fire doors were being replaced as priority to compartmentalise the risk before replacing the others. Shaun Stacey asked if the audit had recommended that all irreparable fire doors were replaced immediately or if enough mitigation was in place with the current doors to give enough protection to safely be able to carry out a horizontal or vertical evacuation until the remainder of the doors could be replaced.

Craig Hodgson stated they were prioritising repairing and replacing the higher risk doors and the replacement program was under way. He would take an action to get further comment from Bill Parkinson in response to the question about the level of mitigation in the event of a fire before the doors had been replaced.

Shaun Stacey stated that the report did not assure the Committee that the mitigation was in place, as it states that the doors are not giving enough protection. The level of risk mitigation from such things as training, fire extinguishers and the current doors was not clear. Simon Parkes stated that from reading the report, the Committee could not be assured that mitigation was in place in the event of a fire. Shaun Stacey agreed but stated that he knew that the mitigation was in place.

ACTION: Craig Hodgson to provide the Committee with further information about the level of risk from faulty fire doors if a fire occurred and the mitigation in place until the doors had been repaired or replaced.

Lee Bond added that this was being picked up at the Capital Investment Board (CIB) meeting.

Kate Truscott referred to page 5 of the report where it stated, 'fire training non-attendance remains high and actions are being implemented to reduce non-attendance' and asked from an assurance point of few what actions were being taken to address that. Craig Hodgson confirmed that non-attendance at fire training was being highlighted at the Trust Management Board (TMB) and Estates and Facilities were seeking to publish the attendance records by division.

Kate Truscott asked what was in place to stop people bringing in domestic white goods that had caused the previous two fires at the Trust in the past 12 month. Craig Hodgson explained they were unsuitable for use in a commercial setting and the risk was being addressed Trust wide. Lee Bond stated that annual Portable Appliance Testing (PAT) was carried out and a discussion ensued about whether a central list of appliances, PAT tested items and unregistered items identified during walkarounds existed. Shaun Stacey added that all requests for appliances should go through Procurement and the NHS supply chain. Lee Bond asked if an all staff communication could be sent and Gill Ponder agreed, adding the need to emphasise that only commercial, approved appliances should be on site as 2 fires had been caused by the use of unsuitable domestic appliances.

ACTION: Craig Hodgson to liaise with the Communications team for staff wide communications to be sent regarding the risk of using domestic appliances in the Trust.

Gill Ponder queried, on page 5, 2nd bullet point, the statement that 'an Authorising Engineer had been appointed,' yet on page 6, 10th bullet point, there was a contradicting statement, '…there is now a strong recommendation being made to consider the appointment of an Authorising Engineer'. Craig Hodgson confirmed that they had appointed an Authorising Engineer for fire and Gill Ponder requested the correction of the report.

ACTION: Craig Hodgson to amend the report to state an Authorising Engineer had been appointed.

Gill Ponder also queried on page 6, under Risk Assurance, it referred to medical gases and asked if this was referring to fire risks and medical gases was an error in the report. Craig Hodgson responded that medical gases was an error. It had been corrected, but the updated report was not circulated prior to the meeting.

ACTION: Craig Hodgson to circulate the updated report.

Gill Ponder also queried on page 7, fire ring mains, as the reference to removing domestic water supply connections was not clear. Craig Hodgson explained there should not be any connections to the ring main but there were. To remove them would require a major water shutdown which would create further risk. He stated that it had been agreed that this work would be completed by March 2024.

Gill Ponder also queried why the Annual Fire Report was going to the Audit, Risk and Governance (ARG) meeting instead of coming to this Committee prior to presentation at Trust Board, as Estates and Facilities (E&F) sits under the Finance and Performance Committee (F&P) TOR. Simon Parkes suggested that it might be because it was related to Health and Safety. He suggested that it was discussed at ARG and the relevant changes made to the Committees' TOR if the report was due to go via F&P in future.

Gill Ponder asked how the Committee can be assured that staff know what to do when a fire alarm sounds if drills are not carried out within the Trust. Craig Hodgson stated that drills were being addressed as part of the action plan from the annual AE audit, referring to the top of page 9 in the fire report. Gill Ponder acknowledged that and added that assurance that staff knew what to do in the event of the fire alarm sounding was more important due to the concerns with the fire doors and lack of attendance by staff at the fire training.

8.2 Reinforced Autoclaved Aerated Concrete (RAAC)

Craig Hodgson had the initial RAAC report from the engineers which stated that further investigation was required. The current view was that the RAAC that had been found was likely to be on top of a concrete slab so was not load-bearing and likely to fail. Investigations were continuing. Gill Ponder asked when the outcome of the investigation would be available. Shaun Stacey suggested that it should be monitored by Trust Management Board (TMB), with an assurance report brought back to F&P once the outcome of the investigations was known.

8.3 Assurance Confirmation & Board Highlights

The Committee would highlight the damaged fire doors and programme of repair and replacement, the appointment of an Authorising Engineer and the domestic appliance fire risk.

8. Review of NLAG Monthly Performance and Activity Delivery (IPR)

8.1 Planned Care

Discussed with unplanned care below.

8.2 Unplanned Care

Ashy Shanker took the paper as read. 8.1 and 8.2 were discussed together. The highlights were that the Trust had maintained a strong position with Cancer 2 Week Wait (2WW) patients with an actual performance of 96.2%, against a target of 93%, which is a continuous improvement maintained in June 2023. The Urgent Care Service (UCS) performance was 99.3%, against a target of 92%, which was an increase of 10% since last year. The number of admissions had not increased with the Emergency Department (ED) working well. The numbers of discharge letters being completed within 24-hours of discharge stood at 91.6%, against a target of 90%. Outpatient (OP) summary letters completed within 7 days of the patient being seen stood at 56.3%, against a target of 50%. Same Day Emergency Care (SDEC) patient discharges were 42.7%, against a target of 40% and the Trust had been commended by the region for that performance. Ashy Shanker also stated that we should be proud of our low percentage of extended stay (21 days plus) patients which is at 11.8%, against a target of 12%. Ashy Shanker and Shaun Stacey are having weekly meetings

with the divisions to look at patient length of stays and they are taking part in hospital walk arounds on each site at least once per week. The average length of an inpatient stay for elective patients was 2.1 nights, against a target of 2.5 nights, with non-elective patients was 3.4 nights, against a target of 3.9 nights. The Trust total length of stay position was commendable against other trusts in the region w,ith 94.8% of all electives being planned day cases.

Ashy Shanker stated that the lowlights were struggling to discharge patients prior to 12:00pm due to overnight pressures including low staffing levels and multiple ambulances arriving together. That had resulted in actual performance being at 16.9%, against a target of 30%. She stated there was lots of work being done to improve, including recording an estimated discharge date on admission and clinicians reviewing the patients every day with that date in mind. Struggling areas were being identified by 13:00 and additional help was provided to those areas. The number of patients waiting over 12 hours in the Emergency Department (ED) for a bed after a decision to admit had remained worryingly high compared to others in the ICB region, due to the patient flow issues.

Ashy Shanker stated there were 34 patients on the Cancer pathway that had been waiting 104+ days for a diagnosis. That number should be zero. The number of patients waiting 62+ days stood at 55.1% having reduced over the past few weeks on a positive trajectory. The Trust were working closing with HUTH regarding the Cancer pathway to ensure patient transfers were happening in a timely way due to capacity issues across NLAG and HUTH. There was a shortage of doctors, but actions were being taken weekly to help reduce the number of patients waiting over 62 days.

The Patient Tracking List (PTL) percentage of patients waiting for treatment was reducing but performance was a long way from the target. Incomplete Referral To Treatment (RTT) pathways target of zero patients waiting 72+ weeks was at zero at the end of the last financial year. The next challenge was having zero patients by the end of the current year waiting over 65 weeks. Ashy Shanker stated that the Trust got one or two validation breaches due to administrative errors that were picked up, but they were dealt with once identified. The Trust were also offering mutual aid to other trusts so some long waiting patients came from them.

The diagnostic waits performance was currently at 35%, with the plan to get to 5% by the end of March 2025 and to do that the Trust had increased capacity by installing two new mobile MRI scanners and increased the capacity of CT services.

Outpatient overdue follow ups were currently at 44,600. To reduce that number, the Trust were doing patient initiated follow ups, discharging patients that did not need to be seen back in clinic, working with clinical leads and challenging and supporting clinicians reluctant to reduce unnecessary follow up appointments.

Ashy Shanker stated that ED performance improvement trajectory at the end of the year should be 76%. It was currently at 65.3%, but the Trust had met monthly targets for the past three months.

Gill Ponder thanked Ashy Shanker and opened up the discussion to the Committee.

Kate Truscott asked to refer to page 8 that referred to the risks of the radiology workforce recruitment by August 2023 and asked if that was already happening. Shaun Stacey responded stating the reason that was happening was the need to revisit the workforce planning for radiographers and radiologists in the light of the new

Community Diagnostic Centres (CDC) coming on stream. The IPR did not make it clear that the trigger was related directly to the CDC workforce plan, combined with the existing workforce plan which had given the Trust a revised figure that would link with the November 2023 international recruitment. Lee Bond added that for CDC's the workforce international recruitment was not instigated by the Trust; it was nationally organised, and the Trust would get funding for that further international requirement.

Craig Hodgson challenged page 19 of the IPR report, stating that the reference around Estates and Facilities (E&F) budgets was not accurate and asked to discuss with Ashy Shanker outside of the meeting to work around the misconceptions.

ACTION: Craig Hodgson and Ashy Shanker to meet to amend the E&F budget reference in the IPR.

Lee Bond asked if the discharges before 12:00pm was more of a struggle at one hospital than the other. Ashy Shanker stated that Diana, Princess of Wales (DPOW) Hospital was worse than Scunthorpe General Hospital (SGH).The Trust was working with DPoW to bring them in line with SGH by doing a long length of stay ward round twice per week and working closely with clinicians to be confident in discharging patients if they were well enough to leave.

Lee Bond asked about progress against the improvement trajectory submitted as part of the annual plan for the UCS pathway and ambulance handovers. Ashy Shanker stated that the Trust were on track for ED performance and ambulance handovers in 30 minutes performance. Lee Bond also asked about the bed occupancy percentage at 91% and whether that could be correct when the Trust had escalation beds open. He also asked if that metric was measured on funded bed position plus escalation beds. Ashy Shanker replied that there was a piece of data quality work being completed on that and that the SITREP related to bed base. Lee Bond asked for confirmation that the Trust was over 100% bed occupancy with escalation beds and Ashy Shanker confirmed that the Patient Administrative Service (PAS) were working with colleagues to correct that metric and suggested that the Committee should ignore the suggestion that 8% of beds were free.

Lee Bond asked if the Trust were accepting more patients on mutual aid, how the Trust planned to get no patients waiting above 50 weeks by the end of the year. Ashy Shanker and Shaun Stacey confirmed the target was zero patients waiting over 65 weeks for the end of 2023/24, with an aspiration to have no patients above 50 weeks by then.

Simons Parkes stated that there had been lots of attention on Cancer figures since he had joined the Trust and commented that the figures showed noticeable improvement. He asked if the impact of poor attendance for virtual outpatients appointments was having an impact on productivity. Ashy Shanker stated from speaking with clinicians there was not much time saved by doing virtual appointments, as opposed to doing Face to Face (F2F) appointments. The Trust were focusing on virtual appointments, getting General Practitioners (GPs) using Advice and Guidance (A&G) to avoid unnecessary referrals into the hospital and patient initiated follow ups (PIFU).

Gill Ponder stated that many clinicians preferred face to face (F2F) appointments as that was what they had done for many years and they believed that patients preferred to be seen F2F, but at her previous Trust one of the strategic objectives was to value patients' time. Virtual appointments took less time and were less expensive for patients, as they did not involve travel or difficulties with parking. She asked how much

the Trust was pushing for virtual appointments with the clinicians. Ashy Shanker replied that they were working closely with them and trying to get the number of F2F appointments down by looking at the non RTT cohort of patients to see who really needed an appointment. Ab Abdi confirmed that and referred to the Planned Care Improvement and Productivity (PCIP) report that stated that they were working on reducing the total number of follow up appointments by converting them to new if needed, which would impact the number of virtual and F2F appointments required.

Gill Ponder asked about the 104-day Cancer target where the Trust was removing patients from the pathway once non- malignancy was confirmed to improve performance, but she was concerned that that would not reduce actual delays for patients. Shaun Stacey responded that clinical harm reviews were being carried out for those long waiting patients, as the wait could be as devastating as a diagnosis. They remain on the Cancer pathway because they may still have a suspected Cancer that clinicians were trying to rule out but that should be done from the beginning by completing diagnostic tests faster. Another contributing factor to this was clinicians were not reviewing the patients Cancer result packs in a timely way which was also causing delay.

Mike Robson observed that with the implementation of a new Performance and Finance Committee in Common meeting as part of the plans for a Group model for HUTH and NLAG it would be possible to have a discussion about how reports could be coordinated. Shaun Stacey responded that we already hold a joint Cancer Board across the Humber region which had resulted in multiple benefits including single Multi-Disciplinary Team (MDT) meetings in lung and colorectal and once we became a group it would be a lot easier to report on Cancer patients. Lee Bond asked if the report included data from York and Harrogate Trusts to which Shaun Stacey answered that Harrogate was in the West Yorkshire region, not the Humber, but the report did include Scarborough and York Trust.

Mike Robson made a further observation that HUTH needed more information on length of stay reporting given the importance of it. Lee Bond stated that NLAG reporting figures were much better than HUTH and that both Trusts needed to have confidence in reporting data.

8.3 Planned Care Improvement and Productivity Updates

Ab Abdi took the paper as read. He stated that theatre utilisation was at 93-98% which was one of the top priorities nationally, also the capped position was 80.8% with uncapped at 81.4% against the target of 85%. The Trust's Cancer position was showing remarkable improvement with the 62 day backlog at 7.6% at the end of June 2023 so the Trust had improved nationally from being 115th to 39th. Gill Ponder stated she didn't understand what the 7.6% refers to as she thought we reported Cancer in actual numbers waiting, not percentages. Ab Abdi responded by saying nationally they are reported using percentages and on slides three and four he had included both figures. Mobile Magnetic Resonance Imaging (MRI) units had been approved and would provide additional capacity and clinic utilisation was at 97%. The targeted Lung Health Check programme was progressing well and was moving to five days per week in September 2023 and six days per week in November 2023.

Ab Abdi then stated that the Junior Doctors' and Consultants' IA had had a significant impact but the Trust had tried to proactively cover Cancer and urgent activity. RTT had one 78+ week patient recently due to a late return back from St Hugh's Hospital, they had now been discharged. The outpatient follow up back log had deteriorated due to

converting follow up slots to new and so there was work ongoing with Medical Directors and clinicians to see patients and discharge if necessary. In June 2023, only 1 pre-validation Cancer standard had been achieved, but for context the table in the report showed neighbouring hospitals standards and what they had achieved and the Trust was better in terms of performance.

Lee Bond stated that the report was encouraging but he would like to see theatres above 85%, instead of 82%, so his question was what was Ab Abdi's current biggest concern. Ab Abdi responded that his biggest concern was workforce capacity, doctors in particular and he stated that if this improved the majority of the Cancer position would improve. Ashy Shanker also agreed that workforce was our biggest issue and resolving that would see a reduction in overdue follow up appointments converting to new appointments. Lee Bond stated he did not believe that reducing the amount of follow up appointments was enough and that the real challenge was a cultural challenge and how the Trust could change that and when.

Kate Truscott thanked Ab Abdi for a great report. She asked under theatre utilisation there was a mention of competing priorities around Information Services and if that was a common theme to be able to support data and information and if it was going to cause problems. Ab Abdi stated it would not cause problems as the top three priorities were being reported on.

Lee Bond left the meeting.

Gill Ponder asked if month one and two Elective Recovery Fund (ERF) performance of 119% was triangulated with Finance data. Brian Shipley confirmed that it did and that Finance were reporting the same level of activity. Gill Ponder then referred to slide seven for length of stay. Minimal access was down to 61.3% and asked how that percentage related to length of stay due to the mix of numbers and percentages. Ab Abdi explained that the length of stay figures had increased which meant access had decreased. Gill Ponder asked for that to made clearer in future. Referring to slide eight, Gill Ponder asked when the Trust would achieve the 75% faster diagnosis target. Ab Abdi explained that it was unrealistic to say when, but they aimed to exceed 75% and had been proactive with the IA and Bank Holidays.

Gill Ponder referenced back to the discussion that was had on the Trust only achieving one out of the nine Cancer standards. The previous discussion had stated that the Cancer performance had improved but from the table there was only one of the nine standards achieved which suggested that performance had deteriorated because the Trust had previously achieved more of those nine standards. Ab Abdi responded that the cancer position was a multi-dimensional concept, with key issues to address by the end of 2023/24 being the national priority of reducing the 62+ days backlog which the Trust were doing well on and with the lung health check position where the Trust were also progressing well. Despite the overall red on the table, he stated the Trust faced serious challenges in Cancer but nationally the Trust was in a good position. Gill Ponder stated again that there was still more red on the table than green. Ab Abdi responded stating the need to look at the Cancer overview including the safety and harm. Simon Parkes agreed with Gill Ponder that it was an important point, but stated that although only one metric was green, the Trust were close to targets on some of the other metrics. Ashy Shanker added that the plan that had been submitted to the ICB included our faster diagnosis target of 75% by the end of the year and that the Trust had already met the trajectory in the first two months.

Gill Ponder also asked about the comment on slide 10 about the loss of CT/MRI due to CDC national ruling and how that was impacting the Trust's patients. Ab Abdi stated that the Trust did not have suitable pads to accept the new specification mobile scanner vehicles. Gill Ponder was aware of that issue, but it had not been clear from the slide that that was what it was referring to.

8.4 Board Highlights

Gill Ponder asked the Committee what points they would like to highlight to the Board. It was agreed by Simon Parkes, Gill Ponder and Kate Truscott to include the improvement on the Cancer position. Gill Ponder asked the Committee if they would like to highlight the reduction of virtual appointments and Shaun Stacey responded advising to highlight the lack of movement in reducing the number of unnecessary outpatient follow up appointments. Ashy Shanker asked to highlight the pressures of urgent care and what was being done to improve patient flow, including the ED 12-hour delays. Shaun Stacey agreed stating that it was a really important target as well as highlighting the delayed discharge numbers and lost bed days, and also asked to raise the positives of the continued improvement in ambulance handovers, the overall improvement of UCS pathway and the continued delivery against trajectory for elective care. Gill Ponder thanked them for the points raised.

Simon Parkes asked to highlight the lack of theatre capacity to recover lost activity due to the junior doctors IA as theatres were already running at 95% capacity. Ashy Shanker added that three theatres had been refurbished but there were many others that still needed refurbishment.

9 Review of NLaG Monthly Finance Position (Finance Report)

9.1 Finance Report M3

Brian Shipley confirmed a £2.5 million deficit in June 2023, which was marginally ahead of the plan. The year-to-date position was £6.9 million, £1.4 million favourable against the plan at the end of quarter one. He outlined the key drivers as awaiting confirmation of the Trust's depreciation funding which was included in the plan, being behind on lung health checks income projection but it was offset with reduced expenditure resulting in a net problem of £0.1 million. Brian Shipley confirmed that the April and June 2023 IA had cost the Trust £0.5 million and key pressures remained on ED due to the 10% increase in attendance. The bed pressures position had slightly improved in June compared with the year-to-date which was a positive, but overall there was £100k shortfall in our year-to-date position. Those pressures had been offset with slippage on Independent Sector (IS) capacity. He stated that the Finance team were working with E&F to look at the reason for an increase energy consumption for the Trust as the overspend was volume and not price related and that was being offset by slippage on the Capital programme.

Completing a straight line projection from month three led to a forecast of a £27.5 million deficit by the end of 2023/24, which was then adjusted for known seasonal pressures and changes which adjusted the forecast deficit to £25.6 million. Brian Shipley stated that the Trust had technical support available of £3.3 million and expected to be able to release its annual leave provision of £6 million.

Lee Bond re-joined the meeting.

Brian Shipley continued that he expected Cost Improvement Programme (CIP) delivery to increase over the second half of the year due to recruitment and retention plans but the current forecast was that the core programme would have a shortfall of £1.4 million. Whilst that would bring the Trust back on plan, there were quite a lot of risks in that trajectory, including annual leave provision, CIP delivery, elective recovery due to IA, the direct cost of IA and bed pressures which equated to a potential impact of £7.5 million against the plan.

CIP delivery was behind the year-to-date planned position by £0.5 million predominantly due to being behind on the Trust's balance sheet release, but the Trust had not needed to release anything due to quarter one being favourable. No progress had been made on the Integrated Care System (ICS) stretch target of £10.1 million. Lee Bond stated since these plans were created in February, the Trust was reviewing actuals and had identified some areas to potentially mitigate the £10.1 million but there was still a gap.

Brian Shipley stated that the Trust's underlying deficit position in the plan had been estimated at £41.5 million and it had now been updated to £47.8 million, driven by confirmation that inflation and Depreciation funding was non-recurrent which was £4.3 million, a shortfall against the Agenda for Change (AfC) Pay Award of £0.9 million and a forecast slippage on recurrent CIP programme of £1.2 million. Lee Bond stated HUTH also had a shortfall on the AfC Pay Award of £1 million and Brian Shipley confirmed that the issue was nationwide.

Brian Shipley stated that the Trust would need just over £4 million in cash support in March 2024. Temporary staffing nursing compliance rates were getting better with reductions in tier three agency staff and increases in tier one and two, but there was no correlation between vacancy position and agency spend.

Simon Parkes stated that the agency spend was charted against vacancies, but sickness and other absence rates had not been included. Lee Bond confirmed that they were missing and suggested that they could be added in along with maternity leave. That would be updated for the next meeting. Gill Ponder agreed that this would be very useful. Simon Parkes stated that something was driving the high agency spend and it was not vacancies. Shaun Stacey stated that he believed that short term sickness was driving the cost of the agency spend. Lee Bond added that the escalation beds would also drive up costs and that was not included and he confirmed that further information would be included for next month's meeting.

ACTION: Lee Bond to include sickness and other absence rates on the vacancy and agency spend charts

Kate Truscott stated that the overall sickness rate for the Trust had been previously at 13%, but it was important to look at each division with one division having 13 doctors off sick at one time and that support needed to be put in place. Agency spend was very high with several agency nurses working more than full time hours and Shaun Stacey stated those nurses would not join the Trust on NHS contracts due to the reduction in pay. Lee Bond confirmed that there were some departments that were unable to cover absences if they were for specialist roles.

Gill Ponder thanked Brian Shipley for his updates. She referred to slide four, paragraph one on slippage and the CIP plan getting more challenging in the second half of the year and was concerned about the £10.1 million and how the Trust would try to close that gap. Lee Bond responded stating there had not been as much spend

on the independent sector, which was positive, it was the CIP plan which remained the problem. Shaun Stacey, Ashy Shanker and Brian Shipley met last week and it had been agreed that splitting the £10 million across divisions was not the right thing to do and it would continue to be held centrally. Electronic Patient Record (EPR) still did not have a business case and the Trust did not know what business processes and resources would change as a result. Lee Bond stated that he had presented to a Board Timeout about expensive ED costs and had been advised by the ICB to exclude any reference to a change of maternity services at SGH from the forthcoming Acute Services consultation. From a financial perspective downgrading or closing maternity services would be the single biggest cost saving possibility, but that could not be done. He stated that the Board needed to be clear about the options to reduce costs, which were service transformation and technology solutions and their appetite for difficult conversations to reduce the underlying deficit. He added from a non-clinical side the EPR business case around Medical Records may yield the ability to release some costs.

Kate Truscott supported Lee Bond with the need to drive down costs with service reconfiguration but that would require formal consultations. She added that it was not cost effective to run duplicated services across sites in this Trust. Lee Bond asked to get views from the Governors as representatives of our population and Kate Truscott supported that proposal. Shaun Stacey agreed with Lee Bond that a review of some services was needed. He used the example of three respiratory and gastroenterology services across the Trust, no vacancies at HUTH and a large amount of vacancies at NLAG and NLAG being very expensive compared to HUTH. He stated if we moved Frailty service to the community, that would save seven beds per day, currently there were over 200 patients over 85 years of age admitted that could be cared for at home which would make a huge saving if that service could be managed in the community.

Richard Peasgood left the meeting.

Shaun Stacey agreed with Lee Bond that the financial situation would be an ongoing problem but it needed to be worked through in a sensible way by the Executive team and needed Board support to take the risk in a similar way to the streamlining of the Haematology service.

Richard Peasgood re-joined the meeting.

Simon Parkes agreed that the Board needed to consider financial sustainability balanced against clinical need.

9.2 Recovery Support Programme update

Lee Bond stated that it had been momentous for the Trust to receive the letter confirming that the Trust had exited from Level 4 of the Recovery Support programme for finance. Gill Ponder congratulated everyone on that achievement.

9.3 National Cost Collection Submission update

Brian Shipley took the paper as read. Paper one of a two-part paper sets out the Trust's approach to the National Cost Collection (NCC) submission. He highlighted the risk to the submission, including delays to the central guidance issued and the software changes that would be required to comply with that guidance, the data warehouse migration activity for the past 12-18 months, although the Information Team had assured him that it would be done by 31st July. The remaining risk was that

the Trust's accounts remain unaudited, but that had been flagged to NHSE, who had requested that the data was submitted without waiting for the completion of the audit. There were four red flag rated items around job plans for medical staffing due to data quality issues. Lee Bond added that had been a problem for Health Education England for a long time on how a clinician's time was spent between tasks. Kate Truscott supported Lee Bond and colleagues on job planning challenges and stated that job plans needed to reflect a clinician's time spent on different activities correctly.

9.4 Financial and Operational Plan letter from Richard Barker including action plan

Lee Bond took the letter as read and stated that he had discussed it with Brian Shipley and was comfortable with most of the points, but the area where the Trust did not have as many controls in place was on authorising Bank and Agency spend. He stated that the plan had been discussed in the Executive team meeting with different Executives responsible for different points and they were in the process of writing the Trust response to confirm the current position and plan for each point in the letter. Analysis of investments in additional staffing since 2019/20 would need to be discussed at TMB, then by this Committee and then Trust Board. Lee Bond and Brian Shipley had reported where investment had been made in the past four years and proposed next month to bring the response to the letter to the Committee for discussion. Gill Ponder agreed to add it to the agenda for next month. Craig Hodgson asked Lee Bond if the Trust would be looking to change the staffing establishment and Lee Bond confirmed that it would be considered but that it would be subject to a discussion at TMB.

ACTION: Richard Peasgood to add Response to Finance and Operational Plan Letter to the agenda in August.

9.5 Business Case Assurance

None to discuss.

9.6 Assurance Confirmation & Board Highlights

Gill Ponder stated the issues around costing were important to raise along with the difficult conversations around ways of closing the financial gap. Simon Parkes agreed.

10 BAF

10.1 SO3-3.1 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

Deepdive

Gill Ponder stated there was a gap in control on systems to recruit and retain staff and what the Trust was doing to control that gap. The response to the letter discussed earlier in the meeting would cover that. Gill Ponder asked if there was risk of lost income or fines if the Trust failed to achieve the ERF target of 109% and if it should be on the BAF as a risk. Lee Bond stated that the ERF issue was a risk but that NHS England were planning to mitigate the costs of the IA by linking it to the funding of elective recovery. For the April IA, they had reduced the elective target to cover the additional spend , but they had not confirmed the plan for June's or any future IA. Ashy Shanker stated in terms of activity no changes had been made. Shaun Stacey stated

the mitigation was already included in the Workforce Committee BAF so did not need to be included on this one. Gill Ponder agreed. The Committee were assured by the BAF and agreed with the current risk score.

11 Items for Information

11.1 Performance Letters to Divisions following PRIMS Meetings

PRIMS meetings had been cancelled, so there were no letters to review.

11.2 CIB Minutes

No CIB meeting had taken place since the last F&P Committee so there were no minutes available.

12 Any Other Urgent Business

12.1 Matters to Highlight to other Trust Board Assurance Committees

- Shaun Stacey stated the board were aware of an issue in Audiology which may result in a future request for special funding to enable the Trust to manage the issues. From an assurance point of view it is a risk not previously known about.
- Lee Bond stated in the absence of CIB minutes, there were some emerging Capital pressures and the Executive team were aware of those.

13 Matters for Escalation to the Trust Board (Public/Private)

Gill Ponder stated that these had been discussed throughout the meeting.

13.1 Review of Meeting

Shaun Stacey stated it had been a successful meeting with the standard of papers improving and a good quality of discussion. The Committee all agreed that there were several priorities that needed to be worked on, but that the focus needed to remain on resolving workforce issues to reduce costs and improve services.

14 Date and Time of the Next Meeting

The next meeting would take place as follows:

Date: 23 August 2023
Time 1:30pm – 4:30pm
Venue: Virtual via MS 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	√	√	√	√	√	x	√					
Fiona Osborne	√	√	√	√	√	√	X					
Lee Bond	√	√	√	x	√	x	√					
Jug Johal	√	√	√	√	√	x	X					
Shaun Stacey	√	√	√	√	√	√	√					
Ian Reekie	x	√	√	√	x	√	√					
Richard Peasgood	√	√	√	√	√	√	√					
Simon Parkes	x	x	√	√	√	√	√					
Brian Shipley	√	√	x	√	x	√	√					
Annabelle Baron	√	√	√	√	√	√	√					
Abdi Abolfazl	√	x	x	√	x	x	√					
Ashy Shanker	x	√	√	x	x	√	√					
Shiv Nand	√	x	x	x	x	x	X					
Dr Peter Reading	x	√	√	x	x	x	X					
Linda Jackson	x	x	x	x	x	√	x					
Craig Hodgson	x	x	x	x	x	√	√					
Kate Truscott	x	x	x	x	x	x	√					

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: **Wednesday 23 August 2023, MS TEAMS**

Present:

Gill Ponder	Non-Executive Director (Chair)
Shaun Stacey	Chief Operating Officer (COO)
Ashy Shanker	Deputy Director of Planning and Performance
Lee Bond	Chief Finance Officer
Brian Shipley	Deputy Director of Finance
Jug Johal	Interim Joint Director of Estates and Facilities
Simon Parkes	Non-Executive Director
Fiona Osborne	Non-Executive Director

In Attendance:

Ian Reekie	Lead Governor
Annabelle Baron-Medlam	Acting Head of Compliance & Assurance (section 6.1)
Richard Peasgood	Executive Assistant to COO
Georgina Birley	Executive Personal Assistant to COO (for the minutes)

ITEM

3. Apologies

No apologies had been received.

13. Quoracy

It was noted that the Committee was quorate.

14. Declarations of Interest

Jug Johal announced that he was now the Interim Joint Director of Estates and Facilities for Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).

15. To Approve the Minutes of the Meeting held on 19 July 2023

Due to the incorrect version of the 19th July minutes being circulated, it was agreed that both the July and August Committee meeting minutes would be approved at the September Committee meeting.

16. Matters Arising

No matters arising were raised.

5.1 **Action Log**

The action log was reviewed and updated as follows:

24.05.23

5.3 – Carried forward to September.

6.1.1 – Confirmed action complete and to be closed.

6.1.2 – Confirmed action complete and to be closed.

7.1 – Incorrect date on the action log, which would be updated to state September, in line with the update recorded from the July meeting.

12 - Shaun Stacey stated the review by the Integrated Care Board (ICB) of Urgent and Emergency Care (UEC) was delayed until 12th July and the recovery plan had not yet been published. It was agreed to carry forward the action to the next meeting.

19.07.23

5.2 – Confirmed action complete and to be closed.

5.3 – Confirmed action complete and to be closed.

5.4 – Confirmed action complete and to be closed.

7.1 – Confirmed action complete and to be closed.

7.2 – Jug Johal informed the Committee that NLaG had joined the National Reinforced Autoclaved Aerated Concrete (RAAC) Group in view of securing national RAAC funding and they were satisfied with the mitigation the Trust had in place. Confirmed action complete and to be closed.

Simon Parkes joined the meeting at 13:43.

Annabelle Baron-Medlam joined the meeting at 13:44.

8.2 – Confirmed action complete and to be closed.

9.1 – Lee Bond apologised as this action had not been completed and it was agreed to carry it forward to the next meeting.

9.4 – Agreed to carry forward to the next meeting.

5.2 **Terms of Reference (ToR)**

The Committee noted the Terms of Reference.

5.3 **2023-24 F&P Committee Workplan V3**

Gill Ponder and Richard Peasgood met prior to the meeting to update the workplan. The revised workplan was agreed by the Committee.

5.4 **Action Plan**

Gill Ponder and Richard Peasgood had met prior to the meeting to update the action plan. The key change was that it showed the highlight report improvements as completed. Lee Bond apologised for the lateness of the papers for the August Committee meeting. Fiona Osborne requested that late papers were circulated separately, rather than all the papers being resent and it was also agreed that amendments to papers should be highlighted to remove the need for the entire paper to be read again. Gill Ponder supported this. Shaun Stacey stated that if papers were not submitted on time, they could not provide assurance to the Committee and should be deferred to the next meeting. Fiona Osborne agreed in principle but stated that some flexibility was needed and suggested bringing the agenda set meeting forward to allow more time for papers to be prepared. The Committee agreed to bring the agenda set meetings forward.

Action: Georgina Birley to discuss dates with Gill Ponder for agenda set meetings and amend the meeting invites.

Jug Johal disagreed with Shaun Stacey regarding the papers being deferred if not ready. He stated that papers could be ready, but due to a new process in place all papers now needed to be reviewed by an Executive Director. Gill Ponder stated if the paper had not been seen by an Executive then it was not ready and should be deferred. Fiona Osborne appreciated that papers needed to be seen by other Committees, but stated that it meant the workplan was wrong, even though it had already been updated. Simon Parkes agreed and added given the changes with a new Chief Executive, he and others needed to meet with Helen Harris, Director of Corporate Governance, to ensure the workplan was correct. Gill Ponder stated the workplan had already been updated and reflected the current ToR, so it was correct at that point. The updated Workplan was agreed by the Committee, recognising that further updates may be required in future if there was insufficient time for papers to be reviewed by the Executive Director before submission to the Committee.

17. Presentations for Assurance

6.3 **Care Quality Commission (CQC) Progress Report**

Annabelle Baron-Medlam took the paper as read and stated there was progress with the Care Quality Commission (CQC) action plan with 10 actions closed and submitted to the CQC. The number of actions that had significant assurance had increased from 19 to 21 with the number of actions with limited assurance down from 39 to 32. There were no changes to the ratings for the actions linked to this Committee, however there had been discussions with divisional managers about how they were interpreting the rating of limited assurance. The timescales for some actions had increased, not due to a lack of focus but due to not understanding the scale of the action from the outset.

Fiona Osborne asked regarding action EOL-02, if the issues had been resolved due to waiting for system enhancements to prevent duplication of work on different systems. Annabelle Baron-Medlam stated that she would find out and bring the answer back to the Committee at the next meeting. Shaun Stacey answered and stated that point focused on the link between the WebV and SystmOne and the duplication of work

would continue due to the systems not interfacing with each other. It would improve once the PAS/EPR was in place, but it still would not link to SystmOne so some duplication would remain an issue.

Fiona Osborne stated in regard to MED-18, the report had better information from the departments rather than statistics but in Endocrinology a long-term locum had been secured to cover a substantive Consultant on long term sick leave and asked if the mitigation was the final solution and whether the action could be closed, or whether additional work was ongoing that was not represented in the report. Shaun Stacey stated it was a temporary fix and a long-term solution would be part of the development of the Humber Acute Services Review (HASR) and the redesign of clinical services to enable the recruitment of the right workforce. He added the action for the department was to describe more accurate responses to the CQC actions and if the responses were short, medium, or long term. Fiona Osborne asked what the end goal was for action MED-18 and Shaun Stacey stated it was a single Patient Administration System (PAS) but that it was not likely to be completed until April 2024.

Simon Parkes stated there was not enough context in the report and referred to the increase and decrease of waiting lists and what that meant and what actions should be taken. Shaun Stacey stated that the challenge was that the report provided assurance around the CQC items and the standard monthly performance reports provided the information on progress with waiting list recovery.

Annabelle Baron-Medlam stated that she had attended an Operational Manager Group (OMG) meeting last month and had spoken with the Associate Chief Operating Officers (ACOO's) about how to get the information relating to the CQC actions due to there being such a large amount of information.

Annabelle Baron-Medlam left the meeting.

7 Review of NLAG Monthly Performance and Activity Delivery (IPR)

7.1 Unplanned Care

Ashy Shanker took the paper as read. She stated there had been an increase in ambulance handovers over 60 minutes. The Emergency Department (ED) 4-hour performance target was 76% by the end of the year. Performance was standing at 63.6%, but it was back on track over the past two weeks. There had been a 10% increase on ED attendance year-to-date (YTD) and that was an ongoing challenge. Work was underway at Place level to understand the cause of that increase. The Urgent Care Service (UCS) 4-hour target of 92% had been achieved, standing at 99.3%. There had been a decrease in patients waiting over 12 hours for a bed from ED, but there remained further work to be done to eliminate 12 hour waits. The target of 40% of same day patient discharges had been over-achieved at 42.2%. Inpatient elective length of stay target of 2.5 nights had been achieved at 2.3 nights and weekly length of stay meetings were taking place with each division. Non elective length of stay had increased from last month at 3.4 nights but was still within the target of 3.9 nights. Extended stay patients of over 7, 14 and 21 nights had decreased and the Trust was one of the best performing Trusts in the region on those measures. Bed occupancy was reported at 91.9% achieving the target of 92%. There was still work being done on data cleansing on WebV and Business Intelligence (BI) to ensure that the data was correct.

Gill Ponder stated that the weekly Board Flash Report included data on ambulance handovers over 60 minutes and that the number of handovers over 60 minutes spiked some days and then there were none the following day and asked if there were specific reasons for this. Ashy Shanker stated the spikes were due to several factors including bed flow and several ambulances arriving at once. Gill Ponder asked if it was a process issue and if it depended which medical staff were on shift that day. Ashy Shanker stated that staff did play a factor, if an experienced Consultant and team oversaw discharging patients the flow would improve. Gill Ponder asked when John Awuah presented the next paper on Unplanned Care to the Committee for him to investigate and include a deep dive into the role human factors played in daily performance variability on ambulance handovers.

Action: John Awuah to include a deep dive on the daily variability in ambulance handover delays and the impact of human factors on daily performance

Fiona Osborne asked if there were pages missing from the report as the executive summary only covered elective care and no high or low lights on urgent care. Ashy Shanker stated these would be added in next month's report. Gill Ponder agreed it would be helpful.

7.2 **Planned Care**

Ashy Shanker stated advice and guidance was at 10%, against a target of 16%. Cancer 2-week-wait appointments was at 94.6% against a target of 93% and 28 day faster diagnostic standards performance had increased to 77.7% against a target of 75%. Request to test in 14 days increased to 86.9% against a target of 100%. The GP 62 day referral had decreased to 58.1% against a target of 85%. The number of patients waiting 104 days was 31, against a target of 0. Incomplete RTT pathways under 18 weeks stood at 62.4% against a target of 92% and the number of incomplete pathways was 40,000. Patients waiting over 65 weeks stood at 88, against a target of 0.

Diagnostic procedure waiting times over six weeks was at 37.1% against a target of 1%, due to Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) machine faults. An MRI mobile van arrived 22nd August 2023, so the Trust had additional capacity to address some of the backlog, but there remained an irreparable MRI machine at Scunthorpe which reduced capacity Lee Bond questioned the need to find funds to replace that machine and Shaun Stacey stated the additional mobile MRI didn't resolve the broken MRI scanner issue as there was a competing need to manage emergency work against elective work. There would be no Community Diagnostic Centre (CDC) MRI or CT capacity by December, as it may take 18-24 months to get these services running at the CDCs. A replacement MRI scanner if ordered now would not be delivered for around two years, so the MRI backlog would continue. Shaun Stacey asked Ashy Shanker at the next meeting to include a new trajectory for MRI capacity in the Deep Dive report to the Committee.

Action: Ashy Shanker to provide a new MRI backlog improvement trajectory in the next report to the Committee.

Outpatient overdue follow ups was a risk due to Referral to Treatment (RTT) incomplete pathways. A paper looking at ways to reduce the risk was being created including clinicians not bringing patients back to clinic unnecessarily and using patient initiated follow ups instead, but it was a challenge within the Integrated Care System (ICS). There was little traction in reducing follow-up appointments by the target of 25%

to create additional capacity for new appointments, Virtual appointments were at 21.9% against a target of 25%. Simon Parkes asked if the low attendance of virtual appointments was having an impact on the ability to do follow ups and how much capacity was being lost by doing virtual appointments. Ashy Shanker stated that the 21.9% was not a Did Not Attend (DNA) rate for Virtual Appointment, but was the percentage of virtual vs face to face appointments and that she would find out the DNA rates.

Action: Ashy Shanker to provide the DNA rates for virtual and Face-to-Face (F2F) outpatient appointments.

Gill Ponder stated that although virtual appointments may take the clinician the same amount of time as a F2F appointment, they reduced the patients' time and that their time also needed to be valued. Shaun Stacey stated it was a cultural challenge from the clinicians as they wanted to see people F2F but he agreed that virtual appointments were often more convenient for patients.

Ashy Shanker stated the DNA rate had decreased since last month to 6.4% against a target of 5%. Patient Initiated Follow Ups (PIFU) had increased to 3.2% against a target of 5%. Theatre session utilisation had decreased from last month at 79% uncapped and 80% capped against a target of 85% and work was being done to ensure accurate data was being reported into WebV by operations colleagues.

Gill Ponder asked in regard to independent sector contracts how it was ensured they delivered according to their contract and were value for money. Ashy Shanker stated that regular meetings with providers took place to discuss contractual obligations and the service team would raise any issues. Lee Bond suggested that any work by independent sector contracts was not good value for money due to the Trust paying a premium for them to make a profit. He added it was still less than the tariffs but it was not best value for money as the Trust could do it at a cheaper rate.

Gill Ponder thanked Ashy Shanker for picking up the data on the capped and uncapped theatre utilisation as when she looked at the IPR graphs they were the same which suggested a data issue. Ashy Shanker confirmed there was work taking place to ensure accurate data was being recorded in WebV.
Gill Ponder asked about the risk to patients when they had to wait six weeks for a first appointment in oncology. Ashy Shanker confirmed that it was due to the lack of clinicians within the department but the Trust were working closely with HUTH and the Cancer Alliance were considering how to improve the pathway. Shaun Stacey added the patient risk was managed by the Clinical Nurse Specialists (CNS's) who supported oncology patients from the point of referral to end of treatment. The challenge was bigger than the Group and the Cancer Alliance were working closely with oncology services at other hospitals including Sheffield and Leeds to look at an effective long-term solution. He also informed the Committee of a new risk to breast radiology, as the current radiologist was retiring at the end of August and there had been five unsuccessful attempts to recruit to the position.

Lee Bond asked when the data work on theatre utilisation would be complete. Ashy Shanker replied that she would confirm the date outside of the meeting.

Action: Ashy Shanker to confirm theatre utilisation data work completion date to Lee Bond outside of the meeting.

Lee Bond asked regarding the increased number of patients waiting 65 and 52 weeks how the Trust were going to prioritise those and stop consistently failing the targets and if everything could not be improved at once, what the priority was. Simon Parkes asked which target measures were the biggest concerns and where the patient harm was potentially coming from. Shaun Stacey stated every single target was a priority and risk stratification operational meetings were taking place daily. A number of factors had contributed to the increase in waiting lists including strike action, mutual aid and overall capacity to see and treat patients within the Trusts existing resourcing structure and the increasing in demand on follow up patients still needing to be seen against first outpatients and treatments. The Trust had 890 patients waiting over 52 weeks and 88 over 65 weeks. Each patient was given a clinical risk priority number from one to four so the risk to each patient was known. He added his worry was the patients spending 12 hours in ED, 30 minutes plus ambulance handover times and patients who had been admitted for over seven days. Smoothing out the U&EC pathway and managing the clinical risk was needed.

7.3 **Productivity and Efficiency Programme**

Deferred to September.

7.4 **Assurance Confirmation & Board Highlights**

Gill Ponder confirmed the highlights to raise with the Board were the spikes in ambulance handover times, the request to understand any human factors at play and the need to address the lack of traction on the reduction of follow up appointments by 25% to create additional capacity for new appointments.

8 Review of NLaG Monthly Finance Position (Finance Report)

8.1 **Finance Report M4**

Brian Shipley stated the Trust reported an in-month deficit for month four of £2.3m, £0.5m favourable against the plan. The year-to-date (YTD) position was a deficit of £9.1m, £1.9m favourable against the plan. Cost pressures included strike costs for the year which so far stood at £0.8m with £0.3m in July, and additional ED costs of around £100k per month totalling £400k this financial year so far. Some of the cost pressures were offset with slippage on some of the investment reserves but they were starting to catch up in terms of recruitment. There had been delays in the diagnostic mobile vans, delays in planned spend with the independent sector and capital programme depreciation slippage which had supported the YTD position. Of the £1.9m, £1.4m was non-operating expenditure in depreciation and interest and the rest of the pressures were mainly within strike action, ED cover and temporary staffing costs.

The straight-line forecast hadn't changed significantly from month three when it was £27.5m deficit. The latest forecast was £27.4m. If the Trust released the balance sheet adjustments, annual leave provision and the CIP run rate improved as planned, it would take the Trust down to a planned deficit position of £13.4 million. The risks remained the same as previous months, being the ability to release the full annual leave provision, any CIP slippage, the big increase in planned activity required over the second half of the year and further strike action costs. There would be an approximate additional cost of around £1 million for the Medical Staff pay award, which would be confirmed next month. There was increasing pressure from NLaG medical staff to increase locum rates and waiting list initiative (WLI) rates.

The Trust was slightly ahead of CIP delivery on the core programme YTD of £0.4m and, like previous months and years, slightly behind on staffing and recruitment, although that was offset by over performance within back-office functions. The Finance team had not released some of the balance sheet reserves intended in the period as it had not been necessary to do so yet, but they would be released later in the year. The forecast achievement of the CIP plan was a £10.3m deficit, mostly due to the £10m unidentified stretch target.

The underlying deficit would be updated once there was clarity on the impact of the Medical Staffing pay award. A verbal update was only available on system performance for month four and it was a quite a deterioration from month two to month four, as the system was at a £13.3m deficit. The ICB and central costs were balanced, so all the pressures were with providers. Whilst NLAG were an outlier with a small surplus, it was possible that the Trust would be asked to contribute more to improving the system position.

Lee Bond added that there had been unrest in the existing workforce, especially anaesthetists and paediatricians, with a request to pay them the BMA rate card and there was a cost risk to sourcing another MRI van to replace the broken unit. He stated there were a number of pressures on the capital side such as the Acute Assessment Unit (AAU) schemes which had increased costs by £4.1m this year, but that was likely to reach £4.9m. The CDC program for Scunthorpe looked like there would be a £2.8m problem and, more worryingly, the Lorenzo/PAS implementation had just flagged a £1.7m cost risk by February. The ICB position was not great either due to York and Scarborough Hospitals deficit YTD exceeding their full year plan. The Capital Investment Board were trying to balance these demands into a deliverable package for the year.

Simon Parkes asked what the Trust was going to do if the system could not deal with forecasting this adverse plan with the last minute £10m additional savings target and what impact it would have if we reined back now or later. He stated they would not prioritise finances over patient care. He asked where the issues were so the Committee could deal with them and stated that it felt like they were observers in this. Gill Ponder agreed and stated as a Committee it was their job to get assurance on the actions being taken to get back on track. Lee Bond stated that the Trust was still on track to hit the plan but the debt was stacking up and the Trust were struggling to find solutions so the team were flagging the level of risk.

Fiona Osborne stated the medical vacancies overspend did not appear under the key risks to the forecast outturn and asked if the assumption was that they were not going to be recruited to or that they would try but had accepted it would not happen. Brian Shipley stated the straight-line projection would assume they would carry on as they were but in the recovery section there was an improvement on the run rate of the CIP delivery which was linked to recruitment and the £1.8m improvement was linked to agency reduction. Fiona Osborne also stated there was a drugs theme on CIP as well as across medicine and surgery but there were no mitigations in medicine and with surgery there were biosimilars but not able to achieve it because of the limited availability of alternative drugs and asked if this was about Consultants being reluctant to accept the biosimilars. Ashy Shanker stated the issue was previously due to Consultants being reluctant to accept the biosimilars, but now it was accepted at ICS level and it was being communicated down. Fiona Osborne asked what was being done about the drugs overspend in medicine. Brian Shipley stated it was due to non-high cost drugs due to non-elective demand through ED and was being looked at by the divisions.

Gill Ponder stated the capital programme was behind by £4.7m and asked what was being done to recover that spend and not leave the Trust in the same position as last year with a scramble to meet the target in quarter 4. Lee Bond stated the majority of it was due to slippage on the bigger building schemes and some of the smaller items such as equipment and IT orders had been placed but had not been sanctioned yet as he would not spend all the budget in the first quarter. Gill Ponder asked Jug Johal what had been done about the big building schemes slipping. Jug Johal stated there was no major slippage on the building schemes as there were not many left. The fire alarm system upgrade would not be spent until 31st March 2024 which was overhanging from last year. CDC's were delayed by the planning process. All Backlog Maintenance funding would be spent. The ED and AAU scheme at DPOW was due to finish on 16th December 2023 and at SGH 8th April 2024, with slippage into the next financial year which might assist with extra capital needed by other schemes in the current year.

8.2 **Financial Recovery Planning**

Brian Shipley took the paper as read and stated it looked at four or five areas and utilising benchmarks for highlighting and mapping potential opportunities. The majority of the reasons why the Trust were not hitting the plan was through non- recurrent measures. Included in the plan was £9m of balance sheet release and £5m of non-recurrent CIP plus the other elements. There was a circa £40-50m problem with underlying deficit brought forward. Given the agency spend last year of just under £29m on premium agency, included in that was £12m on premium agency and bank staff. The CIP target for the current year was to reduce the over spend by £11.7m and the full effect would be for 2024/25 of an opening agency spend of £24m, including £9.5m of premium element. Included in the plan was £12m to deliver ERF activity and the Trust had looked at how to maximise core capacity, increase productivity and efficiency to avoid spending the ICS and the £12m ERF reserve included in that position. There was £1.3m spend relating to the MRI backlog which should be non-recurrent.

Another section focuses on the national cost collection reference cost and model health system. The biggest areas of opportunity laid within general surgery, general acute medicine and obstetrics. With regards to corporate benchmarking, the Trust was doing quite well with back office functions with non-recurrent spend. If the Trust spent to budget, it would move some of the benchmarking into further quartiles and there would be a need to reduce the cost by £4.3m. Estates benchmarked well and highlighted areas included car parking costs, water and waste collection. Lee Bond stated Fiona Osborne asked at the last Committee meeting she attended how much of the agency spend was premium spend and he thought it was around 40% and he confirmed that it was. He stated they were trying to reduce the reliance on agency by 42%.

In the national cost collection there was an issue around the CNST which was a surprise to the executive team and when this was looked into it was a reflection of the number of clinical negligence claims the Trust had had that makes up roughly 60% of CNST premium. He stated there was a need to have services at only one site to reduce medical staffing and obstetrics was not included in the planned HASR consultation but it was likely to get worse due to the 1 in 6 rota needing to be increased in line with the Royal College Guidance. HR benchmarking was the worst as the Trust had an expensive HR function due to significant workforce issues. Jug Johal added not to focus on the straight reds in the paper as there were lots of detail behind

it. Estates and facilities at NLaG was the 7th leanest in the country in quarter one per metre squared.

Fiona Osborne stated there was a lot of good information in the report but she was left frustrated as there was less than six weeks from the half year point and it stated that decisions needed to be made and a benchmarking exercise needed to take place and it did not say who was going to do it and when. She stated that she had hoped it would give assurance as this is an assurance Committee. Gill Ponder agreed. Lee Bond stated he could not solve it alone and that the conversations had to be held at Board level and that it was being escalated. Simon Parkes added that Lee Bond made an important point that he cannot fix the issues as Chief Finance Officer (CFO) as there would be consequences to those decisions, but the Trust were running out of time. He stated the Committee were not assured there was a clear, coherent plan to balance the books and deal with risks for the remainder of the financial year and that the Committee must escalate to the Board that we were not assured. Gill Ponder agreed and stated that she had captured for the highlight report that the Committee were not assured there was a coherent plan to both deliver the financial plan and reduce the underlying deficit and that it needed a Board level discussion to agree next steps. She added that productivity was an issue and that in the table in the report it stated that there was a 44% of opportunity called support but it would be good to understand in more detail what aspects of support those opportunities were in.

Lee Bond stated that he was more bothered about next year's plan with an estimated deficit of £40-50m if nothing changed from the current year.

8.3 **Response to National Financial Controls**

Lee Bond stated in the paper that controls were in place but a couple of exercises needed to be completed including the audit trail from 2019/20 which was happening already and reviewing posts that had been vacant for longer than six months that were not being covered by locum or agency staff.

8.4 **Business Case Assurance**

None.

8.5 **Assurance Confirmation & Board Highlights**

Gill Ponder summarised that the issue around risks to the current year's plan and concerns about the plan to reduce the underlying deficit needed Board discussion. Simon Parkes stated there needed to be a focus for the Group model to ensure efficient services and to get on with that. Shaun Stacey agreed and stated that what Lee Bond had just said was based on 2021/22 data and they had come a long way since then. He stated the functionality of data needed to be improved and that his team were spending 60% of their week doing nothing about -

9 Estates & Facilities (S01.4)

9.1 **Facilities Services & National Standards for Food and Hydration**

Jug Johal took the paper as read and stated the key update was that there was a new strategy and standards required by all NHS trusts which were in the action log. The purpose of the report was to provide the Committee with an update on where the Trust was in terms of national standards of healthcare, food and drink. He explained that

SGH and DPOW provided a cook and freeze food service, whereas GDH was an a la carte service due to the number of patients being small and fluctuating, to help prevent food waste. Funding had been allocated for a dietician to work out the calorific value for patient meals but they had been under significant pressure clinically and that took priority. The research was done from September 2019-March 2020 by NHS England and Prue Leith on how nutrition and hydration aided recovery.

There were eight standards recommended and underpinning those were sub standards. The Board lead was responsible, with Ellie Monkhouse lead for nutrition and Jug Johal the lead for food and hydration. He was required to undertake Food Safety training. Currently NLaG turned its standard food waste into grey water whereas HUTHs food waste went to landfill. Food ordering was going digital allowing ordering on the day to save on waste and that would be integrated with WebV at NLAG. Simon Parkes stated that food safety was another task that NHS England were expecting to be free, but it was not as it would take time and the Trust could not keep taking on extra tasks.

9.2 **Assurance Confirmation & Board Highlights**

The Committee were assured by the actions being taken to meet the new standards.

10 Board Assurance Framework (BAF)

10.1 **SO1-1.2**

Fiona Osborne stated the 'Strategic Threats' section which stated there was a widespread loss of organisational focus on patient safety and quality of care, leading to increased incidence of avoidable harm should be under S)1-1.1, not SO1-1.2. Gill Ponder agreed. Fiona Osborne also stated that she reviewed the two detailed high-level risks associated with SO1-1.2 with a rating of 20, but no gaps in controls were listed but the risks were still rated as a 20. Gill Ponder stated she picked up a similar thing around gaps in controls with risks 2562 and 3168 which needed updating, as the narrative was referring to 2022 and COVID. Ashy Shanker apologised for the BAF not being updated and stated the divisions were working on updates and it would be completed.

Simon Parkes asked with all the effort that went into the BAF were they confident they were getting value from it. He stated there was a lot of effort that went into creating the papers for the Committee and still they find they had not got a clear story about performance. Gill Ponder stated that it was a big issue within the NHS but that with a Group structure there was an opportunity to revisit it. Fiona Osborne added that the BAF should inform the work of the assurance Committee, rather than being part of the agenda and it should be dictating what the agenda and work plan looked like and she did not think that it did. Gill Ponder stated it did in the sense of the topics that were in the TOR, which in turn drove the work plan which the drove the agenda. Simon Parkes agreed.

11 Items for Information

11.1 **Performance Letters to Divisions following PRIMS Meetings**

PRIMS meetings had been cancelled, so there were no letters to review.

11.2 **CIB Minutes**

No CIB meeting had taken place since the last F&P Committee so there were no minutes available.

12 Any Other Urgent Business

No other urgent business was raised and there were no additional emerging issues.

12.1 Matters to Highlight to other Trust Board Assurance Committees

No matters to highlight.

13 Matters for Escalation to the Trust Board (Public/Private)

Gill Ponder stated that these had been discussed throughout the meeting.

13.1 Review of Meeting

Gill Ponder stated the meeting over ran by 3 minutes. Simon Parkes stated there had been some useful discussions, but they needed to find a way to make sure they were escalated to the Board and to push for resolutions. Gill Ponder agreed and stated from January 2024 the Committee meetings would be held on Wednesday mornings.

14 Date and Time of the Next Meeting

The next meeting would take place as follows:

Date: 20 September 2023
Time 1:30pm – 4:30pm
Venue: Virtual via MS 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	√	√	√	√	√	x	√	√				
Fiona Osborne	√	√	√	√	√	√	X	√				
Lee Bond	√	√	√	x	√	x	√	√				
Jug Johal	√	√	√	√	√	x	X	√				
Shaun Stacey	√	√	√	√	√	√	√	√				
Ian Reekie	x	√	√	√	x	√	√	√				
Richard Peasgood	√	√	√	√	√	√	√	√				
Simon Parkes	x	x	√	√	√	√	√	√				
Brian Shipley	√	√	x	√	x	√	√	√				
Annabelle Baron	√	√	√	√	√	√	√	√				
Abdi Abolfazl	√	x	x	√	x	x	√	X				
Ashy Shanker	x	√	√	x	x	√	√	√				
Shiv Nand	√	x	x	x	x	x	X	X				
Dr Peter Reading	x	√	√	x	x	x	X	X				
Linda Jackson	x	x	x	x	x	√	x	X				
Craig Hodgson	x	x	x	x	x	√	√	X				
Kate Truscott	x	x	x	x	x	x	√	X				

NLG(23)190

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	3 October 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 6 July 2023**
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 6 July 2023 and approved at its meeting 7 September 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:	**6 July 2023 – Via Teams Meeting**	
Present:	Neil Gammon	Independent Chair of HTF Trustees
	Susan Liburd	Non-Executive Director
	Gill Ponder	Non-Executive Director
	Shaun Stacey	Interim Chief Executive Officer
	Kate Wood	Chief Medical Officer
	Nicola Parker	Assistant Director of Finance – Financial Planning
	Jug Johal	Director of Estates and Facilities
	Di Hughes	Associate Director – Special Projects
	Michelle Soar	HTF Community Champion
In attendance:	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin (For the Minutes)

Item 1 07/23 **Apologies for Absence**

Apologies for absence were received from: Lee Bond (Nicola Parker), Ellie Monkhouse (Di Hughes), Lucy Skipworth (Michelle Soar), Clare Woodard and Paul Marchant.

Item 2 07/23 **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 07/23 **Minutes of Meeting held on 17 May 2023**

The minutes from the meeting held on 17 May 2023 were approved.

Item 4 07/23 **Matters Arising**

All matters arising were covered within the action log.

Item 5 07/23 **Review of Action Log**

The action log was reviewed and updated accordingly.

Gill Ponder raised that 7% commission for Pennies for Heaven seems to be a big fee. Michelle Soar explained that this is still work in progress and will raise this with Clare Woodard to gain a better understanding of the NHS Charities view. It was agreed that further information would be obtained in order to make a balanced assessment of the charge.

Action: Michelle Soar / Lucy Skipworth

Item 6 07/23 **Items for Discussion / Approval**

6.1 HTF Trustees' Committee Evaluation Assessment

Gill Ponder felt that the evaluation assessment criteria had limited applicability to this Committee as they are too generic and are not well focussed on the Committee's work. She suggested that the Committee should create their own. Kate Wood agreed although did not want to make an industry of this and therefore advised for the HTF to look into what other NHS organisations undertake to review their charity committees as a template may already exist for NLAG to adapt. Shaun Stacey was happy to share his contacts of other larger charities to help with this process and agreed that a standalone assessment was required. Neil Gammon asked Trustees to submit suggested assessment criteria or KPIs to him for further analysis.

Action: All Trustees/Neil Gammon / Lucy Skipworth

6.2 HTF Trustees' Committee – Membership and Terms of Reference

Following further brief discussion around the latest suggested version of the Terms of Reference, it was agreed that Neil Gammon would update the wording around extra ordinary meetings regarding who and how these meetings are called. The Committee were content for this to then be submitted to the Trust Board.

Action: Neil Gammon

Item 7 07/23 **Updates from Health Tree Foundation**

7.1 HTF Manager Update Report

Michelle Soar spoke to the report and highlighted the following key updates expanding the discussion where necessary:

- Big change in staff turnover within HTF last month with members of staff leaving and colleagues stepping into vacant roles. Jemma Qualter has been appointed to the position of admin support and is due to join the team on 7th July 2023.
- The Contact Points are up and running at SGH with another update to follow at the next committee meeting.
- The Armed Forces event with Grimsby Cars was successful with a total of £120 raised while walking the parade. The total amount raised is still to be received from Grimsby Cars.
- Potential legacy of £100k. Further information following this initial notification is awaited.
- Fairchild Legacy – This work was delayed for operational reasons with a start date of 6th July 2023.
- Members of the HTF team have undertaken Grant Training which will help the team to understand and complete the grant forms better in the future.
- Grimsby Cars held a successful fundraising event last year and have confirmed that they would like to hold another this year.

Gill Ponder raised concerns regarding the contactless donation point in A&E and she felt it was not the most sensitive place to be positioned. After discussion it was agreed that other Trusts have donation stations within their A&E departments and that patients/visitors are content to donate here once they have received care or simply because it is a convenient location.

Shaun Stacey thanked Michelle Soar for a comprehensive report for each of the hospital sites and wanted to pass on this thanks to the HTF team. Kate Wood also offered her thanks.

Jug Johal informed The Committee of the two new, recently announced, Community Diagnostic Centres being built in Scunthorpe and Grimsby town centres. Although these are being commissioned by the Humber and North Yorkshire Health & Care Partnership, NLAG has sole responsibility for the build. It was agreed that this presents a significant opportunity for the HTF to advertise and have donation stations on the site, thereby engaging many more people in the community. It was agreed to feed this information back to Lucy Skipworth and Clare Woodard, asking them to consider how best HTF can be involved.

Action: Lucy Skipworth / Clare Woodard

Kate Wood noticed a lot of funds building up in certain areas and wondered what was being done with the fund managers to spend the accumulated funds as not all clinicians understand the process of how and what they are able to spend the money on. Michelle Soar mentioned that Wish Roadshows do now and again take place in the staff canteens but acknowledged that staff need to be continually educated on how to spend raised funds in their area.

Neil Gammon asked that the HTF Team continue to brief the fund guardians on how much money had been raised for their areas and to remind them of their roles and offer support where necessary.

Action: Lucy Skipworth / Michelle Soar

Nicola Parker added that the HTF charitable money features on the Equipment Group agenda every month and Lucy Skipworth attends this meeting.

Gill Ponder noted progress with the amount of money which is now being spent as opposed to the position the charity found themselves in last year but acknowledged there was still work to be done.

7.2 Risk Register

The Risk Register was noted. The Committee members were happy with the progress of the Risk Register template and thought it added a lot of value.

Item 8 07/23 **Sparkle Programme**

8.1 Sparkle Update

Michelle Soar spoke to the report and added that before and after pictures of the staff room updates will be taken to show the overall progress.

Shaun Stacey highlighted that this was a great report which informs Trustees of the work being undertaken by HTF to improve the Trust sites, however believed that more needs to be done for the staff to be briefed on what was happening by way of improvements within the Trust as a result of HTF's work. Michelle Soar informed the Committee that the HTF team meet with the Communication team on a monthly basis and discussion took place regarding utilising the Trust's social media to better inform staff.

Susan Liburd suggested having a periodic HTF briefing to the NEDs and Governors as a way of keeping them informed but also for them to help advertise HTF to staff as a route for potential funds to be spent. Neil Gammon agreed to further explore this idea.

Action: Neil Gammon

Item 9 07/23 **Finance Update**

9.1 Finance Report

In the absence of Paul Marchant, Neil Gammon presented the Finance report and highlighted the key points, including;

- Income for the year to June 2023 is £234k which is just short of plan by £6k.
- Expenditure fell below the £395k target and was recorded at £272k, however a significant number of commitments have been ordered and are yet to be goods received.
- A reminder of the earlier grant received from NHS Charities Together of £143k to fund a staff wellbeing. Part of this grant funded a staff wellbeing coordinator. Unfortunately, this member of staff has left the position early resulting in an unspent grant portion of £33k. This has now been reallocated to the staff room improvements and will thus continue to support staff wellbeing.
- CCLA investment recorded a £2k loss over the period.
- The KPI of £0.69 spent on charitable activities per £1.00 of total donations is lower than the plan of £0.75.
- Auditor fee has now increased to £15k

Kate Wood asked what the KPI spend figure would be if the committed spend was included. Nicola Parker agreed to re-calculate this and circulate it to the Trustees.

Post Meeting Note: Adding the committed spend, the total figure increased to £0.89 per £1.00 donated.

Item 10 07/23 **Any Other Business**

None.

Item 11 07/23 **Matters for Escalation to the Trust Board**

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Community Diagnostic Centres
- Communications
- Annual Self-Assessment

Action: Neil Gammon

Item 12 07/23 **Date and Time of the next meeting:**

Thursday 7 September 2023
9.30am – 12.00pm
Via MS Teams

Attendance Record:

Name	July 2022	Sept 2022	Nov 2022	March 2023	May 2023	July 2023
Neil Gammon	✓	✓	✓	✓	✓	✓
Peter Reading	✓	✓	✓	✓	✓	
Shaun Stacey						✓
Terry Moran						
Linda Jackson						
Gill Ponder	✓	✓	✓	✓	Apols	✓
Mike Proctor	Apols	Apols				
Maneesh Singh	✓					
Lee Bond	✓	Apols	Apols	✓	✓	Apols (Rep)
Jug Johal	✓	✓	✓	✓	✓	✓
Kate Wood	Apols	✓	Apols	Apols	Apols	✓
Ellie Monkhouse	Apols	Apols (Rep)	Apols (Rep)	Apols (Rep)	Apols (Rep)	Apols (Rep)
Christine Brereton	-	-	-			
Paul Marchant	✓	✓	✓	✓	✓	Apols
Andy Barber	-	-	-	-		
Victoria Winterton	✓	-				
Clare Woodard	✓	✓	✓	✓	✓	Apols
Adrian Beddow	-	-	-			
Ian Reekie (Governor)						
Tony Burndred	-	-	-	✓	✓	-
Susan Liburd			✓	Apols	✓	✓
Simon Leonard			✓	✓	✓	✓
Lucy Skipworth			✓	✓	✓	Apols (Rep)
Total	**9**	**7**	**8**	**10**	**10**	**7**

NLG(23)191

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	3 October 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Trust Board & Board Committee Meetings Timetable**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a schedule of Trust Board & Board Committee Meetings for 2024/2025	
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

MEETING SCHEDULE - 2024 - V10

Week 1 (w/c 01.01.24)	Week 2 (w/c 08.01.24)	Week 3 (w/c 15.01.24)	Week 4 (w/c 22.01.24)	Week 5 (w/c 29.01.24)	Week 1 (w/c 05.02.24)
Trust Board Development Operational Meeting (Performance - HUTH) JNCC - HUTH	NED & CEO Executive Team JLNC - NLAG Charitable Funds - NLAG Remuneration Council of Governors	Trust Management Board - NLAG JNCC - NLAG Executive Team LNC - HUTH Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG)	Executive Team Performance, Estates & Finance Audit, Risk & Governance Quality & Safety	Workforce, Education & Culture Executive Team Group Development	Executive Team Operational Meeting (Performance - HUTH) **Trust Board**
Week 2 (w/c 12.02.24)	**Week 3 (w/c 19.02.24)**	**Week 4 (w/c 26.02.24)**	**Week 1 (w/c 04.03.24)**		
Executive Team JLNC - NLAG Operational Meetings (PRIMS - NLAG) NED & CEO Governor Assurance Group	Trust Management Board - NLAG JNCC - NLAG Executive Team Charitable Funds - HUTH Executive Management Committee - HUTH Group Development	Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	**Trust Board Development** Operational Meetings (Performance - HUTH) Charitable Funds - NLAG JNCC - HUTH		
Week 2 (w/c 11.03.24)	**Week 3 (w/c 18.03.24)**	**Week 4 (w/c 25.03.24)**	**Week 1 (w/c 01.04.24)**	**Week 2 (w/c 08.04.24)**	
Executive Team JLNC - NLAG NED & CEO Appointments & Remuneration	Trust Management Board - NLAG JNCC - NLAG Executive Team LNC - HUTH Executive Management Committee - HUTH Operations Meetings (PRIMS - NLAG)	Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	Executive Team Operations Meetings (Performance - HUTH) Remuneration Council of Governors	Executive Team JLNC - NLAG **Trust Board**	
Week 3 (w/c 15.04.24)	**Week 4 (w/c 22.04.24)**	**Week 5 (w/c 29.04.24)**	**Week 1 (w/c 06.05.24)**		
Trust Management Board - NLAG JNCC - NLAG Executive Team Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG) Audit, Risk & Governance - NLAG NED & CEO Governor Assurance Group	Group Development Executive Team Performance, Estates & Finance Audit, Risk & Governance Quality & Safety	Executive Team JNCC - HUTH Workforce, Education & Culture Charitable Funds - NLAG	**Trust Board Development** Operational Meeting (Performance - HUTH)		

Week 2 (w/c 13.05.24)	Week 3 (w/c 20.05.24)	Week 4 (w/c 27.05.24)	Week 1 (w/c 03.06.24)	Week 2 (w/c 10.06.24)	
Executive Team JLNC - NLAG LNC - HUTH Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG) NED & CEO	Trust Management Board - NLAG JNCC - NLAG Executive Team Quality & Safety Workforce, Education & Culture	Group Development Executive Team Performance, Estates & Finance Charitable Funds - HUTH	Executive Team Operational Meeting (Performance - HUTH)	Executive Team JLNC - NLAG **Trust Board**	
Week 3 (w/c 17.06.24)	**Week 4 (w/c 24.06.24)**	**Week 1 (w/c 01.07.24)**			
Trust Management Board - NLAG JNCC - NLAG Executive Team Audit, Risk & Governance - HUTH Executive Management Committee - HUTH PRIMS - NLAG NED & CEO Council of Governors - Annual Review	Governor Assurance Group Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	**Trust Board Development** Operational Meeting (Performance - HUTH) Charitable Funds - NLAG JNCC - HUTH Appointments & Remuneration			
Week 2 (w/c 08.07.24)	**Week 3 (w/c 15.07.24)**	**Week 4 (w/c 22.07.24)**	**Week 5 (w/c 29.07.24)**	**Week 1 (w/c 05.08.24)**	
Executive Team JLNC - NLAG Remuneration NED & CEO Council of Governors	Trust Management Board - NLAG JNCC - NLAG Executive Team Executive Management Committee - HUTH LNC - HUTH Operational Meeting (PRIMS - NLAG)	Executive Team Performance, Estates & Finance Audit, Risk & Governance Workforce, Education & Culture	Group Development Executive Team Quality & Safety	Executive Team Operational Meeting (Performance - HUTH) **Trust Board**	
Week 2 (w/c 12.08.24)	**Week 3 (w/c 19.08.24)**	**Week 4 (w/c 26.08.24)**	**Week 1 (w/c 02.09.24)**		
Executive Team JLNC - NLAG Audit, Risk & Governance - NLAG Operational Meeting (PRIMS - NLAG) NED & CEO Governor Assurance Group	Trust Management Board - NLAG JNCC - NLAG Executive Team Charitable Funds - HUTH Executive Management Committee - HUTH	Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	**Trust Board Development** Operational Meeting (Performance - HUTH) Charitable Funds - NLAG JNCC - HUTH		

Week 2 (w/c 09.09.24)	Week 3 (w/c 16.09.24)	Week 4 (w/c 23.09.24)	Week 5 (w/c 30.09.24)	Week 1 (w/c 07.10.24)	
Executive Team JLNC - NLAG NED & CEO Council of Governors - Annual Members Meeting	Trust Management Board - NLAG JNCC - NLAG Executive Team LNC - HUTH Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG)	Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	Executive Team Operational Meeting (Performance - HUTH) Remuneration Appointment & Remuneration	Executive Team JLNC - NLAG **Trust Board**	
Week 2 (w/c 14.10.24)	**Week 3 (w/c 21.10.24)**	**Week 4 (w/c 28.10.24)**	**Week 1 (w/c 04.11.24)**		
Executive Team Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG) NED & CEO Governor Assurance Group	Trust Management Board - NLAG JNCC - NLAG Group Development Executive Team Quality & Safety Workforce, Education & Culture	Executive Team Performance, Estates & Finance Audit, Risk & Governance Council of Governors	**Trust Board Development** Performance - HUTH JNCC - HUTH		
Week 2 (w/c 11.11.24)	**Week 3 (w/c 18.11.24)**	**Week 4 (w/c 25.11.24)**	**Week 1 (w/c 02.12.24)**	**Week 2 (w/c 09.12.24)**	
Executive Team JLNC - NLAG Charitable Funds - HUTH Charitable Funds - NLAG NED & CEO	Trust Management Board - NLAG JNCC - NLAG Executive Team LNC - HUTH Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG)	Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	Executive Team Operational Meeting (Performance - HUTH)	Executive Team JLNC - NLAG Group Development Workforce, Education & Culture **Trust Board**	
Week 3 (w/c 16.12.24)	**Week 4 (w/c 23.12.24)**	**Week 5 (w/c 30.12.24)**	**Week 1 (w/c 06.01.25)**		
Trust Management Board - NLAG JNCC - NLAG Quality & Safety Executive Team Performance, Estates & Finance Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG) NED & CEO Governor Assurance Group	Executive Team	JNCC - HUTH	**Trust Board Development** Performance - HUTH Remuneration Council of Governors		

Week 2 (w/c 13.01.25)	Week 3 (w/c 20.01.25)	Week 4 (w/c 27.01.25)	Week 1 (w/c 03.02.25)	Week 2 (w/c 10.02.25)
NED & CEO Executive Team JLNC - NLAG LNC - HUTH Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG)	Trust Management Board - NLAG JNCC - NLAG Executive Team Charitable Funds - NLAG Audit, Risk & Governance	Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	Executive Team Operational Meeting (Performance - HUTH) Charitable Funds - HUTH	Executive Team JLNC - NLAG **Trust Board**
Week 3 (w/c 17.02.25)	**Week 4 (w/c 24.02.25)**	**Week 1 (w/c 03.03.25)**		
Trust Management Board - NLAG Executive Team JLNC - NLAG Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG) NED & CEO Governor Assurance Group	Group Development Executive Team Performance, Estates & Finance Quality & Safety Workforce, Education & Culture	**Trust Board Development** Operational Meeting (Performance - HUTH) JNCC - HUTH Appointment & Remuneration		
Week 2 (w/c 10.03.25)	**Week 3 (w/c 17.03.25)**	**Week 4 (w/c 24.03.25)**		
Executive Team JLNC - NLAG Charitable Funds - NLAG NED & CEO	Trust Management Board - NLAG JNCC - NLAG Executive Team LNC - HUTH Executive Management Committee - HUTH Operational Meeting (PRIMS - NLAG)	Executive Team Group Development Performance, Estates & Finance Quality & Safety Workforce, Education & Culture		

MEETING SCHEDULE - 2024 - V10

	Quarter 4 (23/24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 1 (24/25)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Trust Board															
Public & Private (Thursdays - 9.00 am - 5.00 pm)		08.02.24		11.04.24		13.06.24		08.08.24		10.10.24		12.12.24		13.02.25	
Board Development (Tuesdays - 9.00 am - 5.00 pm)	02.01.24		05.03.24		07.05.24		02.07.24		03.09.24		05.11.24		07.01.25		04.03.25
Committees in Common															
Performance, Estates & Finance (Wednesdays - 9.00 am - 12.30 pm)	24.01.24	28.02.24	27.03.24	24.04.24	29.05.24	26.06.24	24.07.24	28.08.24	25.09.24	30.10.24	27.11.24	18.12.24	29.01.25	26.02.25	26.03.25
Group Development (Tuesdays - 9.00 am - 12.00 pm with exceptions as stated)	31.01.24 (Wednesday)	22.02.24 (Thursday)	26.03.24	23.04.24	28.05.24	25.06.24	30.07.24	27.08.24	24.09.24	22.10.24	26.11.24	11.12.24 (Wednesday)	28.01.25	25.02.25	25.03.25
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24 (1.30 pm - 5.00 pm)	29.02.24	28.03.24	25.04.24 (1.30 pm - 5.00 pm)	23.05.24	27.06.24	31.07.24 (Wednesday)	29.08.24	26.09.24	24.10.24	28.11.24	17.12.24 (Tuesday)	30.01.25	27.02.25	27.03.25
Remuneration (Thursdays - 9.00 am - 11.30 am)	11.01.24			04.04.24			11.07.24			03.10.24			09.01.25		
Workforce, Education & Culture (Thursdays - 1.30 pm - 5.00 pm with exceptions as stated)	30.01.24 (Tuesday - 9.00 am - 12.30 pm)	29.02.24	28.03.24	30.04.24 (Tuesday - 9.00 am - 12.30 pm)	23.05.24	27.06.24	25.07.24	29.08.24	26.09.24	24.10.24	28.11.24		30.01.25	27.02.25	27.03.25
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24			25.04.24		19.06.24 (Wednesday - 9.00 am - 10.30 am) **HUTH ONLY**	25.07.24	15.08.24 (9.00 am - 10.30 am) **NLAG ONLY**		31.10.24			23.01.25		
Charitable Funds															
NLAG (9.00 am - 12.00 pm)	10.01.24		07.03.24		01.05.24		04.07.24		05.09.24		14.11.24		22.01.25		13.03.25
HUTH (9.00 am - 12.00 pm)		21.02.24			30.05.24			22.08.24			13.11.24			06.02.25	
Executive Team Meetings															
Executive Team (Tuesdays - 2.00 pm - 5.00 pm)	09.01.24 16.01.24 23.01.24 30.01.24	06.02.24 13.02.24 20.02.24 27.02.24	12.03.24 19.03.24 26.03.24	02.04.24 09.04.24 16.04.24 23.04.24 30.04.24	14.05.24 21.05.24 28.05.24	04.06.24 11.06.24 18.06.24 25.06.24	09.07.24 16.07.24 23.07.24 30.07.24	06.08.24 13.08.24 20.08.24 27.08.24	10.09.24 17.09.24 24.09.24	01.10.24 08.10.24 15.10.24 22.10.24 29.10.24	12.11.24 19.11.24 26.11.24	03.12.24 10.12.24 17.12.24 24.12.24	14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25
Trust Management Board (TMB) (Mondays - 12.00 pm - 2.00 pm)	15.01.24	19.02.24	18.03.24	15.04.24	20.05.24	17.06.24	15.07.24	19.08.24	16.09.24	21.10.24	18.11.24	16.12.24	20.01.25	17.02.25	17.03.25
Executive Management Committee (EMC) (Wednesdays - 2.30 pm - 4.30 pm)	17.01.24	21.02.24	20.03.24	17.04.24	15.05.24	19.06.24	17.07.24	21.08.24	18.09.24	16.10.24	20.11.24	18.12.24	15.01.25	19.02.25	19.03.25
Performance															
PRIMS - NLAG (Thursdays)	18.01.24	15.02.24	21.03.24	18.04.24	16.05.24	20.06.24	18.07.24	15.08.24	19.09.24	17.10.24	21.11.24	19.12.24	16.01.25	20.02.25	20.03.25
Performance - HUTH (Wednesdays)	03.01.24	07.02.24	06.03.24	03.04.24	08.05.24	05.06.24	03.07.24	07.08.24	04.09.24	02.10.24	06.11.24	04.12.24	08.01.25	05.02.25	05.03.25
Governors															
Council of Governors (Thursdays - Business Meetings - 2.00 pm - 5.00 pm, with the exception of ARM)	11.01.24			04.04.24		**Annual Review Meeting** 20.06.24 2.00 pm - 4.00 pm	11.07.24		**Annual Members Meeting** 12.09.24	31.10.24			09.01.25		
Governor Assurance Group (Thursdays - 5.30 pm - 7.00 pm with exception as stated)		15.02.24		18.04.24		24.06.24 (Monday)		15.08.24		17.10.24		19.12.24		20.02.25	
Appointments & Remuneration Committee (Thursdays - 1.30 pm - 3.00 pm)			14.03.24				04.07.24			03.10.24					06.03.25
NED & CEO Meetings															
NED & CEO Meetings (Thursdays - 2.00 pm - 4.00 pm - with exceptions as stated)	09.01.24 (Tuesday - 10.00 am-12.00 pm)	15.02.24	14.03.24 (10.00 am-12.00 pm)	18.04.24	16.05.24	18.06.24 (Tuesday - 10.00 am - 12.00 pm)	09.07.24 (Tuesday - 10.00 am - 12.00 pm)	15.08.24	10.09.24 (Tuesday - 10.00 am - 12.00 pm)	17.10.24	14.11.24	19.12.24	14.01.25 (Tuesday - 10.00 am - 12.00 pm)	20.02.25	13.03.25
Union Meetings															
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	15.01.24	19.02.24	18.03.24	15.04.24	20.05.24	17.06.24	15.07.24	19.08.24	16.09.24	21.10.24	18.11.24	16.12.24	20.01.25	17.02.25	17.03.25
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	04.01.24		07.03.24		02.05.24		04.07.24		05.09.24		07.11.24		02.01.25		06.03.25
Consultant Meetings															
JLNC - NLAG **(Dates to be confirmed)**															
LNC - HUTH (Wednesdays - 10.00 am - 12.00 pm)	17.01.24		20.03.24		15.05.24		17.07.24		18.09.24		20.11.24		15.01.25		19.03.25

NLG(23) 192

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	3/10/2023	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Report**	
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 July and August 2023 and includes an overview of team plans and progress. The Trust Board is recommended to note the report.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ✓ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

October 2022

Kindness • Courage • Respect

Report period: July and August

Contents

Headlines

3,974 Members of the staff Facebook group

171 Ask The Execs questions asked

134 General enquiries dealt with

1604 Opens of the Members Newsletter

100% Of media coverage was positive or neutral

Progress and plans

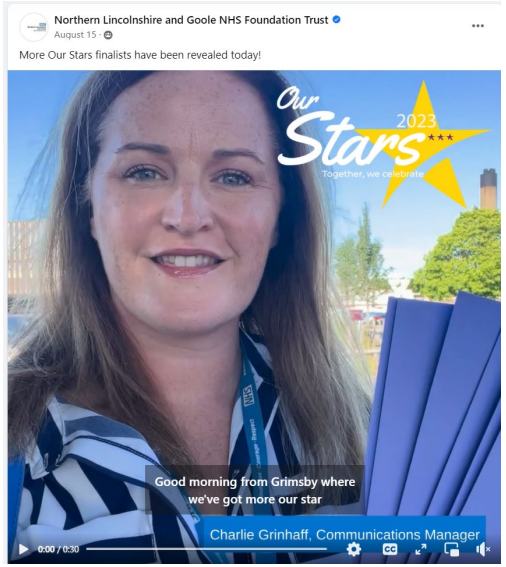
Improve Trust reputation through external communications and patient experience	Improve staff morale and engagement
What we've already done • Launched a new website in line with accessibility requirements • Consistently achieved goals around responsiveness to media enquiries • Responded to 95%+ Freedom of Information requests (FOIs) within statutory time limits. • Taken over the remit of 'Membership communications' and started a new quarterly newsletter • Reviewed the content on our website, and that on the NHS website for our Trust • Introduced regular infographics on maternity stats, Emergency Department statistics and more recently patient feedback • Undertaken video training to enable to the team to produce more video content • Carried out a survey of our Foundation Trust Members to help shape member engagement going forward	**What we've already done** • Created a regular drumbeat for internal communications – Monday Message, Weekly Wednesday News, Building our Future on Thursdays and #ThumbsUpFriday • Put in place a new Thank You System for staff to easily share compliments boosting morale • Created a safe space for staff to raise concerns via the Ask Peter forum • Set up a staff Facebook group (c3.8k members) and have recently carried out a review of this to make improvements • Introduced Team Brief Live • Re-invigorated the way we share compliments on social media – swapping #ThankYouTuesday for #ThankYouNHS • Added the Trust Twitter feed to the home page of the Hub so staff not on social media can see our celebrating success content • Introduced a new managers email so we can target manager specific messages • Relaunched Ask Peter as Ask the Execs • Brought back the annual staff awards ceremony, Our Stars 2023, receiving a record number of nominations – over 1,000 • Aligned everything we do to the People's Promise – introducing the brand to relevant internal content
What we're working on • How we can work more closely with our local media, providing positive news stories • Reviewing our social media channels	**What we're working on** • Working with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work. • Establishing Group communication channels with HUTH

Supporting the Trust's priorities

Trust Priority 1 – Our People
Preparations for Our Stars 2023 (our staff awards) are firmly underway. Throughout the Summer we surprised each of the 33 Our Stars finalists in person to let them know they'd been shortlisted. Sharing the good news has led to lots of engagement on social media, including 217 new followers, 145k impressions, just under 15,000 engagements and more than 350 comments.

New Followers	Post Impressions	Post Engagements	Post Comments
217	145,305	14,791	367

Our videos posted in the closed staff Facebook group had a total reach of 23,390 and 12,802 engagements.



Supporting the Trust's priorities

Trust Priority 3 – Restoring Services

We supported the official launch of Patients Know Best (PKB) with screensavers, printed cards for reception desks, a news release, social media and website updates.

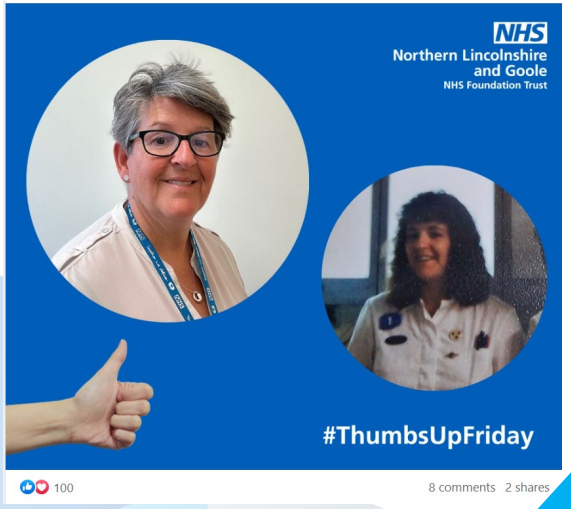
Trust Priority 4 – Reducing health inequalities
We supported the new smokefree policy launch

Trust Priority 5 – Collaborative and System working
We helped to promote the Humber Acute Services staff engagement workshops over the Summer

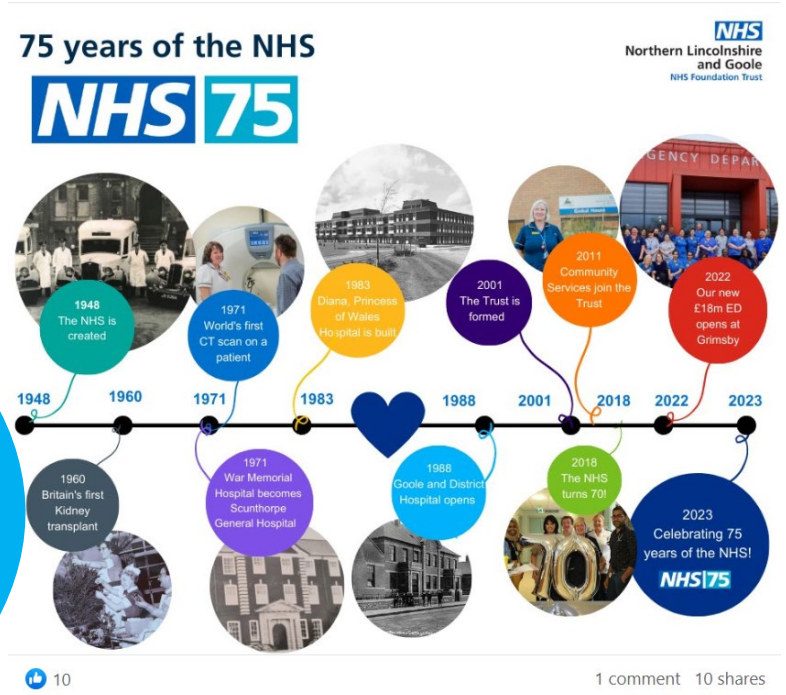
Campaigns and awareness weeks

NHS 75

We used the NHS 75 campaign as an opportunity to share staff stories focusing on the career progression opportunities the health service has to offer. We also created a timeline to highlight the history of our hospitals and community services and how they fit in with key developments in the NHS. The team received a lovely thank you from a member of staff:



"I have absolutely loved seeing the inspiring and uplifting photos and stories of people's NHS careers to mark the NHS75 celebrations. I wish I had thought to nominate you all for an unsung hero award because I really do appreciate not just the help that you give the Library but also the positivity you generate with all the brilliant campaigns you have been doing. I suspect that trying to find positivity in the NHS can be a challenging task sometimes, but your help, cheerfulness and professionalism is really appreciated- and I thought a thank you was long overdue!



We are a team

Improving staff morale and engagement

Keeping staff informed

All staff emails

Each week we send to all staff the Monday Message (a blog from a senior leader on a key topic), Wednesday Weekly News (an e-news round-up of news and updated) and on Thursdays we have a dedicated ‘Building Our Future’ update covering updates on the capital programmes in both estates and digital. The Manager update goes out once a month. There were 49,786 opens of the Weekly Wednesday News in this period.

The most popular edition of the Monday Message, with 7175 opens, came from Dr Kate Wood on our new smoke free policy.

Building Our Future was opened 60,679 times and generated 1,583 click throughs.

There were 1277 opens of the July Manager Update and 1422 in August.

2,699 Opens of the Manager email

60,679 Opens of Building Our Future

Senior Leadership Briefing (SLC)

74 senior leaders attended the SLC briefing in July and 78 joined in August

Staff App

There were 766 downloads of the staff app in this period, with 522,670 page views and 147,817 sessions. The top pages were eRoster, webmail and ESR .

766 Downloads of the staff app

78 Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Giving staff a voice

Ask the Execs

Ask The Execs received a total of 171 questions in July and August, this was a reduction of 55 from the previous two months. During this period, we have redacted one question and removed none. Hot topics across the two months included: parking and park and ride; HR queries relating to such things as policies; maintenance concerns and requests; incentives (and lack of them); complaints about the quality of food, prices and portion sizes in the restaurants; HAS; smoking/vaping, the group with HUTH and safety concerns.

Ask the Execs has now closed.

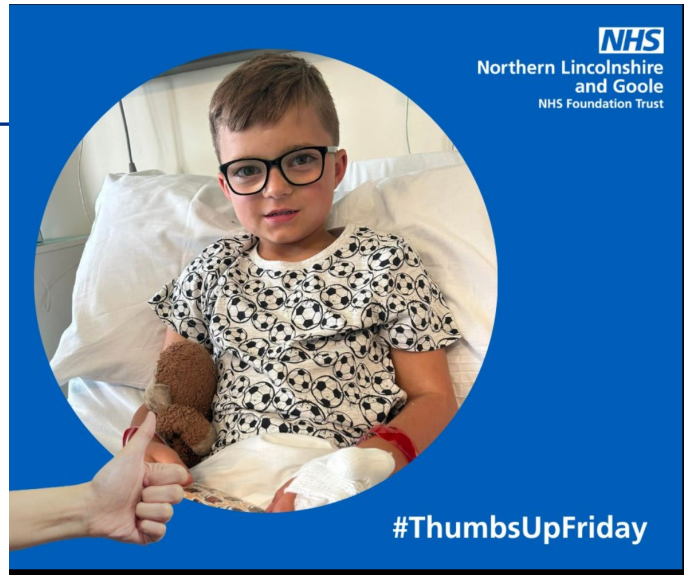
171
Ask The Execs questions

Staff Thank You

Since the 'Thank you' system launched staff have sent more than 1,135 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.

"I met you as a new doctor, new to NHS , new to UK its been an year now , this journey was very smooth and easy. Thanks to you for cheering me , the team and rest of the junior doctors in the department."

Social media



Social media overview
Followers update for the Trust's corporate accounts:

- 13,754 on the Trust's Facebook page
- 5,543 followers on X (formerly Twitter)
- 5751 followers on LinkedIn
- We are rated 4.6 out of 5 stars on reviews on Facebook

We shared 10 #ThankYouNHS posts and 21 #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 just under 4,000 staff members on there and popular topics include

Facebook group stats
3974 members
1064 posts in this period
4786 comments
22,345 reactions

Improving reputation through external communications

Media coverage

There were 48 stories about the Trust in the media during this period. 100% of media coverage was positive or neutral in tone. The majority of coverage was in print or online media.

We categorise the media coverage into themes – in this period '**service development'** was the top theme.

We issued 15 proactive news releases and the most covered was a story was 'operation a first for the Trust - A delighted patient has praised a Grimsby surgeon for his patience, persistence, and skill in mending his complex shoulder problem while he was wide awake when he went under the knife!

Staff have been interviewed on the Humber Acute Service Review, the Hospital at Home team being shortlisted for an award and the doctors' strikes.

Family Services had the most positive media coverage.

100%
Of media coverage was positive or neutral

Media enquiries

42 media enquiries were handled in this time, 90% were dealt with within the requested timescale. The top theme was performance/data. The majority of requests came from Print/Online outlets.

The main reason journalists got in touch was to request information/data.. 12 reactive statements were issued in this period

90%
Of media enquiries dealt with on deadline

Social media

X (formerly Twitter)
Our top tweet in July, (by impressions) was a post about net zero week and our top media tweet was one of our NHS 75 case studies. X has an issue where we cannot retrieve the August data.

JUL 2023 SUMMARY

Tweets	Tweet impressions
36	21.9K
Profile visits	**Mentions**
1,295	64
New followers	
2	

Top tweet July

Top Tweet earned 676 impressions

Today marks the start of #NetZeroWeek. Net zero is the world's answer to stopping climate change. We all need to radically reduce our carbon emissions to combat the effects of climate change. Find out more on the #NetZeroWeek website: buff.ly/3ApSk31

1 3 3

Top mention July

Top mention earned 146 engagements

Jax's stoma journey BCyA
@Jax87539443 · Jul 5

Happy 75th birthday to our @NHSuk @NHSNLaG @NHSEngland we are very thankful for all you do . 💙💙
pic.twitter.com/lkM1LyL9yE

4 6 86

Top media Tweet earned 507 impressions

Staff Nurse, Sue, is proud of her career. She shares her story for #NHS75…

"In 1981, at the age of 17, I started as a Cadet Nurse at Louth County hospital. My favourite memories are when we were trained how to make beds and bath patients correctly. Also my lovely cape!"
pic.twitter.com/TBWqsSIIoH

7

Social media

Facebook page

The Facebook post with the highest engagement was a heart-warming story about a patient in Intensive Care proposing.

July 14, 2023 12:00pm

Congratulations to Shaun and Karen! True love was always on the cards for this happy couple. And this week that was literally what happened, when ITU patient Shaun Camburn popped the question to his beautiful bride to be, Karen Suddaby. Shaun is currently being treated in ITU, after suffering a heart attack and hi

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
3,198	405	10,742	10,093	34.00%	–

August 12, 2023 03:00pm

Garry got a round of applause in Theatres when we surprised him with the news that he's through to the finals of #OurStars2023! Clearly his colleagues think he's Worth his Weight in Gold too! Congrats on being shortlisted Garry. You can see all the Our Stars finalists on our website: https://buff.ly/3KDU5xQ

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
969	282	10,210	9,785	13.12%	–

August 1, 2023 02:43pm

When you have to use our Emergency Department A&E , we want to make sure you feel looked after and cared for by our staff. This is the experience one patient had recently at Grimsby hospital. They said: "The staff were friendly and professional. I was triaged appropriately and came away feeling I had received the app

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,111	199	9,802	9,350	13.93%	–

July 21, 2023 10:01am

A garden to promote patient rehabilitation following critical illness has officially opened. Volunteers have been working tirelessly over the last few months on the Intensive Therapy Unit ITU garden at Grimsby hospital. They've had donations from the Grimsby Hospital League of Friends and a relative of a former patie

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
2,833	223	9,478	8,986	32.55%	–

July 27, 2023 12:02pm

Operation a first for the Trust A delighted patient has praised a Grimsby surgeon for his patience, persistence, and skill in mending his complex shoulder problem while he was wide awake when he went under the knife! John Drinkell, 65, of Grimsby, injured his shoulder two years ago after a fall. However, his surgery

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,333	364	9,422	9,021	18.36%	–

Trust website

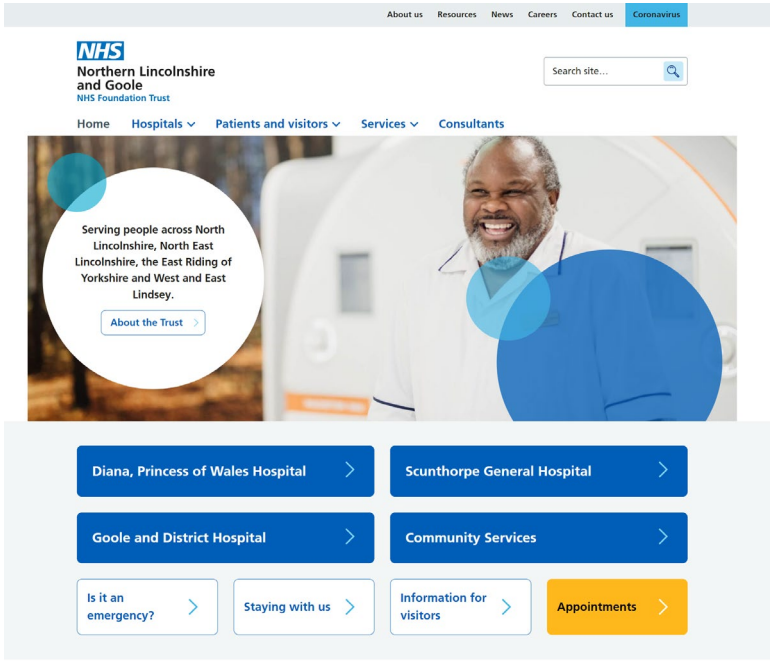
External website – www.nlg.nhs.uk

The Trust remains in the top 20 of all NHS websites on the Silktide Web Accessibility Index which is a real accomplishment. Listed 19th in the August update.

Key stats:

- 39,000 users 428,000 events including 153,563 page views
- Average engagement time was 1 min 30
- 5,503 forms submitted
- 359 file downloads
- Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system followed by Android. 76% of users were mobile users
- Most visited pages: the Consultants A-Z, the staff page and Grimsby hospital home page were the top sections

The top three news releases viewed on the website were the hospital at home team being shortlisted for an award, information about doctors' strikes and the news of the appointment of Jonathan Lofthouse.



01/08/23

Team keeping children out of hospital shortlisted for award

10/07/23

Further Strike action dates announced

14/08/23

New chief executive for region's hospitals takes up his post

Enquiries, information requests and membership

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 134 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.

134
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 84 submitted in July – of these 82 are closed, 0 are still in progress and 2 are awaiting a response from the requester. There were 78 submitted in August – of these 71 are closed, 4 are still in progress and 3 are awaiting a response from the requester.

162
FOIs received

Membership

The Summer edition of the Members' Newsletter had 1,604 opens.

.

1604
Opens of the Member newsletter

This report covers July and August 2023

Social media - update

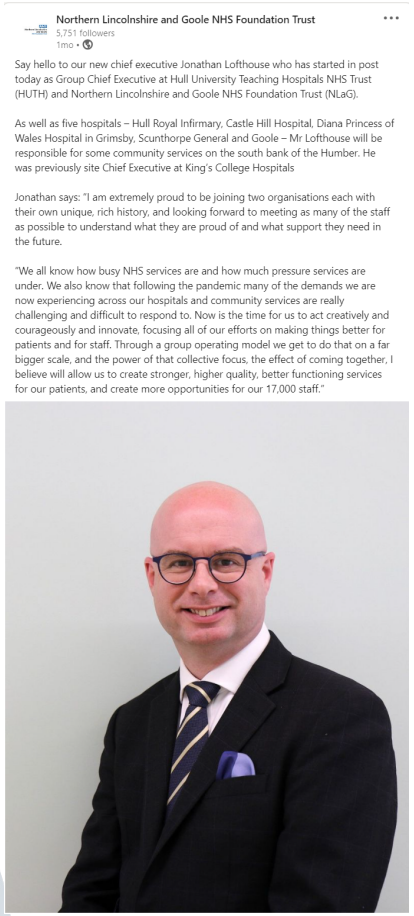
LinkedIn

Stats

1523 page views
568 unique visitors
501 reactions
16 comments
62 reposts

Content

Our top post, with nearly 4,000 reach and 222 clicks was a post welcoming our new Group Chief Executive:



You Tube

Stats

Views	Watch time (hours)	Subscribers
7.8K	234.1	+33

Content

Our top content continues to be one created by our Maternity services giving advice on bottle feeding. Instructional videos from Audiology also made it into the top five videos viewed, as did a video from the new Group Chief Executive reflecting on week one in the role.

	Content	Views	Average view duration
1	Bottle feeding Jul 27, 2018	2,583	1:46 (27.9%)
2	Audiology - hearing aids - mould fit Apr 21, 2020	766	1:01 (28.8%)
3	Jonathan Lofthouse: Week one reflections	392	1:48 (59.5%)
4	MSK Rotator Cuff Exercises Nov 22, 2021	379	3:34 (23.3%)
5	Audiology - hearing aids- fault finding Apr 21, 2020	342	2:53 (34.2%)

NLG(23)193

Name of the Meeting	**Trust Board – Public**	
Date of the Meeting	3 October 2023	
Director Lead	Jonathan Lofthouse, Group Chief Executive	
Contact Officer/Author	As Above	
Title of the Report	**Documents Signed Under Seal**	
Purpose of the Report and Executive Summary (to include recommendations)	The report below provides details of documents signed under Seal since the date of the last report (August 2023 – NLG(23)160).	
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**
276	Tenancy at will relating to Land known as the Parishes Multi Storey Car Park & Lindum Street, Scunthorpe	31.08.2023

Action Required

The Trust Board is asked to note the report.

NLG(23)197

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	3 October 2023	
Director Lead	Shauna McMahon, Chief Information Officer	
Contact Officer/Author	Shaun Stacey, Chief Operating Officer Dr Kate Wood, Chief Medical Officer Ellie Monkhouse, Chief Nurse Simon Nearney, Interim Director of People	
Title of the Report	**Integrated Performance Report (IPR)**	
Purpose of the Report and Executive Summary (to include recommendations)	The IPR aims to provide the Trust Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions tat are under way to deliver the required standards.	
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow (IPR) Quality & Safety (IPR) Workforce (IPR)	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

***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: September 2023**

1. ACCESS & FLOW – Ashy Shanker

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

- Cancer – Two Week Wait
- % UCS Waiting Times (4 Hour Performance)
- Inpatient Non-Elective Average Length of Stay

Lowlights: (share 3 areas of challenge/struggle)

- % of Extended Stay Patients 7+ Days
- Diagnostic Procedures Waiting Times – 6 Week Breach Rate (DM01)
- Cancer Waiting Times – 104+ Day Backlog

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
% of Extended Stay Patients 7+ Days	Virtual Wards plan to operate a step-up model from primary/community care.	The model should decrease the number of non-elective admissions by being more proactive with patients and thus reduce the long staying patients.
Diagnostic Procedures Waiting Times – 6 Week Breach Rate (DM01)	Mobile scanner to replace broken SGH scanner.	Increase of capacity should help to reduce the length of wait for patients.
Cancer Waiting Times – 104+ Day Backlog	Timely removal of patients from cancer tracking once non-malignancy confirmed – targeted daily actions by Cancer Teams	Removal of patients from the waiting list once non-malignancy is confirmed will reduce the overall number of patients on the waiting list and therefore reduce the number over 104 days.

1. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- The SHMI rate of deaths associated with infection linked diagnosis groups is 96.2 and continues to be below the England average 100 and remains within the expected range.
- Improvement in the percentage of in hospital deaths with anticipatory medication prescribed with 88% in August 2023 compared to 28.99% in January 2023.
- The Trust exceeded the CQUIN target (30%) in quarter 1 for recording, escalation and response to NEWS2 score for unplanned critical care admissions and achieved 61.5% as well as sustaining 92% for all adult observations recorded on time.
- There has been a decrease in the total number of reported in-patient falls in July.
- There were no mixed sex accommodation breaches in July.

Lowlights: (share 6 areas of challenge/struggle)

- Delay in development of software bot to feed information from WebV to ePMA to record patient's weight.
- Paediatric sepsis audit data gap remains but resolution plan in place.
- Gap in mortality data oversight continues due to no direct access to the CHKS mortality system.
- There is concern nationally regarding a national rise in cases of C.difficile cases. Whilst the Trust is currently managing well with Cdiff, there is a risk that the case threshold set may not be met this year.
- The number of pressure ulcer incidents in acute and community has increased slightly with all incidences reviewed at the weekly scrutiny meeting. No new root causes were identified, and local actions are in place to address learning.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Gap in mortality data oversight continues due to no direct access to the CHKS mortality system.	The Mortality Improvement Group are continuing to review Nationally published NHS digital mortality data to mitigate risk until the trust has access to the new benchmarking system. The Head of Information Services is pursuing an implementation date with the company.	Improve oversight of mortality data.
Delay in development of software bot to feed information from WebV to ePMA to record patient's weight.	Confirmation is awaited around funding before the robotic process automation team can commence work on this. Once funding has been agreed a timescale of 3 months to develop, test and launch is anticipated.	Improve safety of weight related prescribing.
Paediatric Sepsis audit data gap	New Paediatric sepsis screening audit tool created on MS forms and piloted with sample data. Formal data collection ready to commence next month following communication of change to practice.	Assurance that sepsis screening is undertaken for all relevant children, which appears to be done, but not documented reliably.
National increase in Cdiff cases	Continue to complete in-depth PIRs for all cases. Head of Nursing using data to guide the ongoing education & training provided by the React to Red team to care homes.	Maintain oversight and identify and share learning.
Increase in the number of community acquired pressure ulcers occurring in care homes		Reduction in the number of pressure ulcers and increased collaborative working.

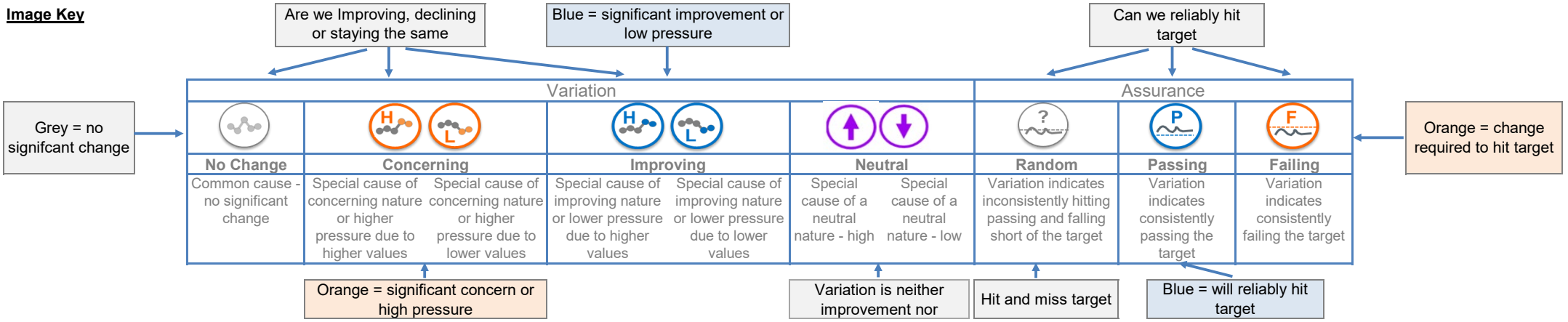
1. WORKFORCE – Simon Nearney
Highlights: (share 3 positive areas of progress/achievement) • The Turnover position has now decreased, this is now at 10.8 and the lowest it has been since recording via the IPR • Core Mandatory Training remains above target at 91.24% • The Medical vacancy has decreased to 12.9% against a target of 15%. This rate has now recovered due to commencement of staff in post to replace doctors leaving in July. Lowlights: (share 3 areas of challenge/struggle) • Role Specific Mandatory Training remains below target, and this month has seen a slight decline of 0.71% • The Trust wide PADR compliance is now below target at 83.8% against a target of 85%. The PADR position is gradually improving each month however, due to the number of PADR's coming out of compliance this month has seen a slight decrease • The sickness position has increased for the first time in 6 months, this is now at 5.2% against a target of 4.1%

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Role Specific Mandatory Training Role specific mandatory training has seen a slight decline (-0.71%) since the previous report and is currently 80.38%. Competencies with the lowest role specific compliance are: Moving and Handling – Module 11 (once only) @ 56.63%, Moving and Handling – Module 4L (community) @ 59.88%, and NG Tube Displacement @ 56.79%.	**Role Specific Mandatory Training** Moving and Handling – Module 11 (once only) is a competency required by doctors and has been impacted recently by the doctors' strikes and the increase in those requiring the competency following the new intake of doctors to the Trust. The Moving and Handling team continue to be flexible in their approach to supporting improvements in this competency; rebooking places where doctors are not able to attend their original booking, reducing the time required to complete the competency,	**Role Specific Mandatory Training** In addition, divisional monthly reports continue to be sent to HRBPs and include the following role specific competencies - Moving and Handling, Resus, Deteriorating Patient, Level 3 Safeguarding Adults and Children, and Corporate Induction. These reports are cascaded by the HRBPs via relevant divisional meetings so that managers are fully aware of attendance / DNA concerns and can action accordingly.

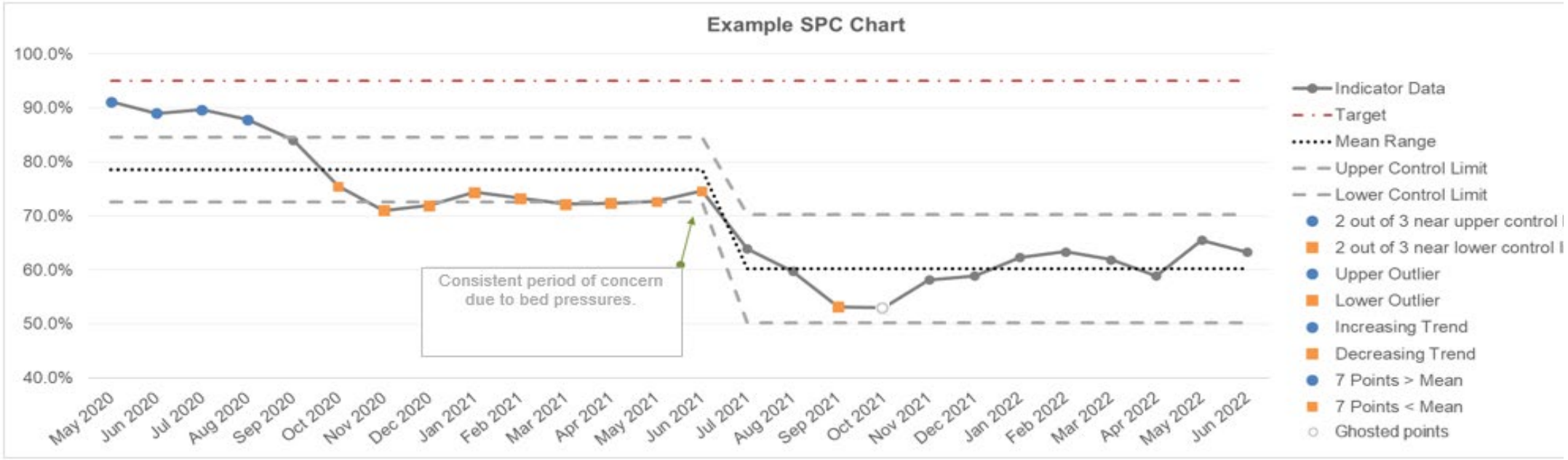
Trust wide PADR The Trust wide PADR compliance is now below target at 83.8% against a target of 85%. The PADR position is gradually improving each month however, due to the high number of PADR's coming out of compliance this month has seen a slight decrease **Sickness** The sickness rate has raised slightly from 4.65% to 5.1% which is disappointing given our previous months position and the downward trend.	and merging classes where possible to prevent cancellations. Similarly, for Module 4L, the team have reviewed planning to ensure sufficient places are made available for the remainder of the year. Wasted spaces through withdrawal and DNA continue to impact moving and handling, with a further 250 WD/DNA reported in August. The process is now established to ensure managers are made aware of this and the team have been asked to analyse key reasons given for non-attendance. Overall moving and handling compliance (all modules) has, however, improved by 3% since July and continues an upward trajectory. NG Tube Displacement is also a requirement for doctors to complete and has, again, been impacted by the increase in numbers through the recent intake of new doctors. Overall role specific compliance for staff group Medical and Dental is currently 68.52%, 19.48% below the Trust target so reminder emails to all those out of compliance within this staff group will be sent out via Training and Development administrators for the remainder of September.	**Trust wide PADR** Planning is now underway for a further communication to managers to now include Due soon PADR's. This will be detailed on the new Workforce KPI reports that will launch to the Trust in October . **Sickness** To further support the training provision and develop existing and new line managers the team are working on short 'how to' videos on key areas such as conducting sickness meetings, return to work interviews and preparing for the case review hearing. The planned managing attendance audits will take place in Sep/Oct and aimed at helping to identify those areas of focus where we are not already aware. HRBP's are leading the work with the management teams to review the sickness data looking at patterns and any themes at the monthly workforce challenge groups/meetings, then where appropriate engaging directly with the individuals to ensure all wellbeing needs are met and to explore if there are any quick wins we can

	Trust wide PADR The ESR Team continue to support managers around PADR compliance with myth busting, gentle reminders, and education. **Sickness** On initial review of the detail, areas of concern have been highlighted and there is robust management of cases with input from the team. The HR team have been working closely with the managers to ensure the reason for absence is recorded correctly and the use of 'reason unknown' is not used to ensure we have a clear understanding as to the reasons for absence. The main reason for absence remains anxiety/stress/depression, the HR team work closely with the OD lead for health and wellbeing which continues to identify areas where staff can be further supported. Part of this workstream is the review of the stress risk assessment process and policy which is estimated to be complete and implemented by the end of November.	achieve to improve attendance at work. Across the divisions there continues to be an increase in the number of case reviews in relation to both long term and short-term absence. The conclusion of the long-term cases will have a positive impact in the reduction of the sickness rate.

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	Arrow = Process Limits Re-calculation point

Notes on Process Limits Re-Calculation

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

This might be shown as:-

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

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

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

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

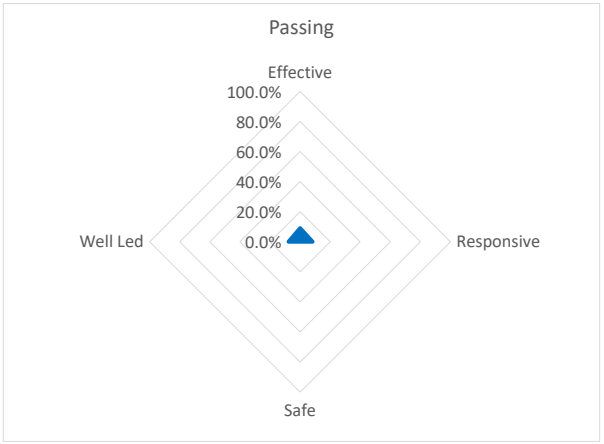
Radar

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

Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

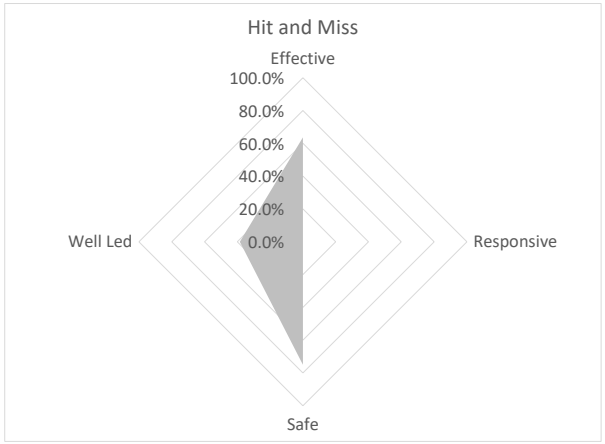
Total: 3



% Discharge Letters Completed Within 24 Hours of Discharge
Core Mandatory Training Compliance Rate
Total Inpatient Waiting List Size

Hit and Miss

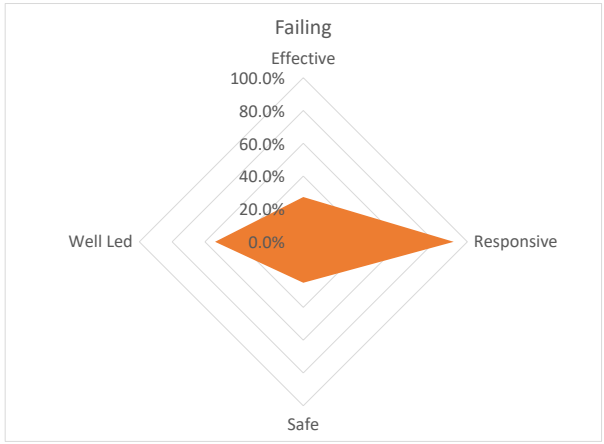
Total: 15



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

Consistently Failing

Total: 22



% 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)*
Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*
Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge
Cancer Request To Test In 7 Days*
Community Acquired Pressure Ulcers (Number)
Unregistered Nurse Vacancy Rate *
Trustwide Vacancy Rate *
Medical Vacancy Rate - Consultants *
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H	% Discharge Letters Completed Within 24 Hours of Discharge	Complaints Responded to on time Medical Staff PADR Rate Sickness Rate	Ambulance Handover Delays - Number 60+ Minutes Turnover Rate PADR Rate Combined AfC and Medical Staff PADR Rate Role Specific Mandatory Training Compliance Rate Unregistered Nurse Vacancy Rate *
		L			
	Common Cause		Core Mandatory Training Compliance Rate	% Patients Discharged On The Same Day As Admission (excluding daycase) % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay Inpatient Non Elective Average Length Of Stay Duty of Candour Rate Venous Thromboembolism (VTE) Risk Assessment Rate Mixed Sex Accommodation Breaches Registered Nurse Vacancy Rate * Medical Vacancy Rate * Medical Vacancy Rate - Other *	% Inpatient Discharges Before 12:00 (Golden Discharges) Outpatient Did Not Attend (DNA) Rate Cancer Waiting Times - 104+ Days Backlog* Cancer Waiting Times - 62 Day GP Referral* Emergency Department Waiting Times (% 4 Hour Performance) 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* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Community Acquired Pressure Ulcers (Number) Trustwide Vacancy Rate *
	Special Cause Concern	H	Total Inpatient Waiting List Size	% Outpatient Non Face To Face Attendances Bed Occupancy Rate (G&A)	Number of Overdue Follow Up Appointments (Non RTT) Number of Incomplete RTT pathways 52 weeks* Percentage Under 18 Weeks Incomplete RTT Pathways* Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Medical Vacancy Rate - Consultants *
		L			

Scorecard - Access and Flow

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Aug 2023	61.1%	92.0%	Alert		
	Number of Incomplete RTT pathways 52 weeks*	Aug 2023	834	0	Alert		
	Total Inpatient Waiting List Size	Aug 2023	11,960	11,563	Alert		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Aug 2023	36.6%	1.0%	Alert		
	Number of Incomplete RTT pathways 65 weeks	Aug 2023	115	No Target			n/a
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Aug 2023	38,224	9,000	Alert		
	Outpatient Did Not Attend (DNA) Rate	Aug 2023	6.2%	5.00%	Alert		
	% Outpatient Non Face To Face Attendances	Aug 2023	18.2%	25.00%	Alert		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Aug 2023	48.4%	85.0%	Alert		
	Cancer Waiting Times - 104+ Days Backlog*	Aug 2023	26	0	Alert		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Aug 2023	9.1%	75.0%	Alert		
	Cancer - Request To Test In 7 Days*	Aug 2023	52.3%	100.0%	Alert		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Aug 2023	65.4%	95.0%	Alert		
	Number Of Emergency Department Attendances	Aug 2023	14,226	No Target	Alert		n/a
	Ambulance Handover Delays - Number 60+ Minutes	Aug 2023	201	0	Alert		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Aug 2023	542	0	Alert		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Aug 2023	247	0	Alert		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Aug 2023	41.5%	40.0%			
	% of Extended Stay Patients 21+ days	Aug 2023	11.6%	12.0%			
	Inpatient Elective Average Length Of Stay	Aug 2023	2.1	2.5			
	Inpatient Non Elective Average Length Of Stay	Aug 2023	3.3	3.9			
	% Discharge Letters Completed Within 24 Hours of Discharge	Aug 2023	97.6%	90.0%			
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Aug 2023	15.6%	30.0%	Alert		
	Bed Occupancy Rate (G&A)	Aug 2023	93.8%	92.0%	Alert		

Scorecard - Quality and Safety

Northern Lincolnshire and Goole NHS Foundation Trust

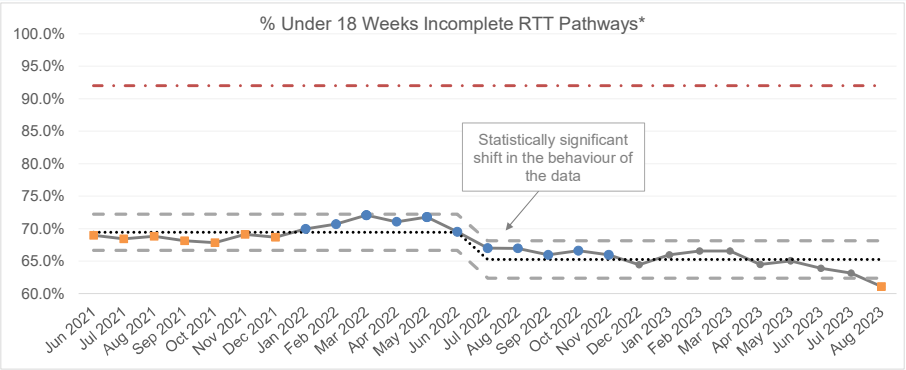
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Jul 2023	0.00	see analysis below			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jul 2023	0.30	see analysis below			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jul 2023	0.15	see analysis below			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jul 2023	0.10	see analysis below			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jul 2023	0.35	see analysis below			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected		L	As expected
	Summary Hospital level Mortality Indicator (SHMI)	Mar 2023	102.7	As expected			As expected
	SHMI diagnosis groups outcome risk percentage (infections)	Mar 2023	96.2%	No target			n/a
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Jun 2023	19.0%	No target		n/a	n/a
Safe Care	Patient Safety Alerts actioned by specified deadlines	Jul 2023	100.0%	100%		H	n/a
	Number of Serious Incidents raised in month	Aug 2023	5	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Aug 2023	0	0		n/a	n/a
	Duty of Candour Rate	Aug 2023	100.0%	100%			?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2023	4.5	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2023	4.2	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Aug 2023	94.6%	95.0%			?
	Care Hours Per Patient Day (CHPPD)	Jul 2023	8.7	No target			n/a
	Mixed Sex Accommodation Breaches	Jul 2023	0	0			?
	Community Acquired Pressure Ulcers (Number)	Jul 2023	44	0	Alert		F
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Jul 2023	6.7	No target			n/a
	Complaints Responded to on time	Jul 2023	92.0%	85.0%		H	?
	Friends & Family Test: Inpatient Score Percentage Positive	Jul 2023	93.3%	0%			n/a
	Friends & Family Test: A&E Score Percentage Positive	Jul 2023	81.2%	No target			n/a
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Jul 2023	9.0	No target			n/a
Mental Capacity	Number of contacts with the MCA/DoLS team	Aug 2023	0.0	No target		n/a	n/a
	Percentage of MCA assessments that meet the legal requirements	Jun 2023	48.0%	No target		n/a	n/a
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Jun 2023	11.0%	No target		n/a	n/a
Prescribing	Harm impact for weight related medication prescribing incidents	Aug 2023	0	No target			n/a
Maternity	Robson Scores - Group 1	Aug 2023	6.5%	No target			n/a
	Robson Scores - Group 2	Aug 2023	27.4%	No target			n/a
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Aug 2023	2	No target			n/a
	Still Birth Rate per 1000	Aug 2023	6.3	No target			n/a
	Spontaneous 3rd or 4th Degree Tear	Aug 2023	1.1%	No target			n/a
	Instrumental 3rd or 4th Degree Tear	Aug 2023	3.2%	No target			n/a

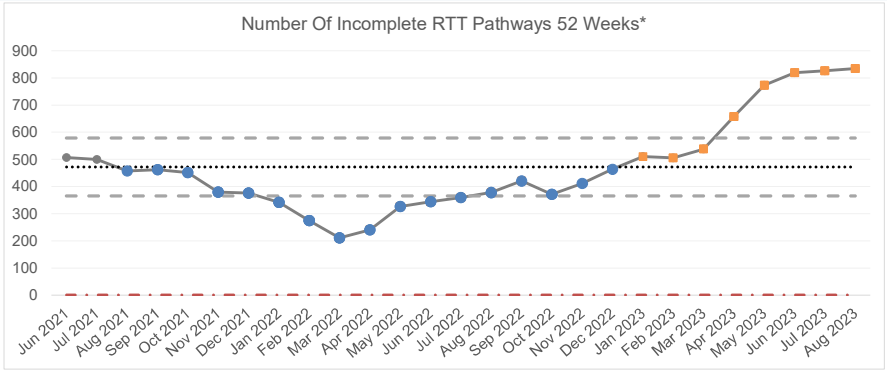
Scorecard - Workforce

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

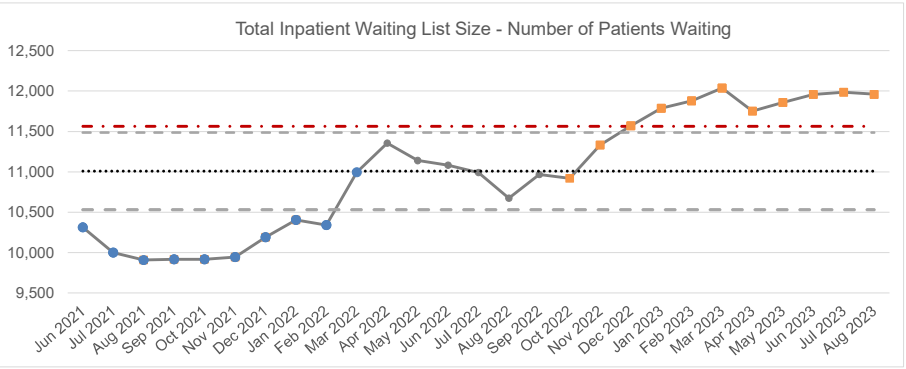
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Aug 2023	10.5%	8.0%	Alert		
	Registered Nurse Vacancy Rate	Aug 2023	12.3%	8.0%			
	Medical Vacancy Rate	Aug 2023	12.9%	15.0%			
	Trustwide Vacancy Rate	Aug 2023	10.0%	8.0%	Alert		
	Medical Vacancy Rate - Consultants	Aug 2023	19.5%	15.0%	Alert		
	Medical Vacancy Rate - Other	Aug 2023	8.9%	15.0%			
Staffing Levels	Turnover Rate	Aug 2023	10.8%	10.0%	Highlight		
	Sickness Rate	Jul 2023	5.2%	4.1%			
Staff Development	PADR Rate	Aug 2023	83.1%	85.0%	Alert		
	Medical Staff PADR Rate	Aug 2023	95.0%	85.0%			
	Combined AfC and Medical Staff PADR Rate	Aug 2023	83.8%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Aug 2023	91.2%	85.0%			
	Role Specific Mandatory Training Compliance Rate	Aug 2023	80.4%	85.0%	Alert		



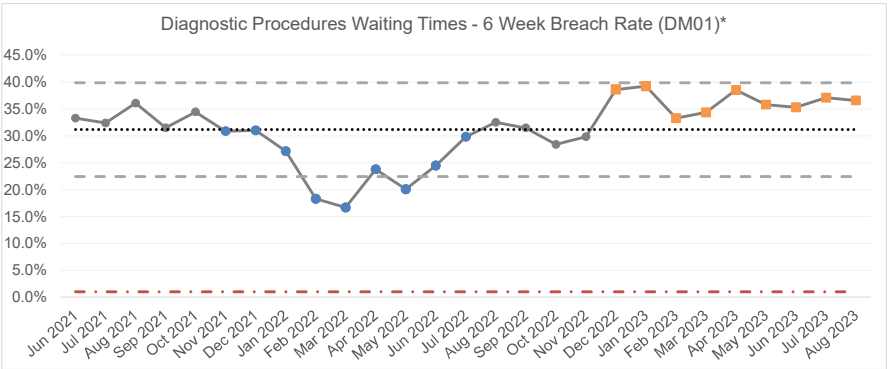
Aug 2023	Target	Variance	Assurance
61.1%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target



Aug 2023	Target	Variance	Assurance
834	0	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target



Aug 2023	Target	Variance	Assurance
11,960	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently passing the target



Aug 2023	Target	Variance	Assurance
36.6%	1.0%	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Following a period of improvement in 2022, this indicator declined in 2023, with the current month indicating concern. The target won't be reached, according to the data currently available, unless the planned actions listed below are taken.
Incomplete 52 weeks*: Since spring of 2022, the frequency of 52-week delays has slowly climbed and is now causing particular cause for concern. Current evidence suggests that without taking the planned actions listed below, the target will not be reached.
Inpatient waiting list: In recent months, there has been an increase in the number of people on the waiting list, which is particularly concerning. The data has currently exceeded the upper process limit for the preceding nine months.
Diagnostics 6 Week Wait (DM01)*: Performance continues to fall within the expected parameters. However, over the last nine months, performance has reported levels that are greater than the average.

Challenges:

- Acceptance of Mutual Aid - further patients are being received into Goole Hub and possible mutual aid outside of ICS
- 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 pathways and sickness, vacancy and leave position (SGH Anaesthetics)
- Delivery of additional £13m - activity needs to increase to support delivery
- Workforce vacancies resulting in reduced capacity for Outpatients
- The tender process for Independent Sector has now been completed but is unlikley to go live with a new contract until around Mid October, this leave a shortfall for new planned activity for both August and September
- Diagnostic Demand is greater than capacity for Echo
- Ageing Diagnostic equipment
- Audiology Review
- Diagnostic Reporting Capacity

Key Risks:

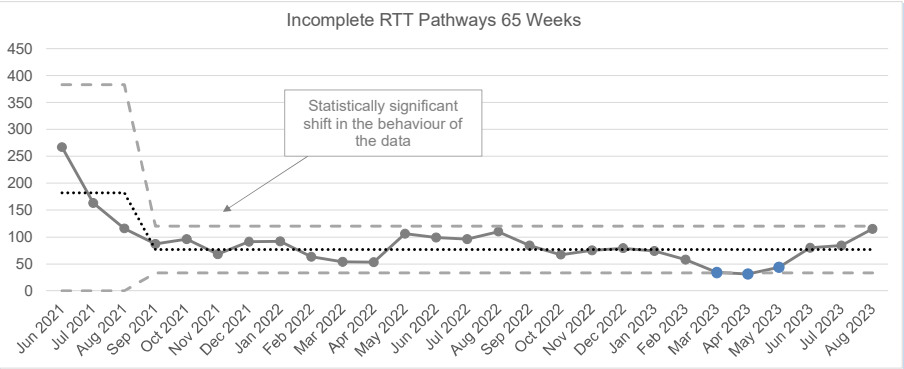
- Site flow and bed capacity
- Mitigation of doctor strikes
- Ongoing management of high levels of acute activity impacting elective work
- Impact of ability to fill consultant vacancies in hard to fill specialties

Actions:

- Continue to push for funding for Waiting List Initiatives to uplift theatre activity to support performance and waiting list position. (ongoing)
- Continue to utilise Independent Sector when waiting lists allow (ongoing)
- Robust recruitment plan for theatres with external company, agreed with recruitment plan being progressed for ODP (ongoing)
- Displacement of lower 52ww specialties in October and increase Orthopaedics to tackle 52ww backlog (October 2023)
- Work currently taking place around desktop reviews of overdue follow up patients to look to see if PIFU/discharge etc is an option (September 2023)
- Mobile scanner to replace broken SGH scanner (September 2023)

Mitigations:

- Additional sessions still being undertaken by NLaG clinicians
- Regular review of waiting lists and focus on long waiting and high risk patients.
- Risk stratification programme continues across all specialities
- Locum staff in place where able to secure
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
- Diagnostic equipment maintenance contracts in place



Aug 2023
115

Target
No Target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

This space is intentionally blank

This space is intentionally blank

This space is intentionally blank

Data Analysis:

Incomplete RTT pathways 65 weeks: Despite an improvement in the spring of this year, the number of incomplete paths has been steadily rising, and the most recent data is close to the upper process limit.

Challenges:

- Acceptance of Mutual Aid - further patients are being received into Goole Hub and possible mutual aid outside of ICS
- 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 pathways and sickness, vacancy and leave position (SGH Anaesthetics)
- Delivery of additional £13m - activity needs to increase to support delivery
- Workforce vacancies resulting in reduced capacity for Outpatients
- The tender process for Independent Sector has now been completed but is unlikley to go live with a new contract until around Mid October, this leave a shortfall for new planned activity for both August and September
- Diagnostic Demand is greater than capacity for Echo
- Ageing Diagnostic equipment
- Audiology Review
- Diagnostic Reporting Capacity

Key Risks:

- Site flow and bed capacity
- Mitigation of doctor strikes
- Ongoing management of high levels of acute activity impacting elective work
- Impact of ability to fill consultant vacancies in hard to fill specialties

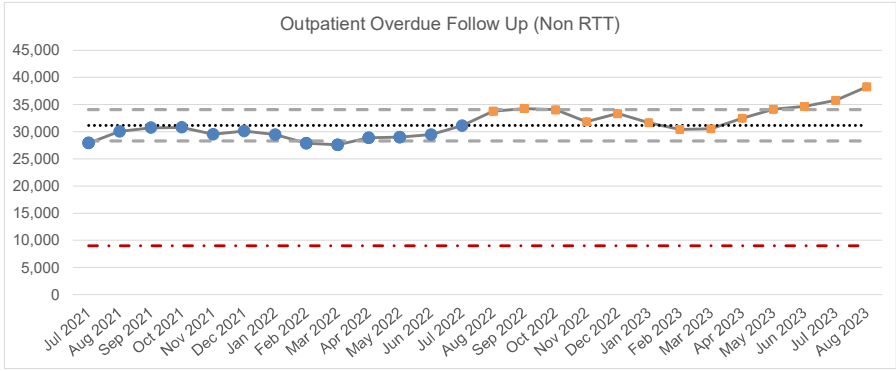
Actions:

- Continue to push for funding for Waiting List Initiatives to uplift theatre activity to support performance and waiting list position. (ongoing)
- Continue to utilise Independent Sector when waiting lists allow (ongoing)
- Robust recruitment plan for theatres with external company, agreed with recruitment plan being progressed for ODP (ongoing)
- Displacement of lower 52ww specialties in October and increase Orthopaedics to tackle 52ww backlog (October 2023)
- Work currently taking place around desktop reviews of overdue follow up patients to look to see if PIFU/discharge etc is an option (September 2023)
- Mobile scanner to replace broken SGH scanner (September 2023)

Mitigations:

- Additional sessions still being undertaken by NLaG clinicians
- Regular review of waiting lists and focus on long waiting and high risk patients.
- Risk stratification programme continues across all specialities
- Locum staff in place where able to secure
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
- Diagnostic equipment maintenance contracts in place

This space is intentionally blank



Aug 2023
38,224

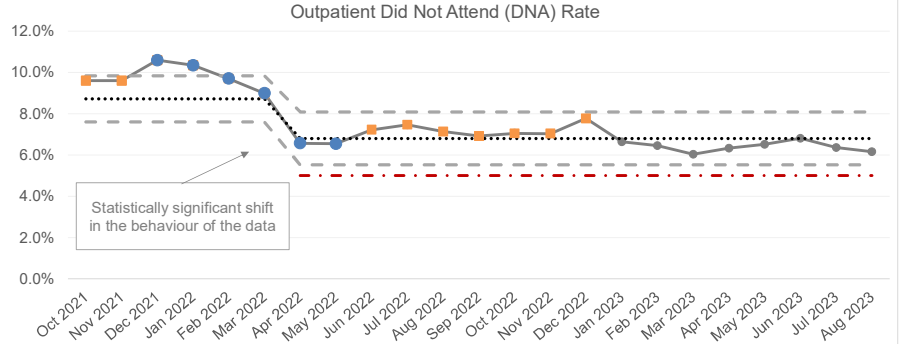
Target
9,000

Variance

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

Assurance

Consistently falling short of the target



Aug 2023
6.2%

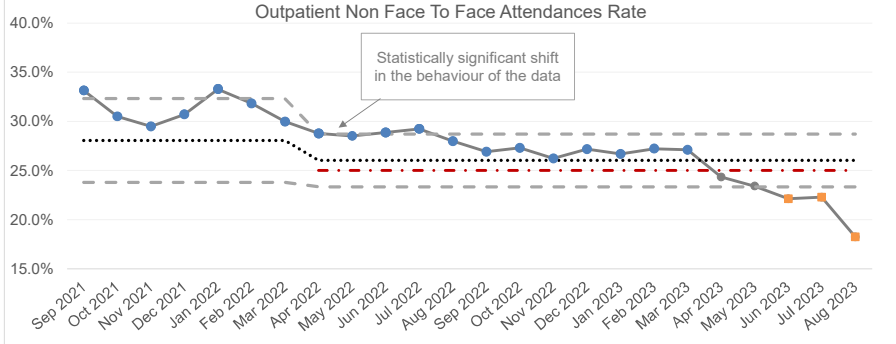
Target
5.0%

Variance

Common cause - no significant change

Assurance

Consistently falling short of the target



Aug 2023
18.2%

Target
25.0%

Variance

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

Assurance

Inconsistently hitting passing and falling short of the target

Data Analysis:

Outpatient Overdue follow up: For the past year this indicator has recorded concern. The indicator is failing the target by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.

Outpatient DNA rate: Data keeps fluctuating within the predicted range. Current evidence suggests that without taking the planned actions listed below, the target will not be reached.

Non Face to Face Outpatient: Values has fallen month on month for the past six months registering concern. The target is within the process limits and may therefore be achieved at random unless the downwards trend continues.

Challenges:

- The 25% reduction in follow-up activity is starting to have a significant impact on the overdue follow-up waiting list, as we try to balance the conversion of follow-up activity to new. Unless we are able to reduce the number of patients being added to the follow list in parallel to reducing activity we will inevitably see a rise in the number of patients waiting
- A proposal to validate overdue follow-ups (via a direct communication to the patient) has been agreed at Exec Team, although there some resistence from clinical leads to move forward with this
- Management resource is also starting to be a challenge, as the Outpatient Programme has been without a Programme Manager for 6 months, and the Lorenzo Project is consuming signficant amounts of leadership resource.
- Funding arrangements for the Connected Health Network Model (CHN) model post 2022-23 fiscal year is a challenge with no designated substantive funding confirmed. Roll-out has been on hold since April 2023

Key Risks:

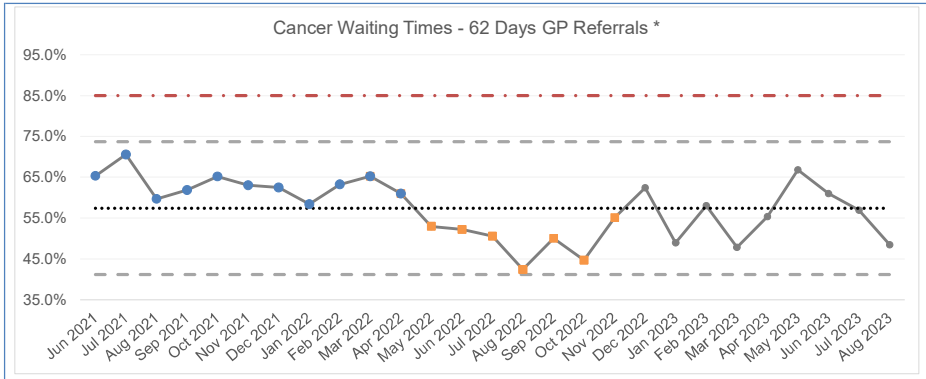
- Clinical buy-in across some specialities to deliver the 25% reduction. Risk to delivery without radical change, particularly as regards validation and PIFU
- Impact on operational delivery due to ongoing industrial action
- The increase of the overdue follow-up waiting list, as follow-up activity is taken out and converted to new.

Actions:

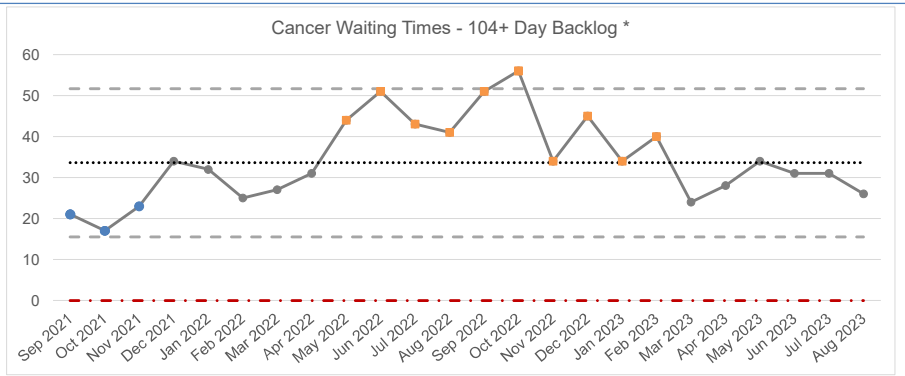
- Working with Clinical and speciality leads to consider PIFU in pathways where clinically appropriate as part of GIRFT recommendations action planning (October 2023)
- Working with Divisional Medical Directors to explore options for delivering the 25% reduction in follow-ups. Pilots now agreed with ENT, Paeds and Gynae for validation. (October 23)
- Getting It Right First Time (GIRFT) Clinically led Outpatient Guidance has completed evaluation and action plans for 14 specialities. There are 78 actions in total, being monitored via the GIRFT Steering Group and action plan (ongoing)
- Discussions on Connected Health Network future finance model in progress with NLAG and Integrated Care Board finance leads, outline proposal developed (September 2023)
- Proposal to Validate Patients (writing to patients) on the Follow-up Outpatient Waiting List agreed at Operational Management Group, with amendments (October 2023)

Mitigations:

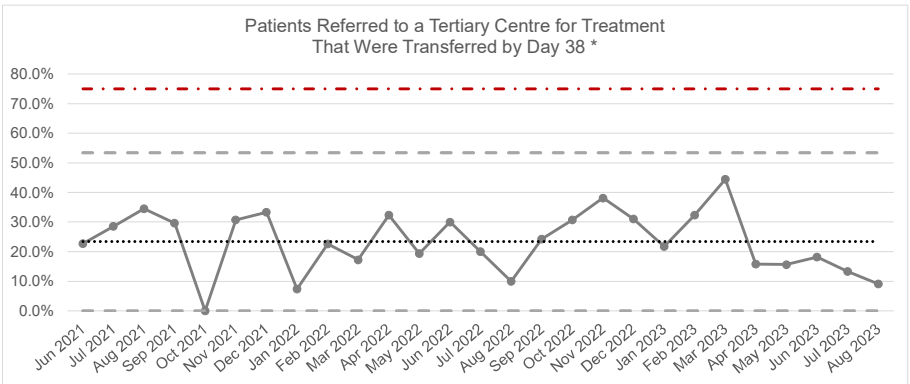
- Clinicians engaged through GIRFT to support PIFU adoption and OP Follow-up Patient Validation. Oversight via the GIRFT Steering Group
- Divisional Medical Director's engaged in discussions and proposals to validate follow-up patients (via direct correspondence with patients)
- Discussions in place with NLAG Deputy Director of Finance and Integrated Care Board Place Finance Director on future finance options for Connected Health Network, anticipate final proposal to be agreed Sept
- Specialty level trajectories in place within the activity plans for 2023-24 for reducing Follow-up activity



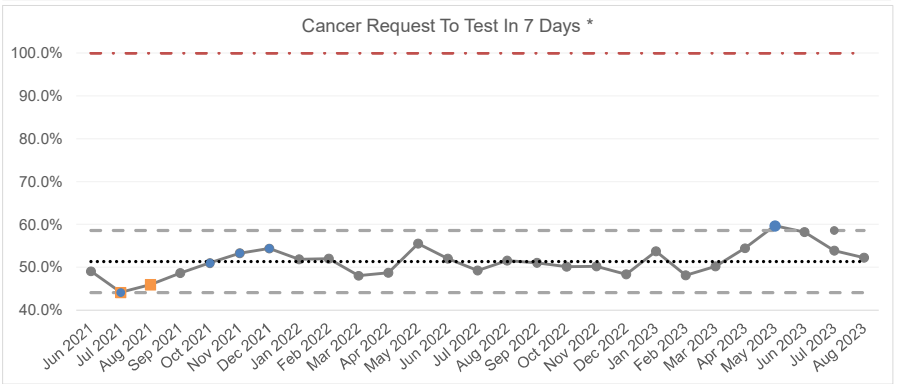
Aug 2023	Target	Variance	Assurance
48.4%	85.0%	Common cause - no significant change	Consistently falling short of the target



Aug 2023	Target	Variance	Assurance
26	0	Common cause - no significant change	Consistently falling short of the target



Aug 2023	Target	Variance	Assurance
9.1%	75.0%	Common cause - no significant change	Consistently falling short of the target



Aug 2023	Target	Variance	Assurance
52.3%	100.0%	Common cause - no significant change	Consistently falling short of the target

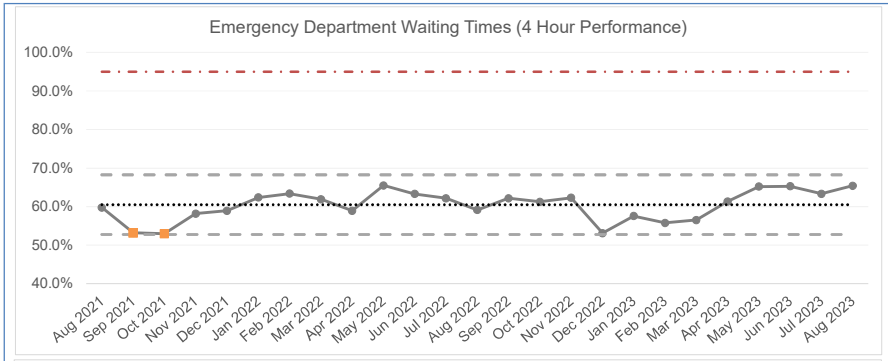
Data Analysis:
62 days GP referral*: Performance is stable and as expected. This target has not been achieved for more than 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.
104+ day backlog*: Performance is as expected. The indicator is consistently failing the target and current data indicates that the target will not be met without action, planned actions outlined below.
Transferred by day 38*: Wide variation is due to very low numbers. Performance has not changed significantly over the past 2 years, 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. 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 (62 day pathways) resulting in increased breaches of 62 days
• Most tumour sites are unable to achieve 62 day standard due to multiple factors, including diagnostic and pathology turnaround times, patient choice.
• Notable increase in Urological Cancer referrals over last 3 months and increase in 62 day breaches due to TURBT no longer being classed nationally as a first treatment.
• Increase in Urology patients awaiting surgery at Hull University Teaching Hospitals due to Urology Renal consultant vacancy.

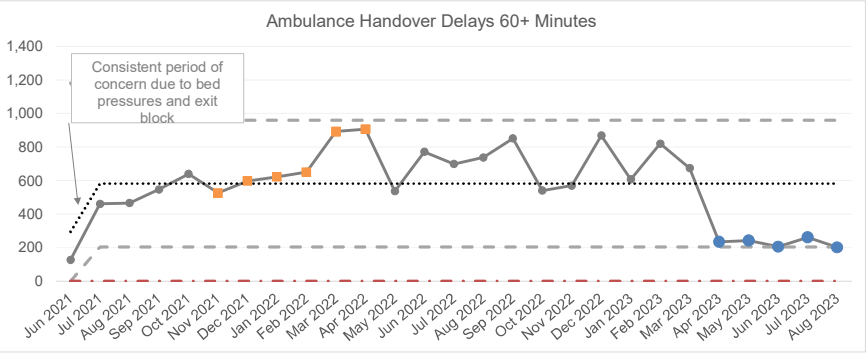
Key Risks:
• Upper Gastrointestinal and Head & Neck surgery is carried out in Hull which is currently causing significant delay- small numbers
• Lack of Oncology Capacity for 1st appointments - now booking 6 weeks from point of referral
• One Clinician at SGH running Straight To Test Upper Gastrointestinal service - manageable as small numbers but during leave and sickness leaves service vulnerable
• Hull University Teaching Hospitals have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times
• Patient choice
• Urology cancer consultant now on phased return following extended sick leave
• There are issues related to visiting consultant services for Oncology referrals for tertiary based staging scans (EUS, PET CT) and associated wait for results affect the ability to transfer for treatment by Day 38
• 1 x wte Consultant vacancy in Respiratory (Lung Cancer). Appointed, but remains a risk until candidate accepts the post formally.

Actions:
• Urology service review completed with additional one stop clinics introduced - impact on pathways being monitored over the next 8 weeks. Meeting held with Hull University Teaching Hospitals to create 1 Urological Cancer PTL (October 2023)
• Timely removal of patients from cancer tracking once non-malignancy confirmed - targeted daily actions by Cancer Teams (ongoing)
• Regular review with Hull University Teaching Hospitals of demand and capacity for Oncology (ongoing)

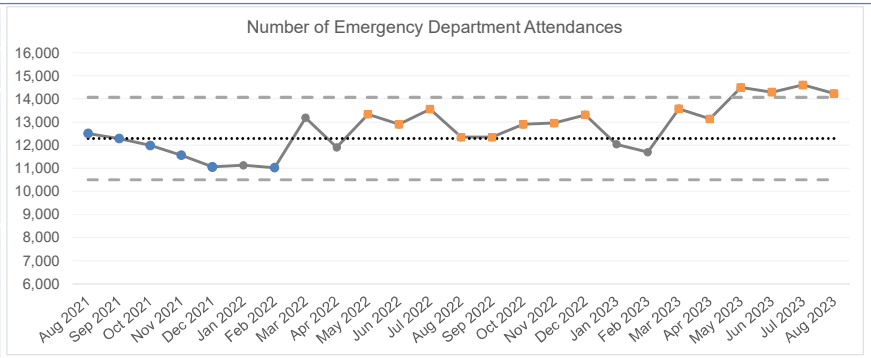
Mitigations:
• Colorectal - Consultant Nurse Specialist straight to test commenced both sites
• All tumour sites have a robust action plan and weekly meetings with the quad to esure man marking
• Funding approved to recruit to Band 3 and Band 2 admin support
• 62 day performance is being reviewed and managed weekly - along with the 28 day performance
• Urology agency consultant currently in post to support the cancer work until cancer consultant fully returned
• Cancer Improvement Plans developed for each cancer tumour site
• The joint transformation pathway work with Hull University Teaching Hospitals will help with the transfer of patients to identify areas where the pathway can be accelerated



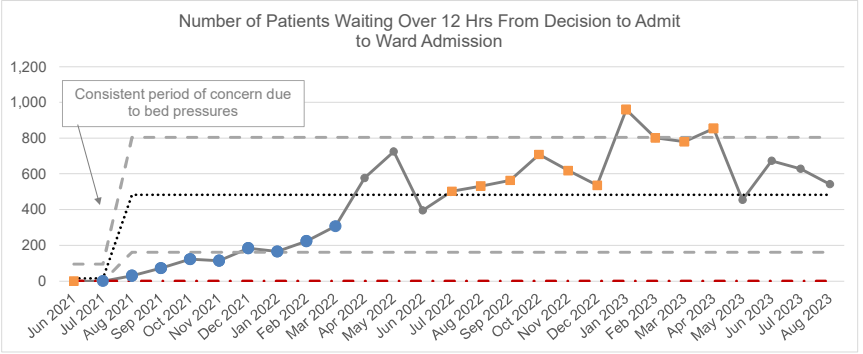
Aug 2023
65.4%
Target
95.0%
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target



Aug 2023
201
Target
0
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently falling short of the target



Aug 2023
14,226
Target
No Target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant



Aug 2023
542
Target
0
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target

Data Analysis:

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

ED Attendances: Values have increased in recent months and have registered concern for the past six months. More data is needed to determine whether the concerning performance will continue.

Ambulance handover 60+ minutes: Performance has been showing improvement for the past five months. However, more data is needed to determine whether this will continue. The indicator continues to fail the target. Current data indicates that the target will not be met without action, planned actions outlined below.

DTA 12 hours: Performance is still recording very high numbers and will unlikely return to the 2021 figures in the near future. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

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

Key Risks:

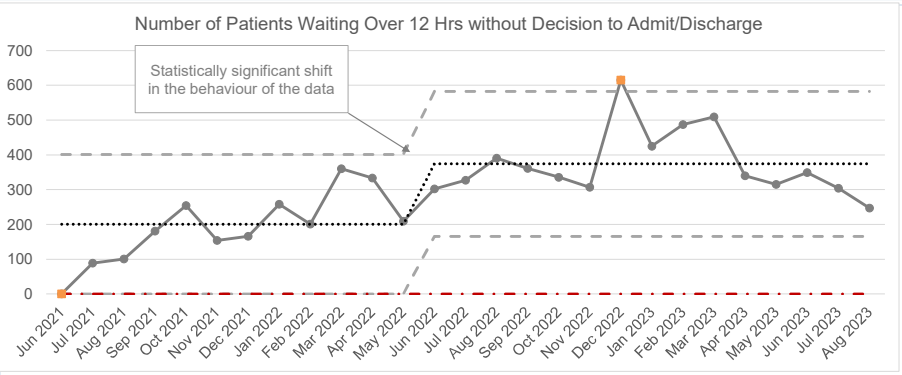
- Inability to meet the Royal College of Emergency Medicine staffing requirements in ED
- Gaps in both medical and nurse staffing resulting in high levels of agency and locum staff
- Challenge to achieve Ambulance Handover targets due to lack of flow within the hospital - however progress being made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

Actions:

- Review of existing ED staffing is taking place. Consultants hours will be redistributed to support an even 7/7 cover. Junior doctor rota will move from 1:10 to 1:12
- Review of all Urgent Care Services across Northern Lincolnshire continues (ongoing)
- Expansion of the Virtual ward services (ongoing)
- QI project is in place to improve the flow within the department (October 23)
- Work carried out on the SAS 2021 doctors rota and the 30 day consultation has began to improve capacity versus demand with the aim to reduce locum spending and improve 4 hour performance (ongoing)
- Process improvement has been carried out in relation to Ambulance Handover to ensure achievement of 30 minute Mean time (ongoing)
- Work being carried out in relation to system issues that are leading to invalid 12 hour breaches (ongoing)
- The Patient Flow Improvement and Ambulance Handover Group have now been restructued into an oversight meeting and a Task & Finish Meetings (ongoing)
- Focus work being carried out in relation to criteria to admit (ongoing)

Mitigations:

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



Aug 2023
247

Target
0

Variance

Common cause - no significant change

Assurance

Consistently falling short of the target

This space is intentionally blank

This space is intentionally blank

This space is intentionally blank

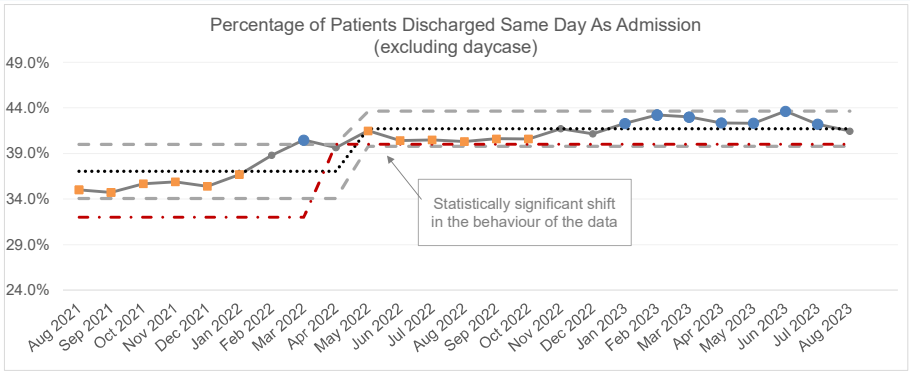
Data Analysis:
Patients waiting 12h+ without decision: Following a process limit recalculation to accommodate the increasing figures the most recent data is now within the expected range. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
- Number of patients with a Decision to admit 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 Treatment Centre rooms overnight to bed patients down resulting in a lack of rooms to see patients the following day

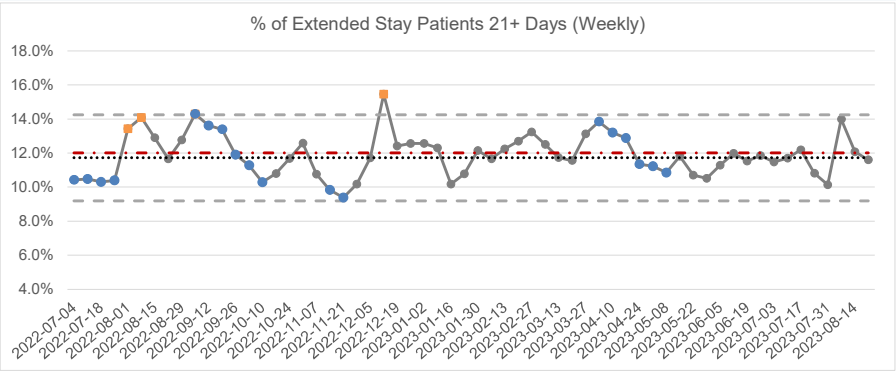
Key Risks:
- Challenge to achieve ambulance handover times due to lack of space within the department caused by lack of flow out of ED
- Lack of rooms to be able to see new patients that arrive within the department due to lack of flow out of ED
- Staff burnout and maintaining morale through ongoing pressures - impacting retention and recruitment
- Number of red flag (higher risk) patients in the Waiting Room
- Failure to meet triage targets
- Lack of flow through ED due to lack of timely dischagres from all in-patient wards.

Actions:
- Quality Improvement project initiated to improve the flow within the department (October 2023)
- Work has commenced on improving ambulance handover mean times (ongoing).
- Progress the work to enable Live review and validation of 12 hour DTAs (ongoing)
- The review of all Urgent care services across Northern Lincolnshire continues further meetings scheduled. Discussions are taking place between the Finance Director and Integrated Care Board/Place leads in relation to future plans (ongoing)

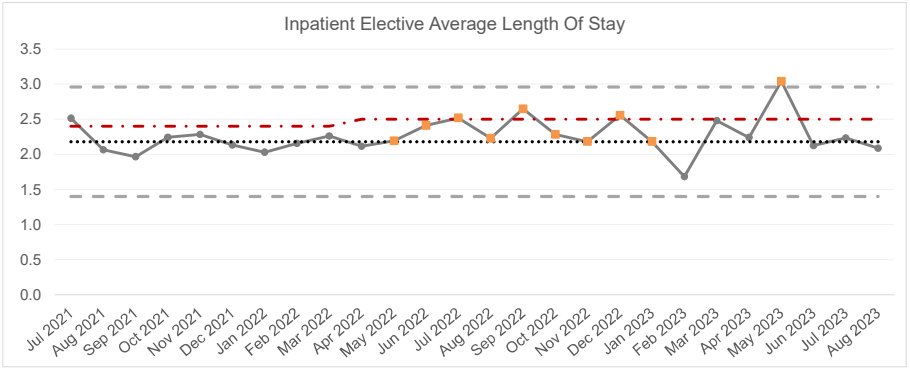
Mitigations:
- Care standards are in place to ensure that the patients are reviewed regularly
- Two hourly Board Rounds in place and patients are reviewed where necessary
- Critical Medication Sheets are in place where required to ensure patients are receiving the medication they require whilst waiting 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



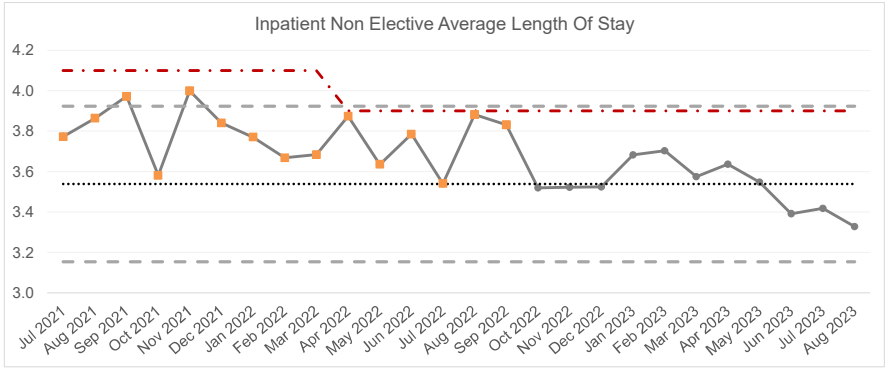
Aug 2023	Target	Variance	Assurance
41.5%	40.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Aug 2023	Target	Variance	Assurance
11.6%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



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



Aug 2023	Target	Variance	Assurance
3.3	3.9	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

Data Analysis:
Discharged same day as admission: Performance has recorded higher values for some time and as such is registering improvement. The indicator can be expected to achieve and fail the target 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: Performance is as expected and within the expected range. The target can be expected to achieve and fail at random.
Non elective length of stay: This indicator has shown an improvement coinciding with an increase in patients discharged on the same day as admission. The indicator can be expected to achieve and fail the target at random.

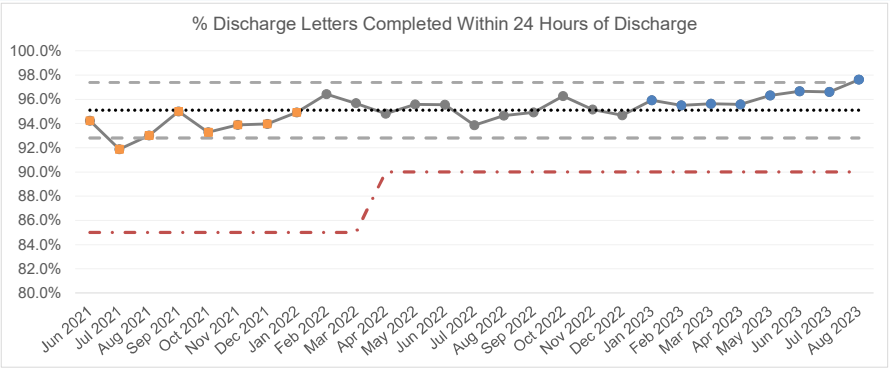
Challenges:
- Consultant vacancies impacting on service delivery
- Increased medical staff sickness
- Covid and infection prevention constraints remain
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and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

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

Actions:
- Virtual Wards plan to operate a step up model from primary/community care (September 2023)
- Plan agreed to create a dedicated OPAT nursing team that will provide a hybrid model between both Outpatient & Home delivery, recruitment commenced and model agreed, agreement to increase to 10 patients (October 2023)
- Community Frailty team working within care homes to support falls (ongoing)
- System wide action plan in place to support patient flow (ongoing)
- Delivery of new IAAU/SDEC New Builds (Q3 DPoW, Q4 SGH)

Mitigations:
- Homecare Team now fully established and providing homecare in NL
- 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
- 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

This space is intentionally blank



Aug 2023
97.6%

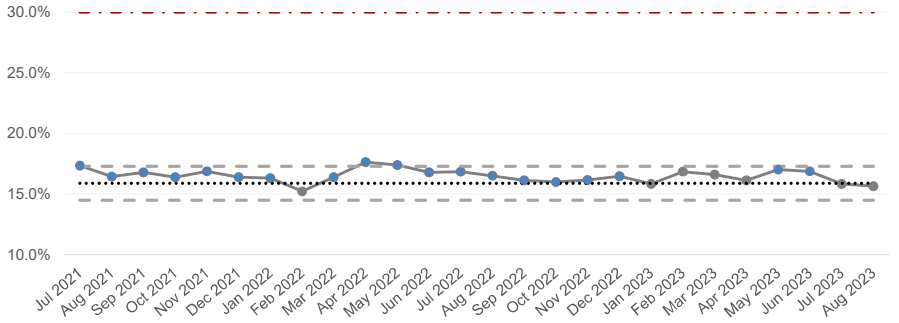
Target
90.0%

Variance

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

Assurance

Consistently passing the target



Aug 2023
15.6%

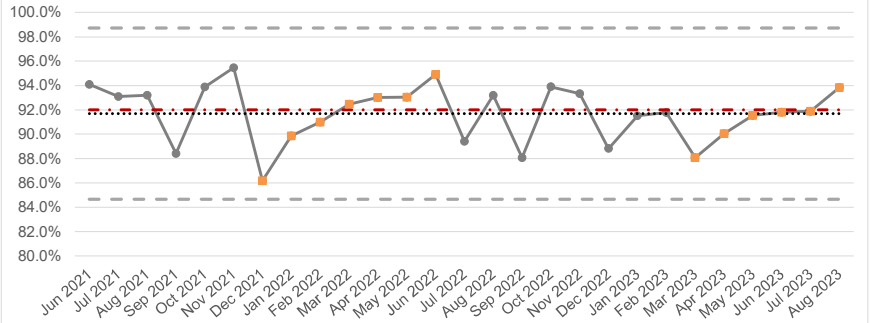
Target
30.0%

Variance

Common cause - no significant change

Assurance

Consistently falling short of the target



Aug 2023
93.8%

Target
92.0%

Variance

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

Assurance

Inconsistently hitting passing and falling short of the target

Data Analysis:
Inpatient discharge letters: The most recent value exceeded the upper process limit, while data for the preceding seven months shows consistent improvement. The indicator's achievement of the target can be confidently predicted.
Inpatient discharges before 12:00: Performance is currently stable. Current data indicates that the target will not be met without action, planned actions outlined below.
G&A Bed Occupancy: Performance has recorded as concerning for the previous six months. The target can be expected to achieve and fail at random.

Challenges:
- Consultant vacancies impacting 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 well to the creation of escalation beds
- Earlier more timely discharge is delayed as the discharge lounge at DPOW as it is also utilised as an inpatient area

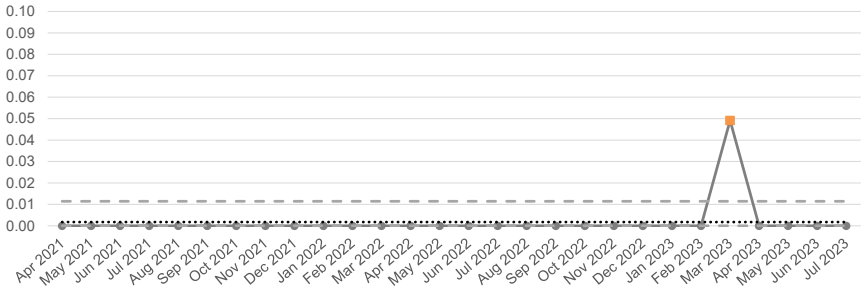
Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Virtual Wards plan to operate a step up model from primary/community care (September 2023)
- Plan agreed to create a dedicated OPAT nursing team that will provide a hybrid model between both Outpatient & Home delivery, recruitment commenced and model agreed, agreement to increase to 10 patients (October 2023)
- Community Frailty team working within care homes to support falls (ongoing)
- System wide action plan in place to support patient flow (ongoing)
- Delivery of new IAAU/SDEC New Builds (Q3 DPoW, Q4 SGH)

Mitigations:
- Homecare Team now fully established and providing homecare in NL
- 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
- 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

Northern Lincolnshire and Goole NHS Foundation Trust

Number of MRSA Infections (Rate Per 1000 Bed Days)



Jul 2023
0.00

*Target
see analysis below

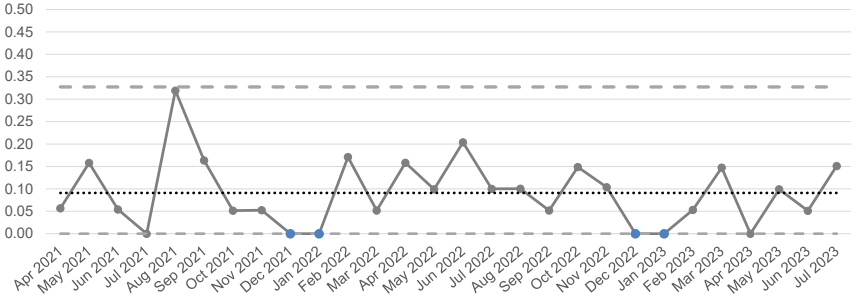
Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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



Jul 2023
0.15

*Target
see analysis below

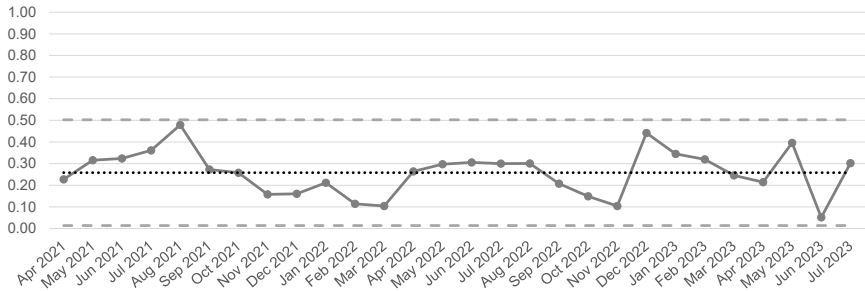
Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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



Jul 2023
0.30

*Target
see analysis below

Variance

Common cause - no significant change

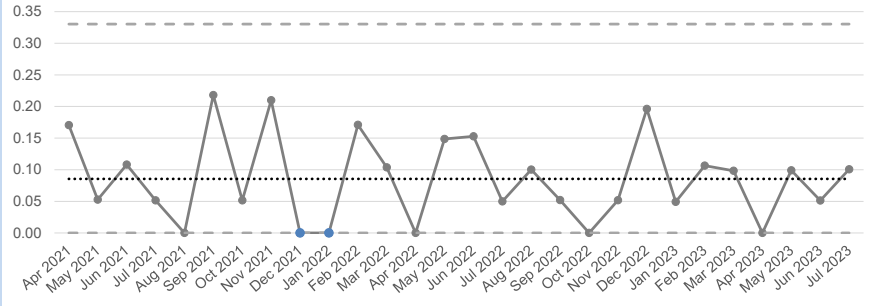
Assurance

There is no target, therefore target assurance is not relevant

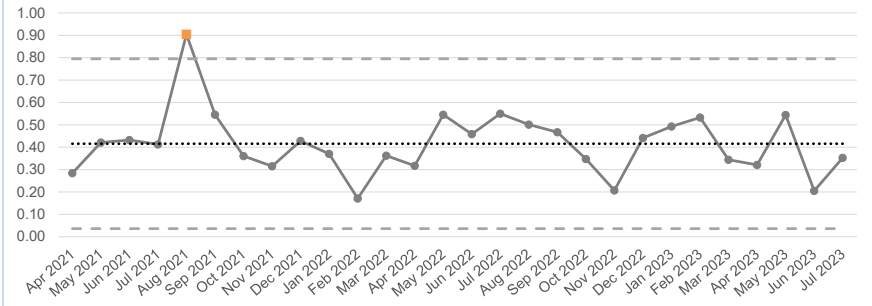
This space is intentionally blank

Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 0 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 8 against an annual target of 20.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 19 against an annual target of 65.

Commentary:
There is a concern regarding a national rise in cases of C.diff. The Trust's performance is stable.



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



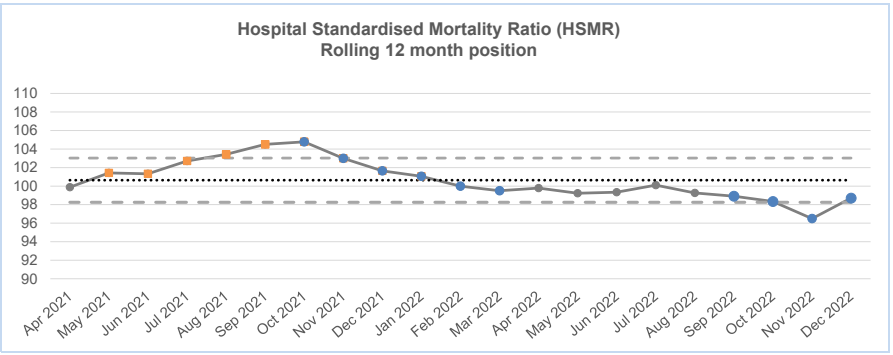
Jul 2023
0.35
Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

This space is intentionally blank

This space is intentionally blank

Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 5, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 26 against an annual target of 97.

Commentary:



Dec 2022
98.7

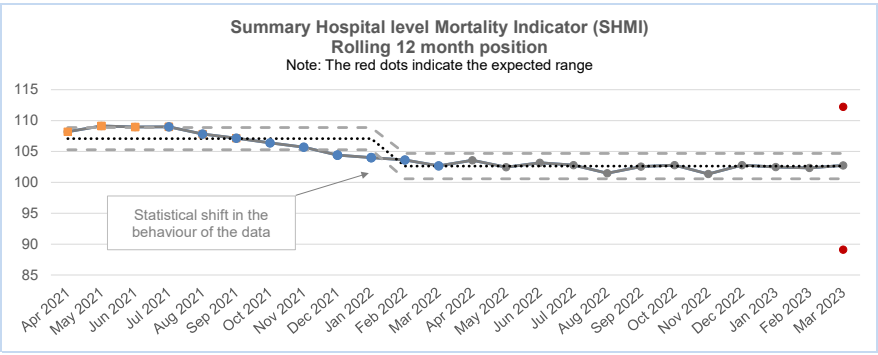
Target
As expected

Variance

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

Assurance

Within 'as expected' range



Mar 2023
102.7

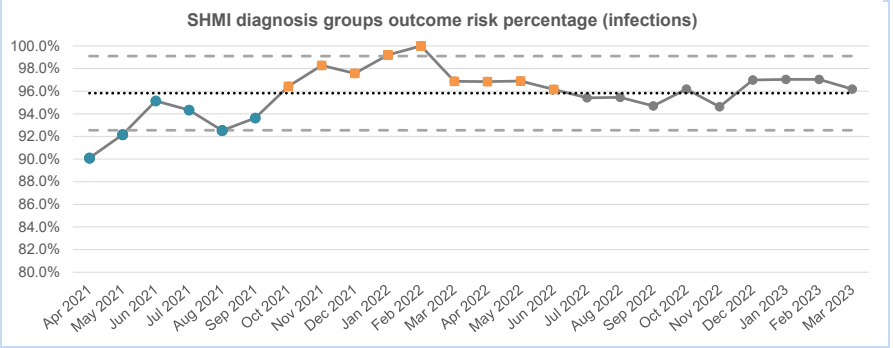
Target
As expected

Variance

Common cause - no significant change

Assurance

Within 'as expected' range



Mar 2023
96.2%

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

This space is intentionally blank

Data Analysis:
HSMR: We are not able to update this data until a new contract is in place which is currently scheduled for November 2023.
SHMI: Performance is stable and continues within the expected range. The data represents a rolling 12 month position.
SHMI diagnosis: The data is stable and has been within the expected range for over a year.

Commentary:
The rolling 12 month SHMI remains within the 'as expected' banding and is stable with the latest value of 102.73 for the period April 2022-March 2023.

The gap in mortality data oversight continues due to no direct access to mortality systems or assurance reports. The Mortality Improvement Group are continuing to review Nationally published NHS digital mortality data to mitigate risk until the trust has access to a new benchmarking system which is expected imminently. The HUTH analysts are now supporting by providing interim mortality data.

SHMI Diagnosis Groups (outcome measure linked to Sepsis quality priority):
The SHMI rate of patients that died with an infection related cause is 96.2 which is below the England average 100 and remains within the expected range.

Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes

Jun 2023
19.0%

Target
No target

Variance

There is insufficient data for variance and assurance

Assurance

There is insufficient data for variance and assurance

This space is intentionally blank

This space is intentionally blank

This space is intentionally blank

This space is intentionally blank

Data Analysis

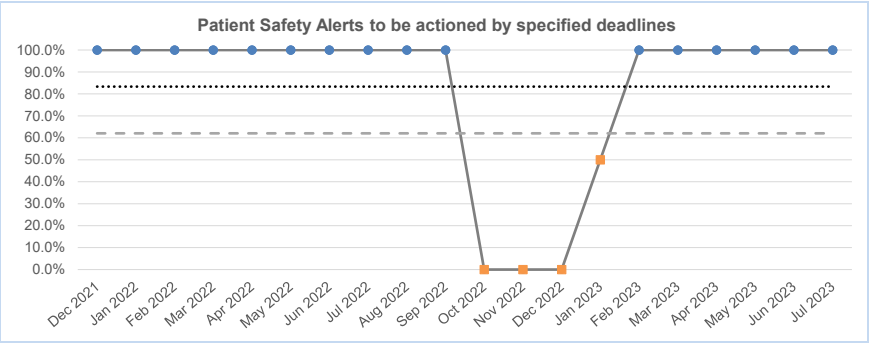
SJRs: This figure is not available every month. June 2023 is the latest date for which data is available. The figures have ranged from 19% to 20%. A chart will be added when there are three data points.

Commentary

The percentage of SJRs sighting problems in care/negative learning associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation was 19% in June 2023 compared to 20% in April 2023.

End of Life Quality Priority:

- Recruitment of 3 additional specialist Palliative care clinical nurse specialists and an end of life practice educator.
- Implementation of 7-day Specialist Pallliative Care commenced at SGH utilising single point for webV referral. Referal data now able from Web V, 98 referrals were submitted in August compared to 56 in July.
- Collaborative working with Care Plus Group, with plans to replicate the 7 day model at DPOW.
- Electronic care in last days of life document successfully trialed on 4 wards. Quality check of data planned before roll out Trust wide.
- Training video created to support staff completing the last days of life document.
- The use of RESPECT forms is now fully rolled out in all areas.



Jul 2023
100.0%

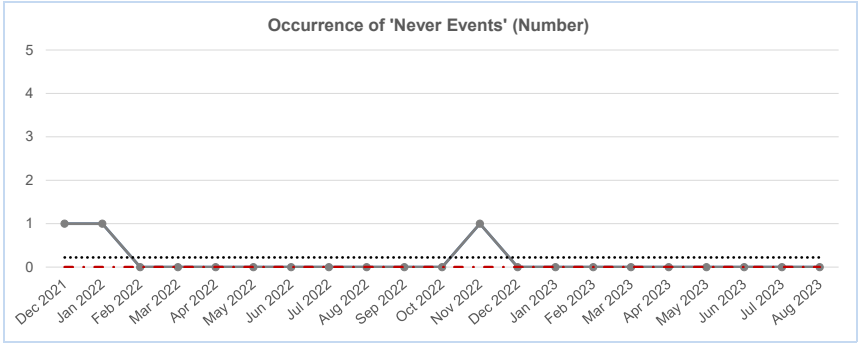
Target
No target

Variance

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

Assurance

There is no target therefore target assurance is not relevant



Aug 2023
0

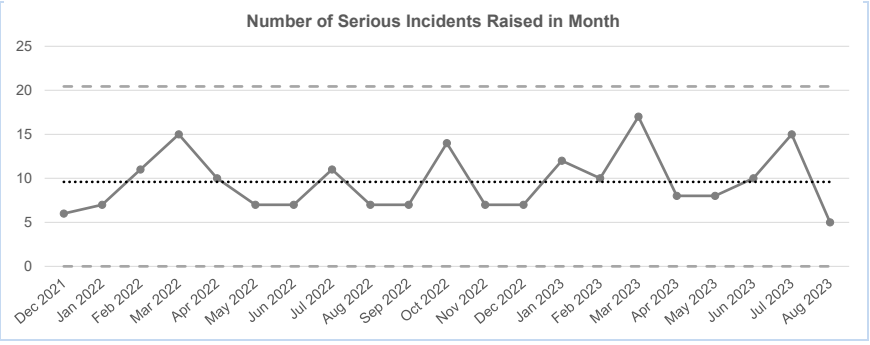
Target
0

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



Aug 2023
5

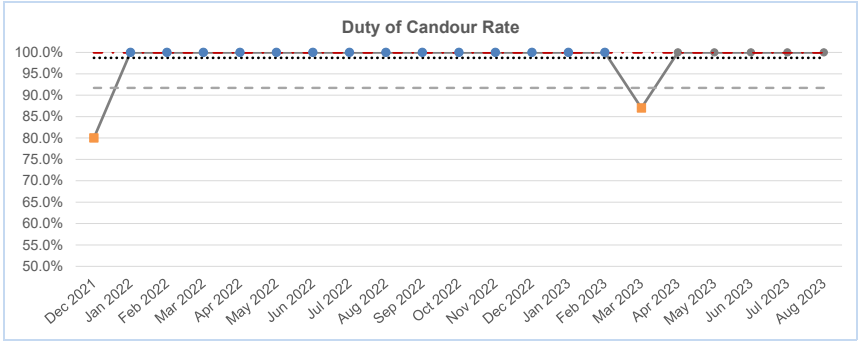
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



Aug 2023
100.0%

Target
100.0%

Variance

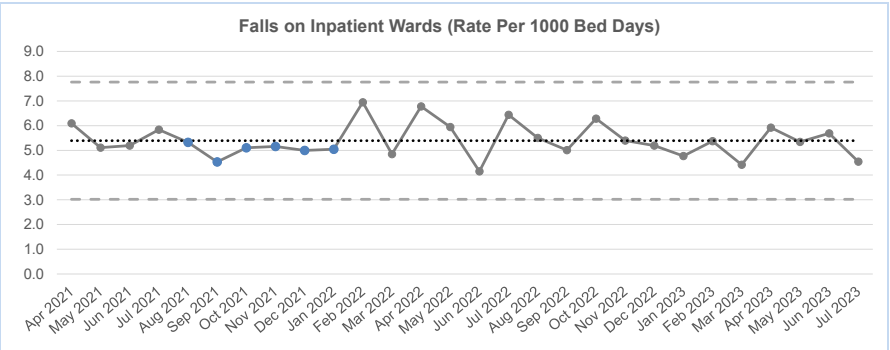
Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target

Data Analysis:
Patient Safety Alerts: Performance is within the expected range and registering improvement. The numbers involved are low.
Never Events: Due to the infrequency of never events an SPC is not appropriate. Never events data are a subset of the serious incidents data.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents. The data is within the expected range of variation.
Duty of Candour: Following a low figure in March the indicator has returned to regularly recording 100%

Commentary:
We continue to manage patient safety alerts, meeting national deadlines for the past 6 months.
Serious incidents reported are within common cause variation and duty of candour rate is maintained at 100%.



Jul 2023
4.5

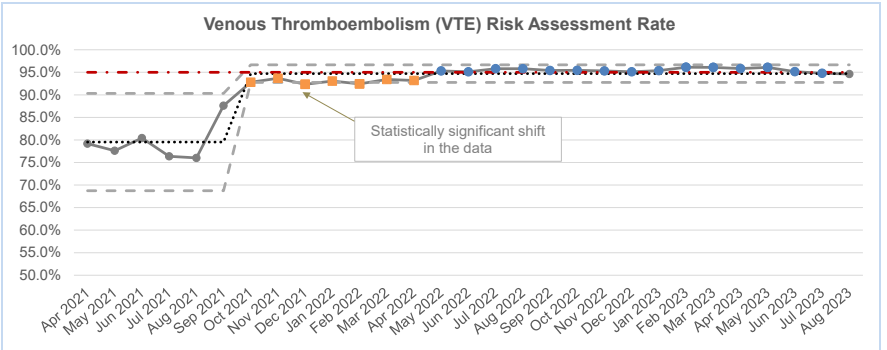
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



Aug 2023
94.6%

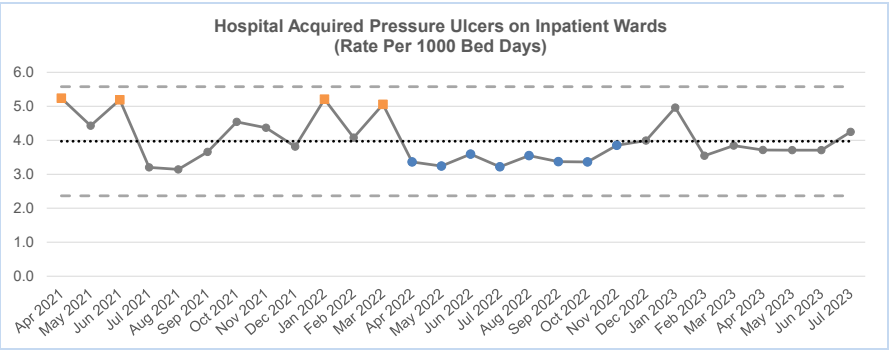
Target
95.0%

Variance

Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target



Jul 2023
4.2

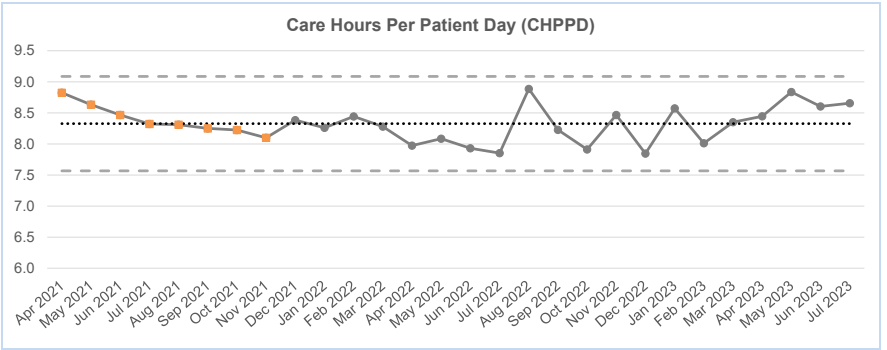
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



Jul 2023
8.7

Target
No target

Variance

Common cause - no significant change

Assurance

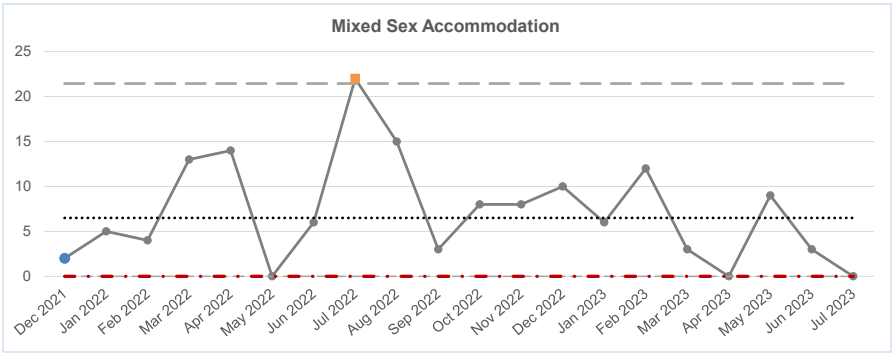
There is no target therefore target assurance is not relevant

Data Analysis:
Falls on Inpatient Wards: Performance is stable and as expected.
VTE Risk Assessment: Performance is within the expected range but has moved out of improvement due to falling below the average of the data. The target will achieve and fail at random.
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.

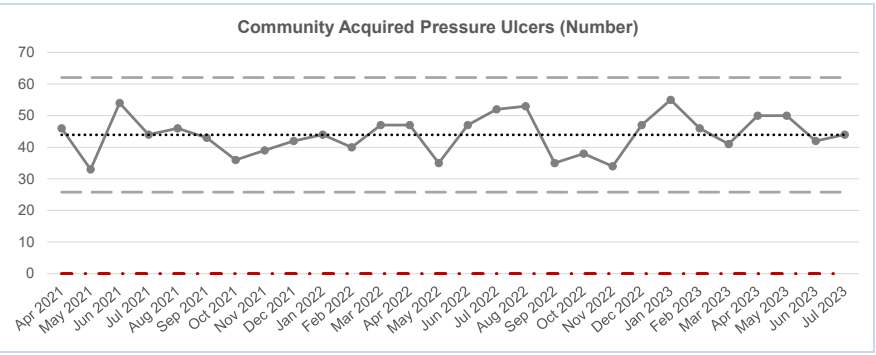
Commentary:
VTE risk assessment rate remains within common cause variation with the same value as last month but is a slight drop (0.4%) below the 95% target.

Falls - The number of reported falls per 1000 Bed Days has decreased slightly and remains within the "as expected" range. Huddles for repeat falls continue to be facilitated by Matrons with actions and learning shared locally and at the Trust's Strategic Falls Group. Huddles for falls with moderate, or greater, harm are facilitated by the Lead Nurse Patient Safety. The AFLOAT assessment tool and supporting documentation has been reviewed and implemented following engagement and feedback from Nursing teams.

Hospital Acquired Pressure Ulcers - There has been a slight increase in the number of reported pressure ulcers however this remains within the "as expected" range. All pressure ulcers reported with moderate harm are now reviewed weekly, as a result, supportive actions can be implemented in a timely manner.



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



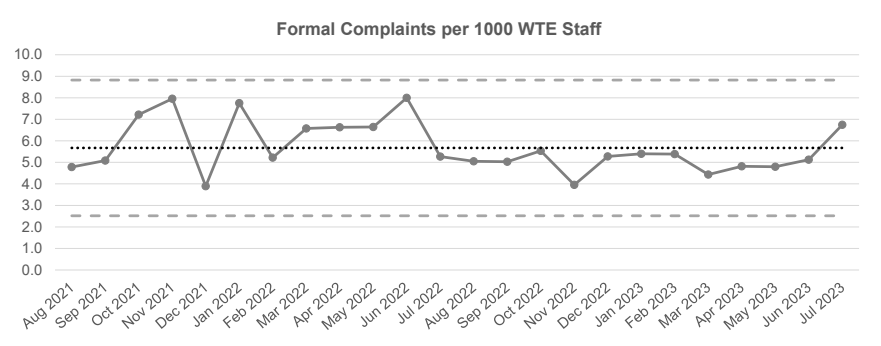
Jul 2023	Target	Variance	Assurance
44	0	Common cause - no significant change	Consistently failing the target

This space is intentionally blank

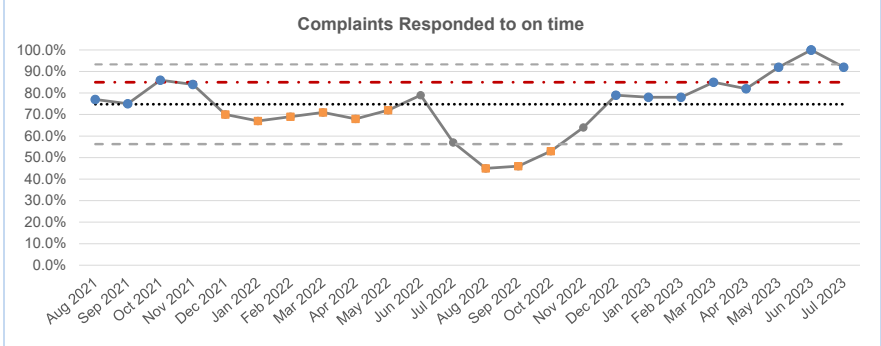
This space is intentionally blank

Data Analysis:
Mixed sex accommodation: Performance is within the expected range of the data and will achieve and fail the target at random.
Community Acquired Pressure Ulcers (Number): Performance is within the expected range of the data. However, the target is unlikely to be met without action.

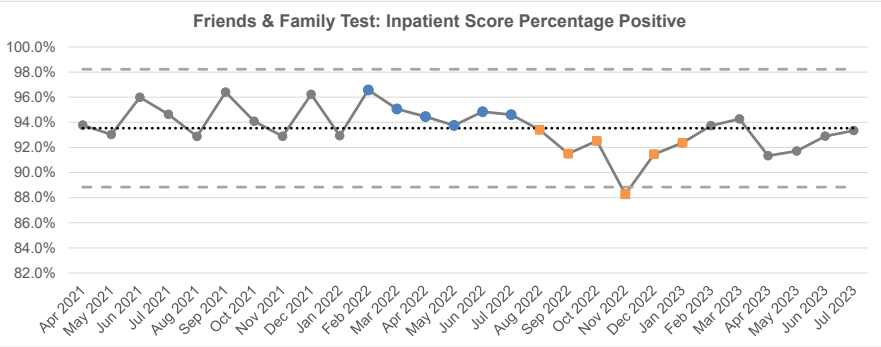
Commentary:



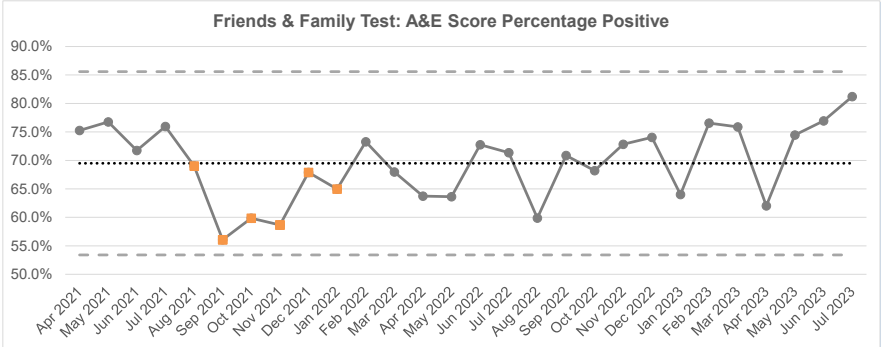
Jul 2023
6.7
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore assurance is not relevant



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



Jul 2023
93.3%
Target
0.0%
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

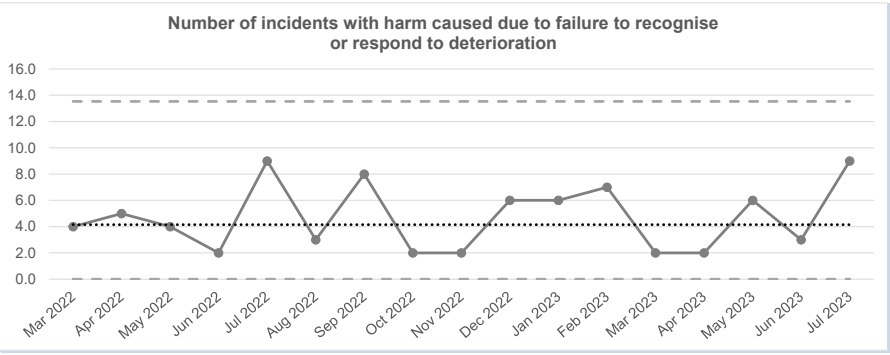


Jul 2023
81.2%
Target
0.0%
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:
Formal Complaints: Performance is stable and continues within the expected range of the data.
Complaints Responded to on time: Performance has recorded higher that the average for the past eight months and is therefore registering improvement. The indicator will achieve and fail the target at random.
FFT Inpatient: The majority of respondents continue to provide positive feedback. The data continues within the expected range.
FFT A&E: The majority of respondents continue to provide positive feedback. The data continues within the expected range.

Commentary:
Formal Complaints
Progress
> Data review as Ullysses extract causing some minor anomilies
> Surgery and Critical Care asked to review their Lead Investigator allocation process as multiple complex complaints being allocated to same people and casuing delays
> Deceased patients family/friend access to complaint process being reviewed with a consent process aligned to Subject Access Request process
> Temporay Patient Experience Manager post extended, at cost pressure, due to risk to both complaint and concerns agenda
Risk
>Small data variance noted
>Delays impacting on divisional and overall Trust position
>Risk of confidentality breech
Mitigations
>Standard Operating Process being written for data extract and inputting on Ulysses
>SPS chart maintained
>Meetings (weekly/fortnightly) re established with Complaint Manager and Surgery and Critical Care
>Pilot deceased patient consent form being trialled
>Business case for Patient Experience Manager being revisited

Friends and Family Test (FFT)
Progress
>Predicted delay to implementation of new provider systems :
- Emergency Department and maternity launch pre new year
- Outpatients, Community, Daycase post new year 2023
- Inpatient will remain paper and is being managed inhouse until provider platform built - this should be by December 2023
>Paper response options circulated to all areas as temporary measure
> All response rates will be signifcantly reduced therefore any assumptions based on positive scores should be taken with caution due to low numbers
Risk
>Impact to Patient Experience Team capacity to undertake work due to interim manual inputting of responses
>Reduced oversight of patient feedback
>Potential further impact of Lorenzo work on progress of FFT project
Mitigations
>Internal interim process in place
>Regular joint meetings with Trust digital team/Patient Experience/ FFT provider to ensure oversight on progress
>Extension of Temporary Patient Experience Manager to support project



Jul 2023
9.0

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

This space is intentionally blank

This space is intentionally blank

This space is intentionally blank

Data Analysis

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

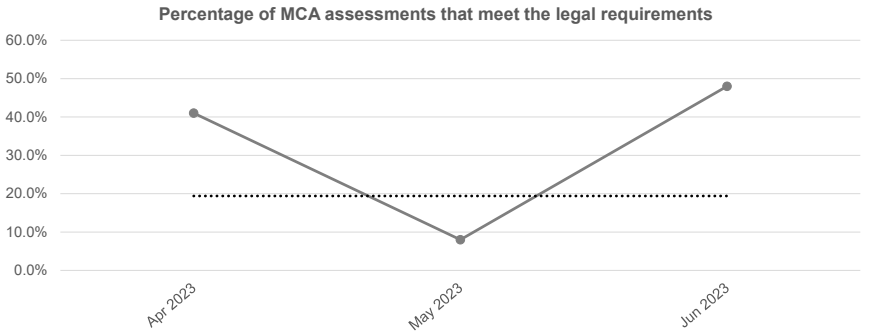
Commentary

9 incidents with low/minor harm were reported in July 2023 but only 8 of these were related to a deteriorating patient. The data is within the expected range with common cause variation. The importance of correctly coding incidents has been highlighted to incident investigators and additional one to one training has been offered by the Risk & Governance Team.

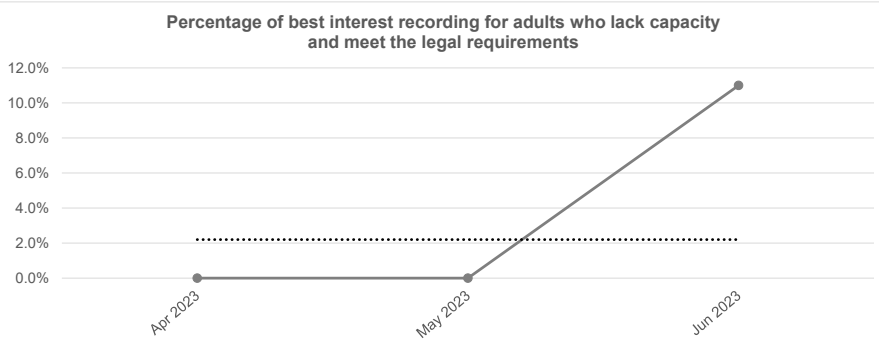
All clinical sisters and ward managers are undertaking applying QI training to focus on deteriorating patient and escalation. Deteriorating patient incidents continue to be monitored through the Deteriorating patient/sepsis group to identify themes and learning.

Number of contacts with the MCA/DoLS team

Aug 2023
0
Target
No target
Variance
There is insufficient data for variance and assurance
Assurance
There is no target, therefore target assurance is not relevant



Jun 2023
48.0%
Target
No target
Variance
There is insufficient data for variance and assurance
Assurance
There is no target, therefore target assurance is not relevant

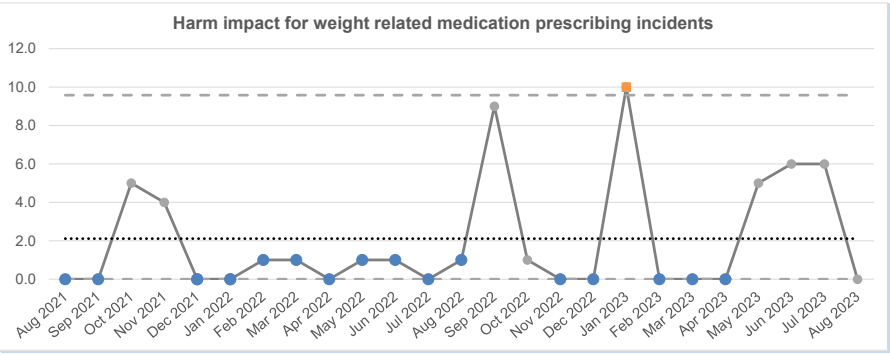


Jun 2023
11.0%
Target
No target
Variance
There is insufficient data for variance and assurance
Assurance
There is no target, therefore target assurance is not relevant

This space is intentionally blank

Data Analysis
MCA/DoLS contacts: A figure of zero has been provided for July 2023 and again for August 2023. A chart will be added when there are three data points.
MCA Assessments: Performance has varied from 8% to 48%.
Best interests: Performance has varied from 0% to 11%.

Commentary
Progress is limited due to single resource in the MCA/DOLS team to support the Mental Capacity quality priority. Recruitment to a deputy MCA/DOLS lead has been successful. A working group with representatives from the divisions continue to meet monhtly for oversight and discussion of quality improvement chnage ideas. An MCA resource folder has been created and implemented on Ward B6. There is a plan in place to roll out the MCA resource folder to all wards. MCA champion standards being drafted to support recruitment of divisional MCA champions. Focussed QI workshop to take place on Ward B6.



Aug 2023
0

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

This space is intentionally blank

This space is intentionally blank

This space is intentionally blank

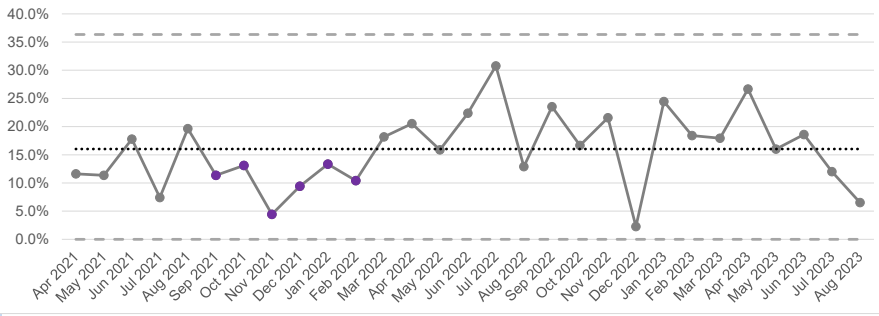
Data Analysis

Harm impact: Performance continues to be sporadic ranging from zero to 10 over the past two years.

Commentary

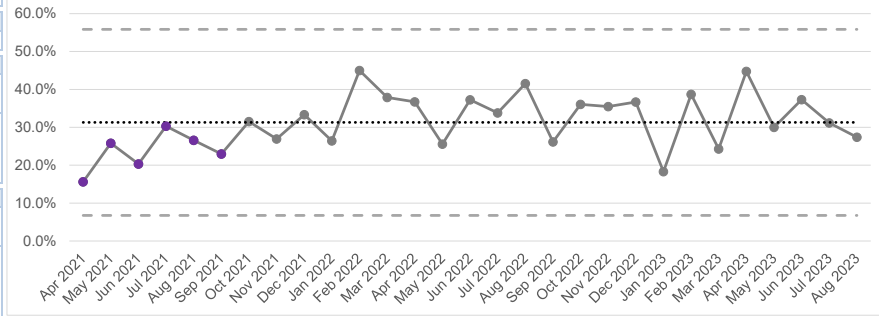
In August 2023 there were 0 no harm / low harm incidents. All medication related incidents are discussed at the Safer Medication Group to raise awareness and share learning.

Robson Scores - Group 1



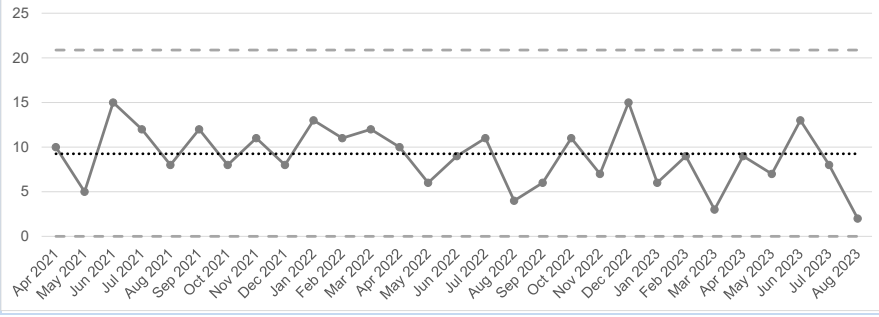
Aug 2023
6.5%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Robson Scores - Group 2



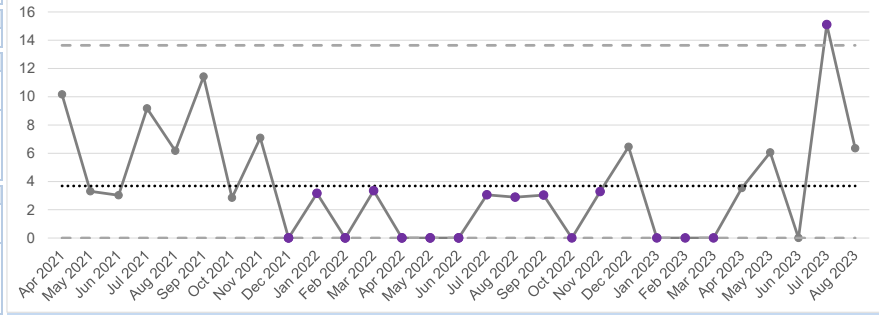
Aug 2023
27.4%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Number of Deliveries With Post Partum Haemorrhage > 1500 ml



Aug 2023
2
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

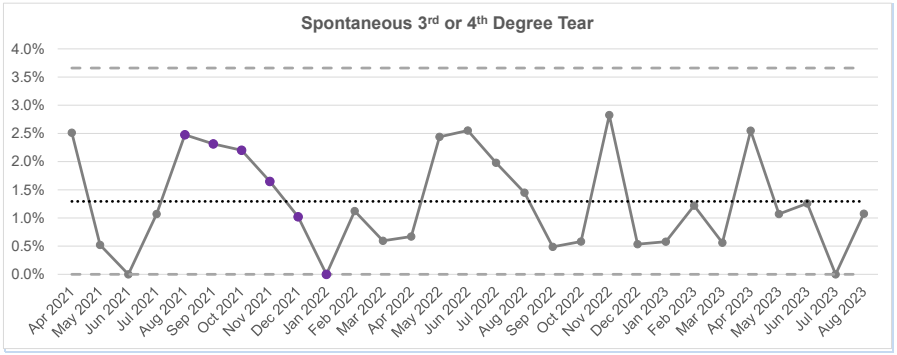
Still Birth Rate per 1000



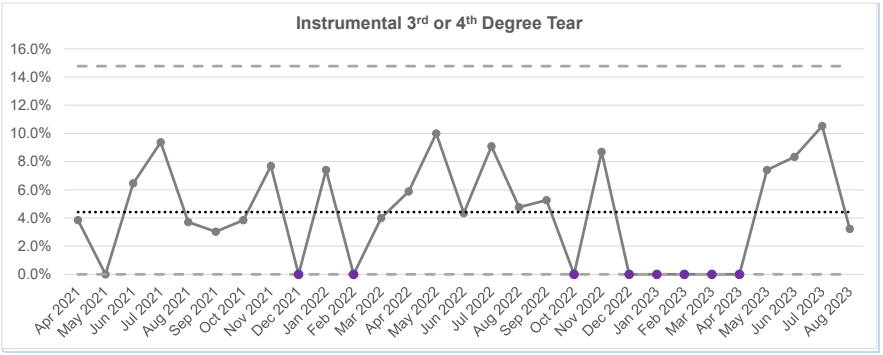
Aug 2023
6.3
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:
Robson Scores 1: Performance is within the expected range of the data.
Robson Scores 2: Performance is within the expected range of the data
PPH > 1500 ml: Performance is within the expected range of the data
Still birth rate per 1000: Although several months record a value of zero, performance continues to be sporadic ranging from zero to 15 over the past two years.

Commentary:



Aug 2023
1.1%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



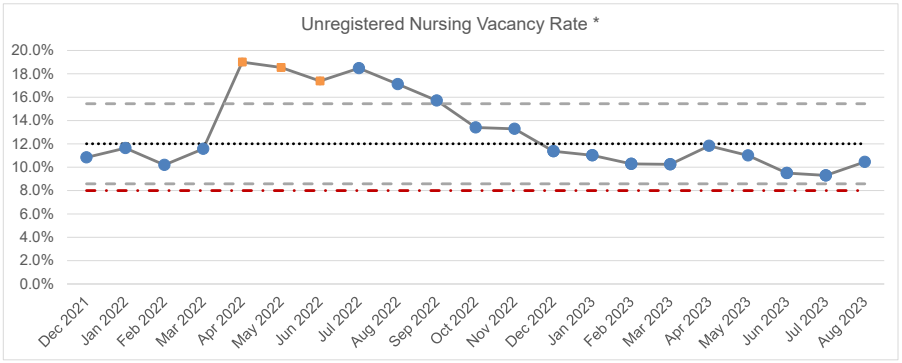
Aug 2023
3.2%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

This space is intentionally blank

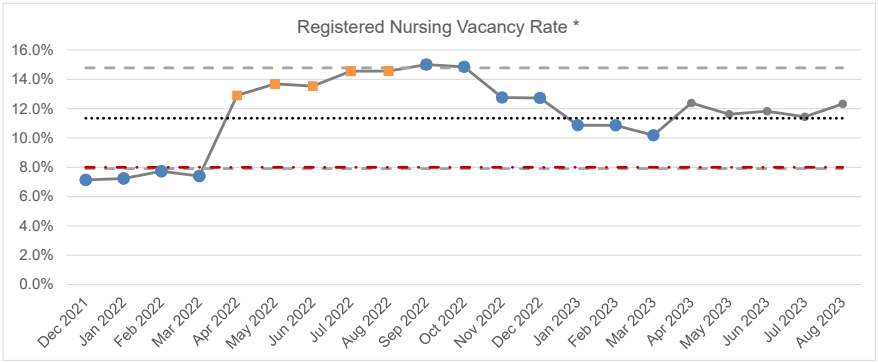
This space is intentionally blank

Data Analysis:
Spontaneous 3rd or 4th degree tear: Performance is stable and within the expected range.
Instrumental 3rd or 4th degree tear: Performance is stable and within the expected range.

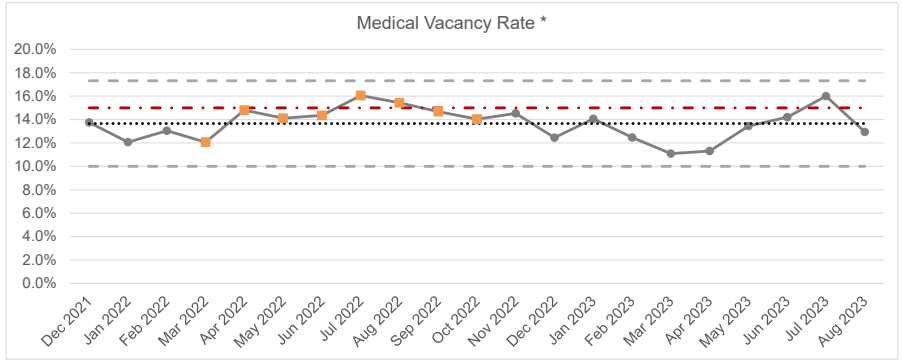
Commentary:



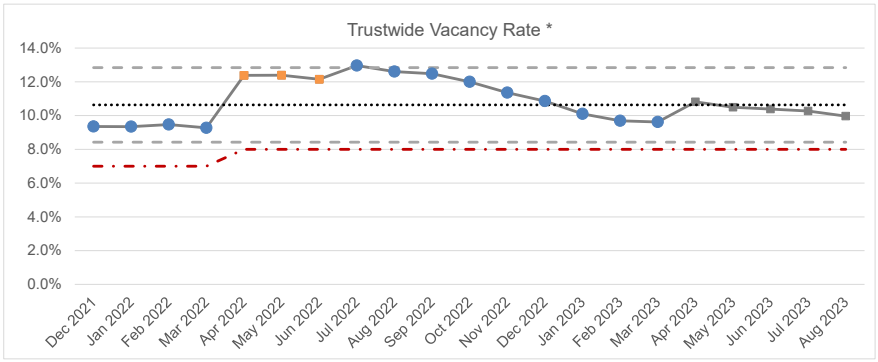
Aug 2023	Target	Variance	Assurance
10.5%	8.0%	Special cause of improving nature or lower pressure due to lower values	Consistently failing the target



Aug 2023	Target	Variance	Assurance
12.3%	8.0%	Common cause - no significant change	Inconsistently hitting passing and failing the target



Aug 2023	Target	Variance	Assurance
12.9%	15.0%	Common cause - no significant change	Inconsistently hitting passing and failing the target



Aug 2023	Target	Variance	Assurance
10.0%	8.0%	Common cause - no significant change	Consistently failing the target

Data Analysis:
Unregistered Nursing Vacancies: Performance remains within the expected range of the data with the last 14 months registering improvement. Current data indicates that the target will not be met without action.
Registered Nursing Vacancies: Performance is stable and within the expected range of the data. Current data suggests that the target is unlikely to be met without action.
Medical Vacancy Rate: Performance is stable and within the expected range of the data. The indicator can be expected to achieve and fail the target at random.
Trustwide Vacancy Rate: Performance is stable and within the expected range of the data. Current data indicates that the target will not be met without action.

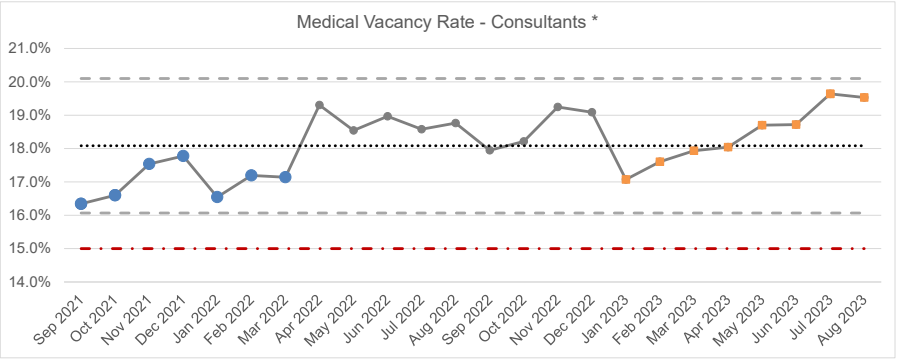
Commentary:
This month sees an increase in the vacancy position due to an in-month establishment increase of 12 WTE, taking the total investment and increase in Unregistered Nursing budgeted establishment to 46 WTE since April. Despite this a general downward trend in the vacancy rate can be seen. In addition to the Pool process Medicine and Surgery have expressed an interest in running Division specfic HCA recruitment projects which the recruitment team are now working with the groups to implement - this will include a review of the selection process and implementing enhanced selection processes where necessary. Work to widen participation and engage with underrepresented groups is ongoing, including work wiht DWP. Regular meetingswith the NHSI/E HCSW Programme Lead for support and accountabilty are ongoing. Despite increase in establishment forecasts are currently expecting the Unregistered nursing staff group to better initial forecasts and reach 39 WTE vacancies by the end of the financial year.

This month shows an increase in the vacancy rate for Registered Nursing. This is due to a further establishment increase of 25 WTE in month. Despite an increase in 70WTE in the budgeted establishment since April recruitment is keeping pace with these increases with a slight downward trend in the vacancy position overall since April. Ongoing engagement with international nurses sourced in Kerala is ongoing with 14 arriving in September and an additional cohort now planned in for January. Engagement with Newly Qualified Nurses is underway, with numbers currently exceeding target, and conversations taking place to allow for overestablishments in areas to reduce withdrawal rates. Planning is now underway for a further recruitment project in Kerala in November 2023 to recruit circa 20 - 30 further international nurses. Forecasts are currently expecting the Registered Nursing staff group to reach 49 WTE vacancies by the end of the financial year. This is an increase over the initial plan of 33 WTE due to increases in establishment impacting upon the forecast and a revised plan will be developed.

Commentary Vacancies Cont/d:

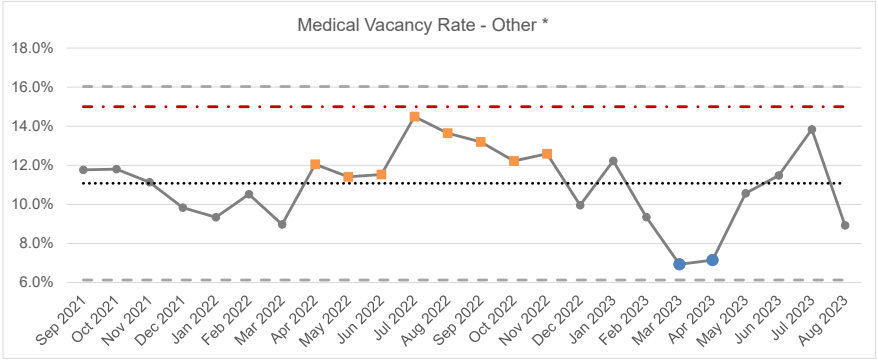
An establishment increase of 26 WTE since April has negatively impacted upon the vacancy rate for Medical Staff overall, however August saw a recovery in the vacancy position, this is following the trend of non-training doctors leaving to take up other opportunities July, and backfill of locally appointed doctors starting to replace these doctors commencing in August. 11 non-training doctors across grades are scheduled to start in September . In addition engagement with the existing pipeline of a further 32 medical staff is ongoing to facilitate starts as soon as possible.Sourcing of senior medical staff via the Talent Acquisition Team following the appointment of an additional Recruitment Specialist has commenced. This is initially focussed upon Emergency Medicine and Acute Medicine Consultant and Specialty Doctor roles, as identified as the highest spend areas. Further Kerala recruitment project planning is underway,with the visit scheduled to take place November 2023 to recruit to Emergency Medicine, Acute Medicine, and Radiology.

Establishment increases of 152 WTE since April have impacted upon the Trustwide vacancy position. Despite this the vacancy rate is showing a downward trend. Various staff group specific projects are underway to impact Registered Nursing, Unregistered Nursing, and Medical Staff. Trustwide recruitment continues at an elevated level with the recruitment team supporting by making 217 offers in month and starting 308 new starters. In August there were 172 active vacancies being recruited to, and 4385 applications received and processed.



Aug 2023
19.5%
Target
15.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently failing the target

This space is intentionally blank



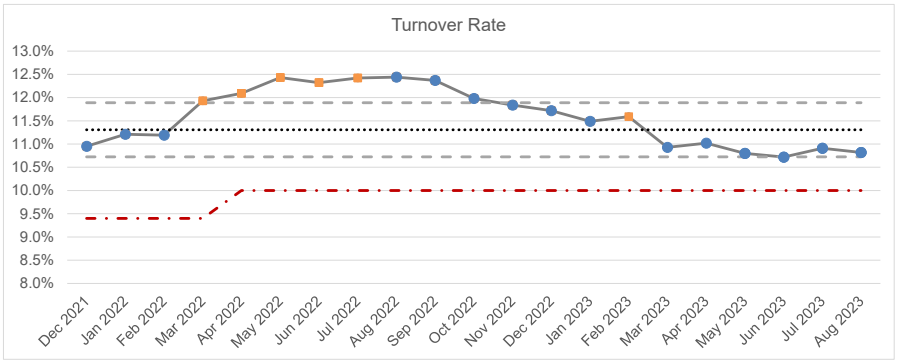
Aug 2023
8.9%
Target
15.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target

This space is intentionally blank

Data Analysis:
Medical Vacancy Rate - Consultants: The indicator continues to record concern with a generally increasing trend. Current data indicates that the target will not be met without action.
Medical Vacancy Rate - Other: The data remains within the expected range. The target lies between the process limits which usually suggests that the target will achieve and fail at random. However, the indicator continues to achieve the target. Data fluctuations mean that this is not reliable.

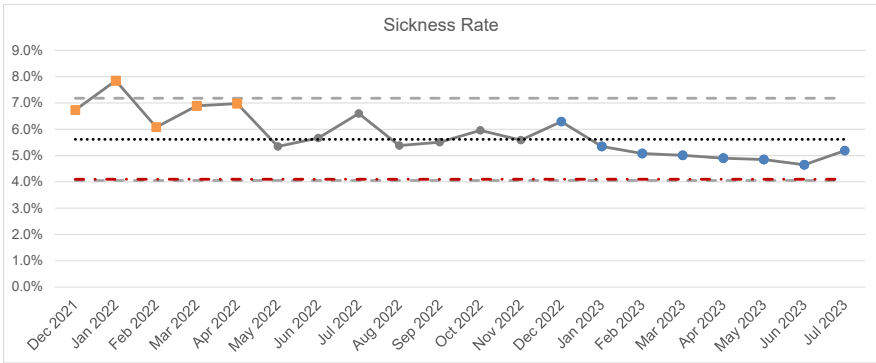
Commentary:
An establishment increase of 10 WTE Consultant posts since April has negatively impacted the vacancy position, however this month sees a reduction in the vacancy rate due to Consultant starts.. A further pipeline of Consultants has been established with 6 Consultants appointed awaiting start, with engagement ongoing to facilitate starts as soon as possible. Sourcing of senior medical staff via the Talent Acquisition Team has commenced with an initial focus upon Emergency Medicine and Acute Medicine as high spend areas with higher vacancy factors in senior grades. Work continues to design and implement a CESR support programme to support employees towards being granted specialist GMC Registration and appointment into substantive Consultant roles.

An establishment increase of 16 WTE other medical staff has negatively impacted the vacancy position. However the vacancy position has decreased in month following the commencement of medics to backfill those junior doctors who left in July (as per expected yearly trend), with further work ongoing to appoint and start locally appointed backfill to training vacancies. A pipeline of a further 26 non-Consultant medical staff has been established awaiting start. Specialty Doctors will be targeted for Acute Medicine and Emergency Medicine as part of the Talent Acquisition Team sourcing work which has now commenced.



Aug 2023
10.8%
Target
10.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target

This space is intentionally blank



Jul 2023
5.2%
Target
4.1%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

This space is intentionally blank

Data Analysis:
Turnover Rate: Performance remains within the expected range of the data and is currently registering improvement due to recording values below than the average. However, the target is unlikely to be met without action.
Sickness Rate: Over the past eight months the indicator has registered improvement. As a result the target is now within the process limits, suggesting the target may achieve and fail at random.

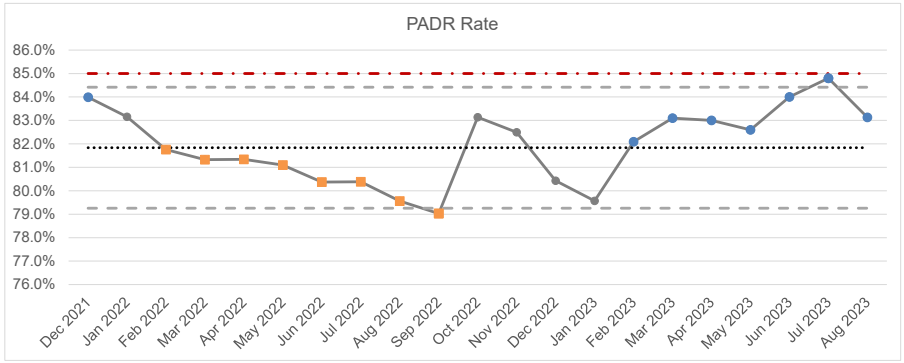
Commentary:

Medicine
•continue to improve employee cycle experience from interview to exit process as per last months activity including support/adjustments to and redeployment to prevent avoidable resignations and case reviews.
•engagement events continue , focus on local colleague recognition and reward
•continue 'Stay' interviews and exit interview analysis
Family Services continue to focus on the staff survey action plan, star of the month award, supporting staff to attend training in addition to mandatory training, managers attending values based leadership course. We are also planning to implement career clinics across the division.
Surgery
Continuing to focus upon reward and recognition within the division in terms of retention – divisional star of the month, utilising the 'thank you' service, work on improving culture
Within C&T ongoing work regarding career development through leadership and development courses, apprenticeship and training opportunities and succession planning. Career conversations part of cultural norm within C&T.
E&F
Actively encourage staff to develop within the NHS so ancillary staff move internally to eg. HCA roles, turnover rate is affected.
New expression of interest process enables staff to easily move rotas within Facilities services more suited to current demands- supports work-life balance. Continue to monitor absence rates and working closely with managers to understand higher absence rates in some areas. Engaging with staff directly to explore "quick wins" to improve their wellbeing: Developping wellbeing boards,seeking a volunteer in each area to maintain these boards.
corporate : continue with inclusivity events and summer leadership events to promote engagement, trustwide service, civility and respect, improve on range of staff benefits including staff lottery superprize draw.

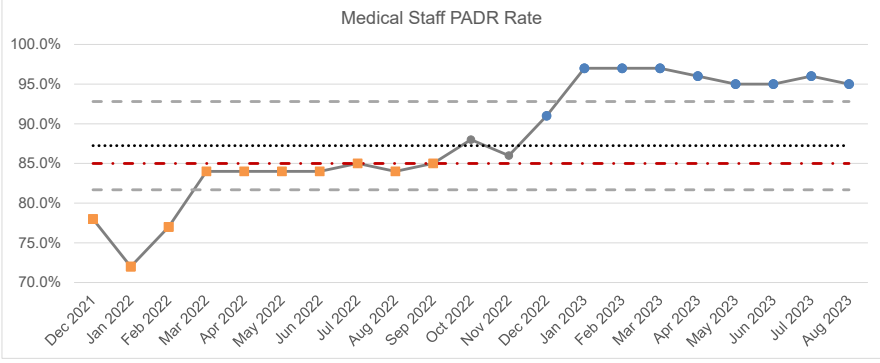
The sickness rate has raised slightly from 4.65% to 5.1% which is disappointing given our previous months position and the downward trend. On initial review of the detail, areas of concern have been highlighted and there is robust management of cases with input from the team. The HR team have been working closely with the managers to ensure the reason for absence is recorded correctly and the use of 'reason unknown' is not used to ensure we have a clear understanding as to the reasons for absence. The main reason for absence remains anxiety/stress/depression, the HR team work closely with the OD lead for health and wellbeing which continues in order to identify areas where staff can be further supported. Part of this workstream is the review of the stress risk assessment process and policy which is estimated to be complete and implemented by the end of November.
In order to further support the training provision and develop exisiting and new line managers the team are working on short 'how to' videos on key areas such as conducting sickness meetings, return to work interviews and preparing for the case review hearing.

The planned managing attendance audits will take place in Sep/Oct and aimed at helping to identify those areas of focus where we are not already aware.

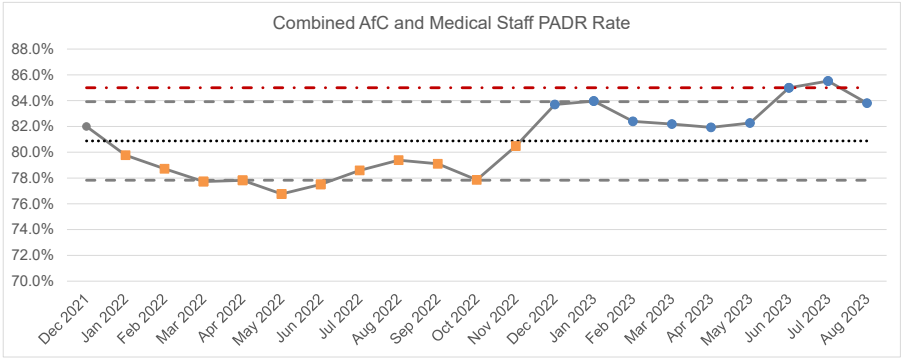
HRBP's are leading the work with the management teams to review the sickness data looking at patterns and any themes at the monthly workforce challenge groups/meetings, then where appropriate engaging directly with the individulas to ensure all wellbeing needs are met and to explore if there are any quick wins we can achieve to improve attendance at work.
Across the divisions there continues to be an increase in the number of case reviews in relation to both long term and short term absence. The conclusion of the long term cases will have a positive impact in the reduction of the sickness rate.



Aug 2023	Target	Variance	Assurance
83.1%	85.0%	Special cause of improving nature or lower pressure due to higher values	Consistently failing the target



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



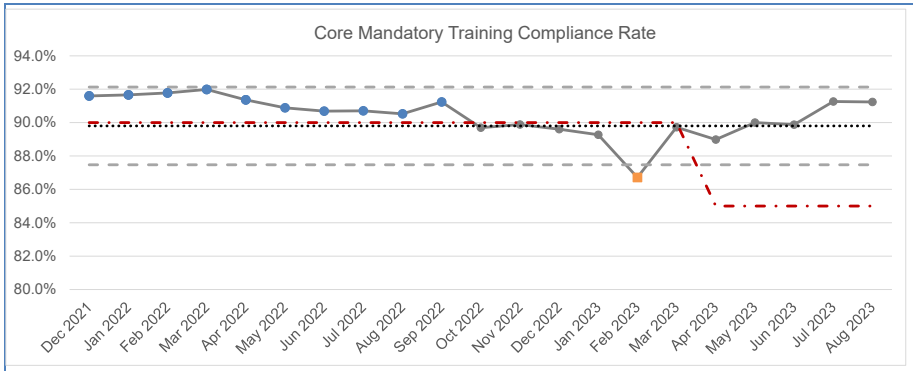
Aug 2023	Target	Variance	Assurance
83.8%	85.0%	Special cause of improving nature or lower pressure due to higher values	Consistently failing the target

This space is intentionally blank

Data Analysis:
PADR Rate: The indicator has registered improvement for the last seven months. However, current data indicates that the target is unlikely to be met without action.
Medical Staff PADR Rate: There has been significant improvement over the last nine months. Performance is now above the expected range and has achieved the target for the past year.
Combined AfC and Medical Staff PADR Rate: The indicator has registered improvement for the last nine months. The target has been achieved twice during that time. However, this is not yet reliable.

Commentary:
The Trust PADR compliance rate has reduced by 1.7% and is now below target. This is due to the amount of Agenda for Change PADR's due to come out of compliance each year in August. The ESR Team continue to support managers around PADR compliance with myth busting, gentle reminders and education.

Commentary:
The RO/CMOD office continues to support and provide the necessary resources for doctors to engage in appraisal in a timely manner. The process whereby doctors whose appraisals are delayed continues to function at a level whereby there is early intervention, in the form of communication and support, until appraisal is complete.



Aug 2023
91.2%

Target
85.0%

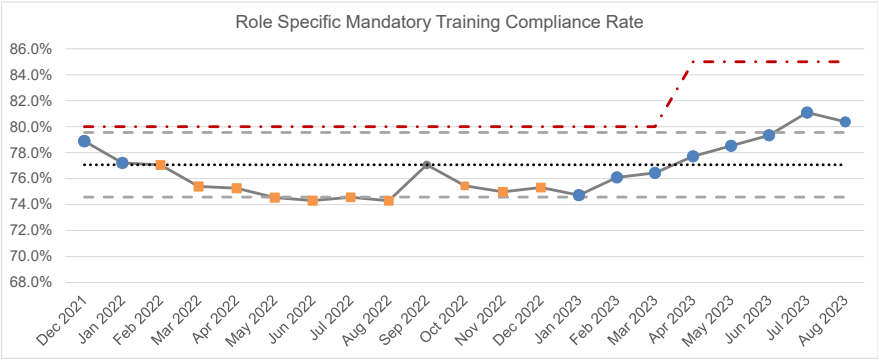
Variance

Common cause - no significant change

Assurance

Consistently passing the target

This space is intentionally blank



Aug 2023
80.4%

Target
85.0%

Variance

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

Assurance

Consistently failing the target

This space is intentionally blank

Data Analysis:
Core Mandatory Training: Performance is stable and within the expected range of the data. The target will reliably be achieved.
Role Specific Mandatory Training: The indicator has registered improvement for the past eight months with the most recent two months higher than the upper process limit. However current data indicates that the target will not be met without action.

Commentary:

Core mandatory training compliance has remained stable with only a 0.02% variation since the previous report. Fire Safety and Preventing Radicalisation – Advanced Prevent Awareness remain the lowest compliance for all core mandatory training at 76.70% and 79.94% respectively (@ 5.9.23). Both competencies continue to show a slight increase from the previous report through targeted intervention to those staff out of compliance. Fire Safety has, also, seen a slight decline in wasted spaces to classroom delivery with 183 withdrawals / DNA in August (-20 from the previous month). Information Governance and Data Security also remains an area of focus with a current compliance of 89.15% (with 718 currently out of compliance), remaining 5.85% below the target of 95% for this compliance. Data relating to these key areas is now included in monthly divisional reports sent to HRBPs for Medicine, Surgery and Critical Care, Family Services, and Therapy and Community, who are then able to cascade this information via relevant divisional meetings. In addition, for the remainder of September, Training and Development administrators will target emails to those out of compliance in staff group Medical and Dental, whose overall compliance for core mandatory training is 74.65% (@ 5.9.23), 10.35% below the Trust target.

Role specific mandatory training has seen a slight decline (-0.71%) since the previous report and is currently 80.38%. Competencies with the lowest role specific compliance are: Moving and Handling – Module 11 (once only) @ 56.63%, Moving and Handling – Module 4L (community) @ 59.88%, and NG Tube Displacement @ 56.79% (data correct @ 5.9.23). Moving and Handling – Module 11 (once only) is a competency required by doctors and has been impacted recently by the doctors' strikes and the increase in those requiring the competency following the new intake of doctors to the Trust. The Moving and Handling team continue to be flexible in their approach to supporting improvements in this competency; rebooking places where doctors are not able to attend their original booking, reducing the time required to complete the competency, and merging classes where possible to prevent cancellations. Similarly, for Module 4L, the team have reviewed planning to ensure sufficient places are made available for the remainder of the year. Wasted spaces through withdrawal and DNA continue to impact moving and handling, with a further 250 WD/DNA reported in August. The process is now established to ensure managers are made aware of this and the team have been asked to analyse key reasons given for non-attendance. Overall moving and handling compliance (all modules) has, however, improved by 3% since July and continues on an upward trajectory. NG Tube Displacement is also a requirement for doctors to complete and has, again, been impacted by the increase in numbers through the recent intake of new doctors. Overall role specific compliance for staff group Medical and Dental is currently 68.52% (@ 5.9.23), 19.48% below the Trust target so reminder emails to all those out of compliance within this staff group will be sent out via Training and Development administrators for the remainder of September. In addition, divisional monthly reports continue to be sent to HRBPs and include the following role specific competencies - Moving and Handling, Resus, Deteriorating Patient, Level 3 Safeguarding Adults and Children, and Corporate Induction. These reports are cascaded by the HRBPs via relevant divisional meetings so that managers are fully aware of attendance / DNA concerns and can action accordingly.

IPR Appendix A - 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 organisations. 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 19/09/2023

* 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	Aug 23	61.1%	92.0%	59	71 / 170	Jul 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Aug 23	834	0	58	72 / 170	May 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Aug 23	36.6%	1.0%	18	129 / 157	Jun 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Aug 23	48.4%	85.0%	21	106 / 134	Jul 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Aug 23	65.4%	95.0%	14	111 / 144	Jul 23
	Urgent Care	Number Of Emergency Department Attendances	Aug 23	14,226	No target	45	85 / 144	Jul 23
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Aug 23	542	0	9	130 / 153	Jul 23
	Flow	Bed Occupancy Rate (General & Acute)	Aug 23	93.8%	92.0%	37	98 / 156	Q1 23/24
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Aug 23	6.2%	5.0%	62	60 / 156	Jul 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Jul 23	0.00	No target	90	47 / 136	Jun 23
	Infection Control	Number of E Coli Infections	Jul 23	0.30	No target	50	68 / 136	Jun 23
	Infection Control	Number of Trust Attributed C-Difficile Infections	Jul 23	0.15	No target	97	5 / 136	Jun 23
	Infection Control	Number of MSSA Infections	Jul 23	0.10	No target	78	31 / 136	Jun 23
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Mar 23	102.7	As expected	39	74 / 120	Apr 23
	Safe Care	Number of Serious Incidents Raised in Month	Aug 23	5	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Jul 23	8.7	No target	39	117 / 192	Jun 23
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Aug 23	94.6%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Jul 23	6.7	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Percentage Positive Inpatient Scores	Jul 23	93.3%	No target	73	36 / 133	Jul 3

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Jul 23	5.2%	4.1%	40	128 / 213	Apr 23

IPR Appendix B
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*	Aug 2023	61.1%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Aug 2023	834	0	Alert			Board
	Total Inpatient Waiting List Size	Aug 2023	11,960	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Aug 2023	36.6%	1.0%	Alert			Board
	Number of Incomplete RTT pathways 65 weeks	Aug 2023	115	No Target			n/a	Board
	Number of Incomplete RTT Pathways*	Aug 2023	40,908	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Aug 2023	16,743	No Target			n/a	FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Aug 2023	47.6%	37%	Alert			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Aug 2023	38,224	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Aug 2023	6.2%	5.0%	Alert			Board
	% Outpatient Non Face To Face Attendances	Aug 2023	18.2%	25.0%	Alert			Board
	% Outpatient summary letters with GPs within 7 days	Jul 2023	60.5%	50.0%	Alert			FPC
	Advice and Guidance as a Percentage of all Referrals	Aug 2023	10.5%	No Target			n/a	FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Aug 2023	84.1%	99.0%	Alert			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Aug 2023	31.4%	23.0%	Alert			FPC
	Patient Initiated Follow Up	Aug 2023	2.9%	5.0%	Alert			FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Aug 2023	48.4%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Aug 2023	26	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Aug 2023	9.1%	75.0%	Alert			Board
	Cancer Request To Test In 7 Days*	Aug 2023	52.3%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Aug 2023	96.4%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Aug 2023	88.5%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Aug 2023	73.7%	75.0%				FPC
	Cancer Request To Test In 14 Days*	Aug 2023	85.5%	100.0%	Alert			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Aug 2023	93.2%	96.0%				FPC
	Cancer Waiting Times - Cancer 62-day backlog	Aug 2023	115	No Target			n/a	FPC
	Cancer Waiting Times - 62 day Screening*	Aug 2023	62.5%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Aug 2023	65.4%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Aug 2023	14,226	No Target	Alert		n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Aug 2023	201	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Aug 2023	542	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge Aug 2023		247	0	Alert			Board
	Number of UCS Attendances	Aug 2023	5,469	No target	Alert		n/a	FPC
	% UCS Waiting Times (4 Hour Performance)	Aug 2023	99.4%	92.0%				FPC
	Ambulance Handover Delays - Number 30-60 Minutes	Aug 2023	295	No Target			n/a	FPC
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase) Aug 2023		41.5%	40.0%				Board
	% of Extended Stay Patients 21+ days	Aug 2023	11.6%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Aug 2023	2.1	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Aug 2023	3.3	3.9				Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Aug 2023	97.6%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Aug 2023	15.6%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Aug 2023	93.8%	92.0%	Alert			Board
	Percentage of patients re-admitted as an emergency within 30 days	Aug 2023	8.3%	No Target			n/a	FPC
	Percentage of Daycase Spells From Elective Activity	Aug 2023	90.9%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Aug 2023	46.8%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Aug 2023	22.1%	No Target			n/a	FPC
	% Inpatient Discharges Before 17:00	Aug 2023	68.2%	80.0%	Alert			FPC
Theatre	Theatre Session Utilisation (Core Capacity)	Aug 2023	56.0%	No Target			n/a	FPC
	Theatre In Session Capped Utilisation	Aug 2023	82.8%	No Target			n/a	FPC
	Theatre In Session Non-Capped Utilisation	Aug 2023	83.4%	No target			n/a	FPC

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	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Jul 2023	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jul 2023	0.30	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jul 2023	0.15	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jul 2023	0.10	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jul 2023	0.35	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected		L	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Mar 2023	102.7	As expected			As expected	Board
	SHMI diagnosis groups outcome risk percentage (infections)	Mar 2023	96.2%	No target			n/a	Board
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Jun 2023	19.0%	No target		n/a	n/a	Board
	Percentage of in hospital deaths with anticipatory medication prescribed	Mar 2023	10.7%	No target		L	n/a	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Jul 2023	100.0%	No target		H	n/a	Board
	Number of Serious Incidents raised in month	Aug 2023	5	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Aug 2023	0	0		n/a	n/a	Board
	Duty of Candour Rate	Aug 2023	100.0%	100.0%			?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2023	4.5	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jul 2023	4.2	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Aug 2023	94.6%	95.0%			?	Board
	Care Hours Per Patient Day (CHPPD)	Jul 2023	8.7	No target			n/a	Board
	Mixed Sex Accommodation Breaches	Jul 2023	0.0	0			?	Board
	Community Acquired Pressure Ulcers (Number)	Jul 2023	44.0	0	Alert		F	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Jul 2023	6.7	No target			n/a	Board
	Complaints Responded to on time	Jul 2023	92.0%	85.0%		H	?	Board
	Friends & Family Test: Inpatient Score Percentage Positive	Jul 2023	93.3%	0%			n/a	Board
	Friends & Family Test: A&E Score Percentage Positive	Jul 2023	81.2%	No target			n/a	Board
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Jul 2023	9.0	No target			n/a	Board
	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Aug 2023	92.4%	90.0%		H	?	Q&S
	Recording of and response to NEWS2 score for unplanned critical care admissions	Jun 2023	61.5%	30.0%		n/a	n/a	Q&S
Mental Capacity	Number of contacts with the MCA/DoLS team	Aug 2023	0.0	No target		n/a	n/a	Board
	Percentage of MCA assessments that meet the legal requirements	Jun 2023	48.0%	No target		n/a	n/a	Board
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Jun 2023	11.0%	No target		n/a	n/a	Board
Sepsis	Percentage of paediatric primary sepsis screenings using national risk stratification criteria	Aug 2023	No Data	No target		n/a	n/a	Q&S
	Percentage of Adult Sepsis screening completed within 15 minutes in response to elevated NEWS2 score	Aug 2023	26.4%	90.0%	Alert	H	F	Q&S
Prescribing	Harm impact for weight related medication prescribing incidents	Aug 2023	0	No target			n/a	Board
	Actual weight recorded on Web V within 24 hours of admission	Aug 2023	No Data	No target		n/a	n/a	Q&S
	Weight recorded on EPMA matches actual weight recorded in Web V	Aug 2023	No Data	No target		n/a	n/a	Q&S
Maternity	Robson Scores - Group 1	Aug 2023	6.5%	No target			n/a	Board
	Robson Scores - Group 2	Aug 2023	27.4%	No target			n/a	Board
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Aug 2023	2	No target			n/a	Board
	Still Birth Rate per 1000	Aug 2023	6.3	No target			n/a	Board
	Spontaneous 3rd or 4th Degree Tear	Aug 2023	1.1%	No target			n/a	Board
	Instrumental 3rd or 4th Degree Tear	Aug 2023	3.2%	No target			n/a	Board

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 *	Aug 2023	10.5%	8.0%	Alert			Board
	Registered Nurse Vacancy Rate *	Aug 2023	12.3%	8.0%				Board
	Medical Vacancy Rate *	Aug 2023	12.9%	15.0%				Board
	Trustwide Vacancy Rate *	Aug 2023	10.0%	8.0%	Alert			Board
	Medical Vacancy Rate - Consultants *	Aug 2023	19.5%	15.0%	Alert			Board
	Medical Vacancy Rate - Other *	Aug 2023	8.9%	15.0%				Board
Staffing Levels	Turnover Rate	Aug 2023	10.8%	10.0%	Highlight			Board
	Sickness Rate	Jul 2023	5.2%	4.1%				Board
Staff Development	PADR Rate	Aug 2023	83.1%	85.0%	Alert			Board
	Medical Staff PADR Rate	Aug 2023	95.0%	85.0%				Board
	Combined AfC and Medical Staff PADR Rate	Aug 2023	83.8%	85.0%	Alert			Board
	Core Mandatory Training Compliance Rate	Aug 2023	91.2%	85.0%				Board
	Role Specific Mandatory Training Compliance Rate	Aug 2023	80.4%	85.0%	Alert			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Aug 2023	3	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Aug 2023	0	12				WFC
	Number of Suspensions Live in Month	Aug 2023	1	No Target	Highlight		n/a	WFC
	Average Length of Suspension (Weeks)	Aug 2023	47	No Target	Alert		n/a	WFC
Culture	Staff Survey - Advocacy	Jul 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Involvement	Jul 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Motivation	Jul 2023	6.6	7.0		n/a	n/a	WFC

Appendix C - Glossary

A&E	Accident and Emergency
A&F	Access and Flow
ACN	Associate Chief Nurse
ADQG	Associate Director Quality Governance
AfC	Agenda for Change
CDI	Clostridioides difficile infection
CESR	Certificate of Eligibility for Specialist
CHPPD	Care hours per patient day
CMO	Chief Medical Officer
DM01	Diagnostic Waiting Times and Activity
DNA	Did not attend
DOLS	Deprivation Of Liberty Safeguards
DPOW	Diana Princess of Wales Hospital
DWP	Department of Work and Pension
ED	Emergency Department
EMAS	East Midlands Ambulance Service
EPIC	Emergency Physician in Charge
EPMA	Electronic Prescribing and Medicines
FFT	Friends and Family Test
GMC	General Medical Council
GP	General Practitioner
HCSW	Health Care Support Worker
HEE	Health Education England
HIT	High Intensity Theatre
HR	Human Resources
HSMR	Hospital Standardised Mortality Ratio
HUTH	Hull University Teaching Hospital
IAAU	Integrated Acute Assessment Units
ICS	Integrated Care Systems
IPC	Infection Prevention and Control
KPI	Key Performance Indicators
LOS	Length of Stay
MCA	Mental Capacity Act
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NEWS	National Early Warning System
NG	National Guidance
NHSE/I	NHS England and Improvement
NL	North Lincolnshire
NLAG	Northern Lincolnshire and Goole NHS Trust
OD	Organisational Development
OOH	Out of Hospital
OP	Outpatient
OPAT	Outpatient Parenteral Antimicrobial Therapy
OPEL	Operational Pressures Escalation Levels
PADR	Performance Appraisal and Development
PALS	Patient Advice and Liaison Service
PBI	Power BI, a Microsoft software
PE	Patient Experience
PIFU	Patient Initiated Follow Ups
PTL	Patient Tracking List
Q&S	Quality and Safety
QI	Quality Improvement
RDC	Rapid Diagnostics Centre
RTT	Referral to Treatment
SAS	Specialist and Specialty
SGH	Scunthorpe General Hospital
SHMI	Summary Hospital Mortality Index
SJR	Structured Judgement Reviews
SPA	Single Point of Access
SPC	Statistical Process Charts
T&D	Training and Development
UCS	Urgent Care Centre
VTE	Venous Thromboembolism
WLIs	Waiting List Initiative's
WTE	Whole Time Equivalent
YTD	Year to Date