Agenda

Council of Governor Business Meetings

Will be held on 19th January 2021, between 14:00 – 15:30 hours using GoTo meeting

For the purpose of transacting the business set out below

Elected governors are reminded that they have signed a declaration stating that they are eligible to vote as members of the Trust and that they are not prevented by any of the terms of the Constitution from being a member of the Council of Governors (CoG). Elected governors will be deemed to have confirmed that declaration by attending this meeting

1. BUSINESS ITEMS 14:00

1.1 CHAIRS OPENING REMARKS Verbal
Terry Moran, Trust Chair
(To note the Chair's opening remarks)

1.2 APOLOGIES FOR ABSENCE* Verbal
Terry Moran, Trust Chair
(To note apologies for absence)

1.3 DECLARATIONS OF INTEREST Verbal
Terry Moran, Trust Chair
(To note any declarations of interest in any of the agenda items)

1.4 TO APPROVE THE DRAFT MINUTES OF THE MEETING HELD ON 15th October 2020 Attached
Terry Moran, Trust Chair
(To approve or amend the minutes from the previous meeting)

1.5 MATTERS ARISING Verbal
Terry Moran, Trust Chair
(To discuss any matters arising from the minutes that are not on the agenda)

1.6 REVIEW OF ACTION LOG Attached
Terry Moran, Trust Chair
(To consider progress against actions agreed at the previous meetings)

2. QUALITY AND PATIENT IMPACT 14:15

2.1 Patient Impact Report Attached
Mike Proctor, Committee Chair
(To report issues from the Q&SC requiring escalation by exception to the CoG for discussion and agreement of any required actions)

2.2 CHIEF EXECUTIVES UPDATE 14:25

2.2.1 COVID-19 Presentation
Shaun Stacey, Chief Operating Office
(To receive and note the COVID-19 presentation)

2.2.2 Integrating Care Verbal
Peter Reading, Chief Executive
(To receive and note the Integrating Care update)

Information items

(a) **Integrating Care - Next steps to building strong and effective integrated care systems across England** document at the link below:

https://www.england.nhs.uk/integratedcare/integrated-care-systems/

(b) **Integrated Care System Partnership Working Update** Attached
'Integrating Care: Next steps to building strong and Effective Integrated care systems across England' NHS England/ Improvement (NHSE/I)
Peter Reading, Chief Executive
(To receive and note the Integrated Care System Partnership Working update)

3. ITEMS FOR APPROVAL Verbal 15:00

3.1 Revised Governor Assurance Group (GAG) Report including the revised Terms of Reference and Annual Work Plan Attached
Helen Harris, Trust Secretary
(To consider and approve the plans for future GAG meetings, the revised GAG Terms of Reference and Annual Work Plan)

3.2 Governors' Annual Register of Interests Attached
Alison Hurley, Membership Manager and Assistant Trust Secretary
(To receive and approve the Governors' Annual Register of Interests)

4. ITEM TO NOTE Verbal 15:10

4.1 Non-Executive Director (NED) Term of Office Extension
Helen Harris, Trust Secretary
(To note the NED Term of Office Extension for Neil Gammon)

4.2 Minutes of Private CoG Meeting Held on 15th October 2020
Terry Moran, Trust Chair
(To note the minutes from the previous private meeting)

5. QUESTIONS FROM GOVERNORS Verbal 15:20
Terry Moran, Trust Chair
(To raise and respond to questions from governors for consideration at the CoG)

6. ANY OTHER URGENT BUSINESS Verbal
Terry Moran, Trust Chair
(To discuss any other urgent business)

7. MATTERS TO BE ESCALATED TO THE TRUST BOARD Verbal

8. COUNCIL REFLECTION Verbal
Terry Moran, Trust Chair
(To consider the performance of the CoG including asking the following whether you are satisfied with agenda items, updates and level of discussion at today's CoG meeting?)

9. DATE AND TIME OF THE NEXT FORMAL BUSINESS MEETING Verbal
Terry Moran, Trust Chair
(To note the date and time of the next formal business meeting)

Date: 20th April 2021
Time: 14:00 - 17:00 hours
Venue: GoTo meeting

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

• In accordance with Standing Order 2.4.3 (at Annex 6 of the Trust Constitution), any Governor wishing to submit an agenda item must notify the Chair's Office in writing at least **10 clear days prior to the meeting at which it is to be considered.** Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Chair.
• Governors are asked to raise any questions on which they require information or clarification in advance of meetings. This will allow time for the information to be gathered and an appropriate response provided.

Minutes

PUBLIC COUNCIL OF GOVERNORS MEETING

Minutes of the Meeting held Thursday, 15th October 2020, from 14:00 to 16:45 hours
Virtual Meeting held by GoToMeeting

Present:

Terry Moran CB	Trust Chair	Eddie McCabe	Stakeholder Governor
Ahmed Aftab	Staff Governor	Joanne Nejrup	Staff Governor
Kevin Allen	Public Governor	Brian Page	Lead Governor
David Cuckson	Public Governor	Rob Pickersgill	Public Governor
Diana Barnes	Public Governor	Steve Price	Public Governor
Tony Burndred	Public Governor	Ian Reekie	Public Governor
Maureen Dobson	Public Governor	Cllr Stan Shreeve	Stakeholder Governor
Vince Garrington	Public Governor	Liz Stones	Public Governor
Paul Grinell	Public Governor	Dr Gorajala Vijay	Public Governor
Tim Mawson	Staff Governor		

In Attendance:

Adrian Beddow	Associate Director of Communications
Lee Bond	Interim Director of Finance
Tony Bramley	Non-Executive Director
Kerry Carroll	Deputy Director of Strategic Development
Neil Gammon	Non-Executive Director
Helen Harris	Trust Secretary
Stuart Hall	Associate Non-Executive Director
Claire Hansen	Deputy Chief Operating Officer(representing Shaun Stacey)
Alison Hurley	Membership Manager & Assistant Trust Secretary
Linda Jackson	Trust Vice Chair
Jug Johal	Director of Estates & Facilities
Claire Low	Acting Director of People & Organisational Effectiveness
Ivan McConnell	Director of Strategic Development
Michael Proctor	Non-Executive Director
Dr Peter Reading	Chief Executive
Andrew Smith	Associate Non-Executive Director
Michael Whitworth	Non-Executive Director
Dr Kate Wood	Medical Director
Serena Mumby	Membership Officer (minutes)

1. BUSINESS ITEMS

1.1 CHAIR'S OPENING REMARKS

Terry Moran opened the virtual Council of Governors (CoG) meeting and welcomed everyone. Governors were informed that business items would generally be taken as read with any exceptions or updates added and feedback and questions invited.

Following the annual Governor elections, newly elected Governors were congratulated. This included public Governors for North Lincolnshire Kevin Allen and David Cuckson, staff Governors Ahmed Aftab and Joanne Nejrup, and re-elected Governors Tim Mawson as a staff Governor and Liz Stones as a public Governor.

Welcomes were extended to the new Non-Executive Directors (NED) Mike Proctor and Andrew Smith, and also to Lee Bond in his role as Interim Director of Finance. Thanks and best wishes were noted for NEDs, Sandra Hills who had recently retired from her role, and Neil Gammon who was due to retire and this would be his last meeting. Thanks were also offered retrospectively to public Governor John Balderson, who had resigned from his position and also to Brian Page who was stepping down from the role as Lead Governor, but remaining as a public Governor.

Sincere thanks were expressed to the Trust staff, to Trust Board members, Executive Directors and NEDs for their tireless work in addressing the enormous challenges during this extraordinary time. This had entailed dealing not only with COVID-19; but also the Trust's legacy issues such as double Care Quality Commission (CQC) special measures.

Terry Moran reported that despite all of the issues faced by the Trust, positive progress continued which had been noted by the CQC. The Trust was expected to meet an agreed financial plan for the 2021/22, continue to manage the legacy of the past and remain mindful of this when seeking to deliver against plans for the future during the COVID-19 pandemic.

1.1.1 Reflections on the 22nd July 2020 Council of Governors Business Meeting

Terry Moran was encouraged by the constructive feedback received from the CoG meeting held on the 22nd July 2020 and referred members to the summary report provided. The overarching response was positive with comments that the meeting was effective, efficient and well chaired. Paul Grinell queried the low number of responses. Mrs Hurley reported that this may be due to the fact that it was a new process and a reduced agenda.

Council Decision: The Council received and noted the reflections from the 22nd July Governors Business Meeting

1.2 APOLOGIES FOR ABSENCE

Terry Moran provided apologies for absence as detailed below:

Apologies for absence were received from: Shaun Stacey (represented by Claire Hansen).

Alison Hurley added that Brian Page would join the meeting at 15:15 hours due to existing commitments and Stuart Hall was required to leave the meeting at 15:45 hours for a further meeting.

1.3. DECLARATION OF INTERESTS

Terry Moran requested members of the Council to raise any conflicts of interest relating to specific agenda items or provide any updates to their annual declaration of interests. None were received.

1.4. TO APPROVE THE MINUTES OF THE PREVIOUS MEETING

1.4.1 Council of Governors' Annual Review Meeting - 30th June 2020

Terry Moran invited members to approve the minutes and action plan for the CoG Annual Review meeting held on the 30th June 2020. Subject to an amendment from the name Paul Page to Brian Page on page four of the minutes, the minutes were approved as a true and accurate record.

Council Decision: The Council received, noted and approved the minutes and the action plan

1.4.2 Council of Governors' Public Business Meeting - 22nd July 2020

Terry Moran invited members to approve the minutes of the CoG Public Business meeting held on the 22nd July 2020. The minutes were approved as a true and accurate record.

Council Decision: The Council received, noted and approved the minutes

1.5 MATTERS ARISING

There were no matters arising which were not covered on the agenda.

1.6 COUNCIL OF GOVERNORS ACTION LOG

The Action Log from the July 2020 CoG meeting was reviewed. There were no further updates on the two remaining actions. Terry Moran thanked Alison Hurley for the update and invited any questions. None was received.

Council Decision: The Council received and agreed updates to the CoG Action Log

1.7 TRUST CHAIR'S REPORT

1.7.1 Trust Chair's Report

The CoG received the Trust Chair's Report. Terry Moran invited any questions or points for clarification. Ian Reekie was very impressed with the Trust Board approach of drilling down into specific strategic risks at each Trust Board meeting in order to achieve assurance.

Council Decision: The Council received the Trust Chair's Report

1.8 CHIEF EXECUTIVE'S REPORT

1.8.1 Chief Executive Report

Dr Peter Reading reported that much of the meeting's agenda was designated to strategic issues due to the need to focus on important and urgent issues at present. It was confirmed that plans were in place to address issues regarding the structural limitations within the Trust. The tremendous efforts of Trust staff and the burden placed upon them during the COVID-19 pandemic was recognised. This was anticipated to increase somewhat in the first wave as the staff were already tired, many had not taken proper breaks and had surrendered annual leave, and working in full Personal Protection Equipment (PPE) remained demanding. The Trust continues to endeavour to minimise any impact on waiting lists whilst managing the multiple challenges from the first wave of COVID-19 whilst managing the implications of the second wave. It was acknowledged that elective work may be further impacted as critical beds fill up.

Dr Peter Reading invited any questions and comments.

Ian Reekie reported that the national mobilisation of the revised Accident and Emergency (A&E) standards had been delayed due to COVID-19 and queried whether the Trust expected to maintain the four hour Accident and Emergency waiting time standard. Dr Peter Reading advised the Trust would maintain the four hour standard as an internal measure.

Dr Peter Reading responded to a query from Ian Reekie and advised that the Trust was keen to implement the 'Talk before you Walk' regime but at present was not in a position to do so, and confirmed this was currently being piloted in Hull.

Ian Reekie raised concerns regarding the national Roche reagent supply chain shortage and the impact on patient care. Dr Kate Wood reported that Roche was a pharmaceutical company that produces and supplies reagent required to perform biochemical testing, and the impact currently was that non-urgent tests had been placed on hold until a delivery was received. The backlog of routine tests had been cleared but the Trust was only performing urgent blood tests at present. General Practitioner (GP) colleagues were required to prioritise what they deemed urgent. Laboratories in the region were communicating regularly with each other and the local councils were reassured that the Trust did not use Roche for COVID-19 testing, and as such this had not been affected.

Council Decision: The Council received the Chief Executive's Report

2. COG ASSURANCE

2.1 Board Assurance Framework (BAF)

Helen Harris informed the Council that non-delivery of constitutional performance targets remains a very high risk and thanked Ian Reekie for his comments regarding the strategic objective deep dives. A brief summary was provided and attention drew to the risk rating for strategic objective three which had reduced from 15 to 12 due to top up payments received by the Trust which should ensure a break even position.

Terry Moran thanked Helen Harris for her update and the very helpful executive summary and invited any points of clarification. None were received.

Council Decision: The Council received the Board Assurance Framework

3. STRATEGY AND PLANNING – Council of Governor Briefings

3.1 Trust Capital Programme Update

The Council received a presentation on the Trust capital programme which outlined the exciting and challenging current and future capital developments in terms of scope, status of each scheme and timelines. This would lead to positive impacts for both patients and staff. Jug Johal added that the biggest capital programmes to deliver in his time at the Trust.

Terry Moran thanked Ivan McConnell for the presentation and congratulated all involved due to the significant amount of effort and work undertaken. Questions were invited and Vince Garrington wished to note his congratulations too to Ivan McConnell and Jug Johal for their exceptional work.

Paul Grinell referred to table one within the presentation which outlined the Emergency Department (ED) and the Acute Assessment Unit (AAU) projects and queried the inter-dependency of the units what were the risks if the Trust were unable to complete the ED element if the AAU was not approved or was scaled down. Although the avalanche of funding was very welcome, did the programme timescales allow for slippage considering the potential impact of COVID-19. Ivan McConnell explained it was very complicated and had two sources of funding. The AAU aspect was initiated prior to receiving the ED funding, although it made sense to combine the two elements. The Trust had appointed a contractor who would be prepared to work on a ‘live’ site and had provided assurance that engagement with staff and all interdependencies would be considered. Jug Johal confirmed this project was not dependent upon additional funding due to the way the project was phased and planned which would ensure that the new A&E would be completed during the first phase. Paul Grinell expressed his thanks and confirmed he was very reassured with the sequential phases planned. Tim Mawson advised that the impacts of COVID-19 were likely to be a national issue and it would be difficult to judge how this would impact at present.

David Cuckson queried whether a hospital rebuild would be on a new site. Jug Johal reported that a partial redevelopment was considered but not progressed due to the complexities with decanting critical services. An overview was provided for the reasons to currently remain on site and in a similar footprint. The Trust was working closely with local authorities regarding a new hospital in North Lincolnshire though no outcome had been determined.

Council Decision: The Council received the Trust Capital Programme update

3.2 Humber Acute Services (HAS)

The Council were presented with an update on the Humber Acute Services (HAS) outlining the three key programmes which underpin the delivery of HAS. This included an update on work already undertaken and proposed next steps in the aim to contextualise and support a greater understanding of the

complexity of the programme.

Terry Moran thanked Ivan McConnell and confirmed that further updates would be provided as required in future on this complex programme and sought any points for clarification.

Michael Whitworth joined the meeting at 15:05 hours

David Cuckson felt this was a very impressive vision and programme of works, and queried whether a secretariat would be appointed to support the practicalities or if it would be serviced by the individual stakeholders. Ivan McConnell confirmed an overarching director would be appointed, with director leads established for each work stream along with a programme manager with executive oversight across the system to ensure an appropriate governance structure is established. A senior working group would meet fortnightly to ensure the programme was resourced effectively with a skilled workforce.

Ivan McConnell responded to a query from Ahmed Aftab and confirmed the importance of having safe and sustainable services which also address health inequalities.

Ian Reekie expressed concern regarding the proposed level of engagement regarding changes to the 11 vulnerable specialities and queried when the details of service model changes would be finalised; what was meant by targeted engagement with patients; would engagement be led by the Trust or the Clinical Commissioning Groups (CCGs); and would details of the proposed changes be shared with governors at the Governor and NED Briefing scheduled for the 4th November.

Post Meeting Note: An engagement update would not be provided at the November Governor briefing as the briefing provided at the CoG contained the latest update available

Stan Shreeve thanked Ivan McConnell for the very comprehensive presentation and advised the consultation process should not be seen as a tick exercise but should drive the whole process. Concerns remain on the south of the river regarding the migration of services to the North, and the impact this would have on the North East Lincolnshire community where transportation ownership remains the lowest in the country. Such patient transport considerations would require inclusion in the process.

Dr Peter Reading thanked Ivan McConnell and Dr Kate Wood for their update and confirmed that engagement would be led by CCGs as it is their statutory responsibility to engage with the public. Members were encouraged to feed any concerns into the CCGs as well as the Trust.

In response to a suggestion from Rob Pickersgill, Ivan McConnell confirmed that the Trust was currently investigating options to simulate patient pathways and further develop lean services.

Stan Shreeve drew attention to the need for CoG approval of significant transactions, and suggested that some or all of these changes would fall within this criteria, and stressed the need for a robust public consultation process. A discussion ensued around engagement and consultation processes.

Council Action: The significant transactions element of the Trust Constitution to be circulated to CoG members

Council Decision: The Council received the Humber Acute Services Update

A short comfort break took place and the meeting continued at 16:05 hours

Terry Moran thanked Brian Page personally and on behalf of the Trust for his work as Lead Governor, confirming he had been an appropriately challenging and supportive Leader of the Council. Voting was due to conclude shortly for the appointment of the new Lead Governor.

4. FINANCE AND PERFORMANCE

4.1 Governor Assurance Group (GAG) Highlight Report

Members received and reviewed the GAG Highlight Report from the 9th September meeting.

Terry Moran thanked Brian Page as Chair of the GAG and invited questions and comments. There were no comments or questions received.

Council Decision: The Council received the GAG Update

4.2 Finance and Performance Committee (FPC) Highlight Report

The reports covering the FPC meetings on 27th August and 30th September 2020 were received and questions were welcomed. No questions were raised.

Council Decision: The Council received the FPC Highlight Report

4.3 Supporting Papers

4.3.1 Finance Overview (Month 5 position)

Lee Bond provided an overview of the month five position and stated that the Trust had reported a balanced financial position for August 2020 and highlighted that the clinical pay overspend remains under investigation to ascertain the reasons for this. The Trust was endeavouring to improve performance on payment of invoices as not all invoices were paid within the 30 day target. As funding remains limited, it is vital that the Trust does not overspend during the second half of the financial year. Questions and comments were then invited.

David Cuckson reported that it was good to see a Trust focus on paying creditors earlier and queried whether the Trust were making any short term investments. Lee Bond stated that interest rates were extremely low and any interest received would be minimal but agreed to find out and feedback to the next CoG meeting.

Terry Moran thanked Lee Bond for the finance overview.

Council Action: Lee Bond to investigate and provide an update at the January CoG meeting on any short term Trust investments

Council Decision: The Council received the Month 5 Finance Report

5. QUALITY AND SAFETY

5.1 Quality Review Group (QRG) Highlight Report

Rob Pickersgill informed the Council that the QRG had not met since February and referred to agenda item 10.1 would address the future of the QRG.

5.2 Quality and Safety Committee (QSC) Highlight Report

Tony Bramley informed the Council that Sandra Hills had stepped down from her role as Non-Executive Director and Mike Proctor would be taking up the position as chair of the QSC. The report was received and comments and questions invited. No comments or questions were received.

Council Decision: The Council received the QSC Highlight Report

5.3 Membership and Patient Engagement (MPEG) Highlight Report

Members received and reviewed the MPEG Highlight Report from the 27th February and the 7th October 2020 meetings. Ian Reekie highlighted the actions required by the Council which were outlined on the MPEG highlight report. The council agreed to support all of the proposed actions in principle dependent upon the outcome of agenda item 10.1 would address the future of the MPEG and other CoG sub-groups.

Terry Moran thanked Ian Reekie for his update and sought any points of query. None were received.

Council Decision: The Council received the MPEG Highlight Report

6. LEADERSHIP, ORGANISATIONAL DEVELOPMENT AND CULTURE

6.1 Staff Governor Working Group (SGWG) Highlight Report

Tim Mawson reported that there had not been a SGWG meeting as he was the only staff governor remaining in post and added that following the appointment of the two new staff governors the meetings would be reinstated.

Terry Moran thanked Tim Mawson and requested any queries be raised. None were raised.

Council Decision: The Council received a verbal update on the SGWG

6.2 Appointments and Remuneration Committee (ARC) Highlight Report

Members received and reviewed the ARC Highlight Report from the 7th September 2020 meeting. Brian Page informed the Council of the appointment of NEDs Mike Proctor and Andrew Smith, and of the departure of Sandra Hills and the need to seek expressions of interest for the position of Senior Independent Director (SID).

Terry Moran thanked Brian Page for his update and requested any queries be raised. None were raised.

Council Decision: The Council received the ARC Highlight Report

6.2.1 Workforce Committee (WTC) Highlight Report

Michael Whitworth was unavailable to provide an update on the WTC highlight report. Terry Moran asked members if they wished to raise any queries. No queries were raised.

Council Decision: The Council received the WTC Highlight Report

7. AUDIT, RISK AND GOVERNANCE COMMITTEE

7.1 Audit, Risk and Governance Committee (ARGC) Highlight Report

Members received and reviewed the ARGC Highlight Report from the 23rd July 2020 meeting which was took as read.

Terry Moran thanked Tony Bramley and requested members raise any points for clarification. None were raised.

Council Decision: The Council received the ARGC Highlight Report

8. HEALTH TREE FOUNDATION TRUSTEES' COMMITTEE (HTFC) HIGHLIGHT REPORT

8.1 Health Tree Foundation Trustees' Committee (HTFC) Highlight Report

Members received and reviewed the HTFC Highlight Report which covered the 3rd September meeting.

Terry Moran thanked Neil Gammon for his report and invited any questions. None were received.

Council Decision: The Council received the HTFC Highlight Report

9. ITEMS TO NOTE

9.1 Governor Attendance at the CoG and Sub-groups

Alison Hurley advised that there were no areas for concern and asked Governors to note the report. No queries were raised and Terry Moran thanked Alison Hurley.

Council Decision: The Council received the Governor Attendance at the CoG and Sub-groups Report

9.2 Attendance at Governor Briefings, Training and Development Opportunities

Alison Hurley advised that there were no areas for concern and asked Governors to note the report. Tim Mawson highlighted an error to the attendance figures in the total column which Alison Hurley confirmed would be amended.

Terry Moran thanked Alison Hurley and invited comments. None were received.

Council Action: Membership Office to amend the Governor Attendance at Briefings Document

Council Decision: The Council received the Attendance at Governor Briefings, Training and Development Opportunities Report

10. ITEMS FOR APPROVAL

10.1 Council of Governor Sub-Group Meetings Proposal and Governor Briefings

Alison Hurley reported that the proposal was created following a request from the Governor Assurance Group (GAG) to evaluate the purpose of the group and other CoG sub-groups as there was an overlap of content. The proposal to subsume three CoG sub-groups into the GAG would reduce the overlap of content and the number of meetings for attendance of Governors, NEDs and Executive Directors. Alison Hurley invited questions and comments.

Paul Grinell queried if the Staff Governor Working Group (SGWG) would continue to support a separate meeting as much of the information contained within the meeting was outside of the knowledge of public governors. Dr Peter Reading confirmed he would attend the GAG meetings to ensure his availability for staff Governors.

Terry Moran thanked Alison Hurley and sought any further queries or comments. None were raised.

Council Decision: The Council approved the proposal

10.2 Governors' Register of Interests

Terry Moran invited Governors to review the Governors' Register of Interests document.

Council Decision: The Council approved the Governors' Register of Interests

11. QUESTIONS FROM GOVERNORS

David Cuckson requested guidance regarding access to hospital sites for Governors and Alison Hurley advised the latest guideline outlined that Governors were not to have any face to face meetings or meetings on site.

Any further Governor questions were sought and none were received.

12. ITEMS FOR INFORMATION

Terry Moran drew the Council's attention to the items for information contained within appendix A.

13. ANY URGENT BUSINESS

Terry Moran invited members to raise any additional items of urgent business. None were received.

14. QUESTIONS FROM THE PUBLIC

There were no members of the public present at the meeting.

15. COUNCIL REFLECTION

Terry Moran advised that a questionnaire would be distributed following the CoG meeting and thanked the Council for their attendance. Questions were then invited. None was received.

16. DATE AND TIME OF NEXT COUNCIL OF GOVERNORS MEETINGS AND BRIEFINGS

Terry Moran advised that the venues for the next CoG Meetings would be confirmed shortly in line with Government recommendations to ensure appropriate social distancing and the safety of staff and CoG members.

Governor and NED Briefing
Date: 4th November 2020
Time: 10:00 - 13:00 hours
Venue: GoToMeeting (virtual)

Council of Governors Business Meeting
Date: 19th January 2021
Time: 14:00 - 17:00 hours
Venue: GoToMeeting (virtual)

Please notify the Membership Office of any apologies for these events.

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

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• Governors were asked to raise any questions on which they require information or clarification in advance of meetings. This would allow time for the information to be gathered and an appropriate response provided.

Terry Moran thanked members for their attendance and contributions and the meeting closed at 16:38 hours.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

COUNCIL OF GOVERNORS

ACTION LOG & TRACKER

2019-2020

(updated December 2020)

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors (CoG) Meeting

Minute Reference	Date/Month of Meeting	Subject	Action Reference (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored
COG(20)234	16/04/2019	Governor Briefing	4.2	Membership Office to invite Mrs Plant to provide a briefing on planned initiatives for improving financial and operating targets	Membership Office	Jul-19	Discussed within July CoG briefing	Complete	July CoG briefing agenda	Yes
COG(20)249	04/07/2019	IT Sponsorship	9	Mrs Hurley to investigate potential sponsorship for IT tablets for Governors	Alison Hurley	Oct-19	Oversight will be maintained at the Governor Assurance Group meeting	Complete	GAG Agenda	Yes
COG(20)253	14/01/2020	Governor Briefing	1.7.1	Health Tree Foundation briefing for Governors to be organised	Membership Office	Nov-20	On hold until the COVID-19 restrictions are lifted and normal business resumes			
COG(20)254	22/07/2020	Governor Briefing	3.2	Virtual Governor waiting list briefing to be organised	Membership Office	Nov-20	On hold until the COVID-19 restrictions are lifted and normal business resumes			
COG(20)255	22/07/2020	Governor Briefing	7.1	Claire Low to provide an update on the incidents of potential inappropriate access to WebV	Claire Low	Oct-20	Addressed in the all staff e-mail shared with Governors on 6th October 2020	Complete	E-mail	Yes
COG(20)256	22/07/2020	Public Attendance at CoG meetings	13	Alison Hurley, Linda Jackson and Helen Harris to discuss public attendance at CoG meetings outside of the meeting	Alison Hurley	Oct-20	Considered and addressed via a virtual meeting which also considered general Governor engagement	Complete	E-mail	Yes
COG(20)257	15/10/2020	Trust Constitution	3.2	The significant transactions element of the Trust Constitution to be circulated to CoG members	Membership Office	Oct-20	The significant transactions element of the Trust Constitution circulated to CoG members	Complete	E-mail	Yes
COG(20)258	15/10/2020	Trust Investments Update	4.3.1	Lee Bond to investigate and provide an update at the January CoG meeting on any short term Trust investments	Lee Bond	Jan-21	On hold until the COVID-19 restrictions are lifted and normal business resumes			
COG(20)259	15/10/2020	CoG Governor Attendance document	9.2	Membership Office to amend the Governor Attendance at Briefings Document	Membership Office	Jan-21	Governor Attendance at Briefings Document amended	Complete	Governor attendance document	Yes

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

Kindness · Courage · Respect

CoG (01/21) Item 2.1

DATE	Tuesday 19th January 2021
REPORT FOR	Council of Governors Business Meeting (CoG),
REPORT FROM	Kate Wood, Medical Director, and Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance Jenny Hinchliffe, Deputy Chief Nurse Jackie France, Head of Patient Administration Dawn Harper, Deputy Chief Nurse Denise Gale, Associate Director for Cancer Lucy Kent, Associate Director for Compliance Maurice Madeo, Assistant Director for Infection Prevention Ivan Pannell, Head of Procurement Jeremy Daws, Head of Quality Assurance Helen Turner, Head of Nursing for Community Kelly Burcham, Head of Risk Paul Bunyan, Associate Director of HR Jane Warner, Head of Midwifery
SUBJECT	Patient Impacts and Clinical Risk Paper
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF THE REPORT	The report outlines key areas of clinical risk and the mitigation steps.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality and Safety Committee
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This paper outlines the key issues relating to clinical risk / harm, and the mitigating actions, with significant pressures relating to Covid-19. The areas considered are: Staffing Daily Deputy Chief Nurse/Head of Nursing led staffing review meetings continue to be held. This reviews SafeCare data to enable a review of patient acuity and dependency against staff availability. Staffing continues to be a daily challenge due to sickness, self-isolation. A review of Bank and Agency escalation has been undertaken with earlier escalation agreed. A number of actions are in place to support staff wellbeing with both onsite and virtual services being utilised. Waiting Lists: A process is in place to risk stratify patents as added to

	the Waiting List. There are patients who will require a re-review as they were last reviewed in June. programme, A clinical validation letter will be sent to all patients on the Inpatient Waiting List before 31 December to understand their future intention as regards their procedure. Risk Stratification of the Out-Patient waiting list poses more of a challenge due to Wave 2. The Trust has secured funds from NHSEI to engage with GP's to risk stratify patients within Medicine. Elective work continues to be delivered at St Hughes and Goole, prioritising patients risk stratified as Priority 2. <u>Cancer</u> Performance in cancer dropped in Wave 2 of Covid, and there has been a significant increase in late stage cancer diagnosis. Work is underway to mitigate the drop in surgical performance, using St Hugh's for cancer surgery. <u>Complaints</u> The new Complaint process went live on 2 November with divisional ownership, this will be at risk during Wave 2 due to clinical pressures. The central team are concentrating on closing older complaints by 28th February 2021. <u>CQC Actions</u> Risk of slowing action delivery and evidence due to the Wave 2 impact on the frontline. The central team are endeavouring to source as much evidence as feasible to support and meetings continue with reduced attendance. Covid has affected the achievement of mandatory training targets. <u>IPC including Outbreaks:</u> There is a risk of Covid-19 outbreaks on wards; these are subject to an IPC RCA. Work continues to increase single room availability to reduce the risk. <u>PPE</u>: There are currently no supply concerns with PPE. <u>12 Hour Breaches</u> 12 hour breaches significantly increased as patient numbers with Covid in Wave 2 increased. A number of initiatives, including discharge to assess, were undertaken to improve flow and reduce 12 hour breaches. <u>Black Ambulance Breaches</u> Black Ambulance Breaches continued to rise in November 2020, a new handover process was implemented on 9th December 2020 to improve efficiency and clinical safety.

	<u>Mortality</u> Coding comorbidities, linking coding reviews with quality of care screening is being rolled out but has been delayed in Surgery. The aim is to pick this up in December to enable seamless transfer from Grant Thornton at the end of the year. <u>End of Life</u> End of Life improvement work is continuing via the Steering Group. Concerns that some projects, such as: the training, launch of the pain assessment tool, use of the last days of life document and divisional engagement in the Steering Group, are being affected by Covid pressures. Mitigations are in place to try to reduce the impact. <u>Serious Incidents</u> The second wave has impacted on the ability to complete Serious Incident investigations in a timely way. Key investigations have been identified to prioritise completion. The new key Serious Incident is the Majax declared to maintain the safety of patients on oxygen. An external investigator has been established to investigate this. <u>Lateral Flow Testing</u> Lateral Flow testing has been rolled out and feedback from staff has been positive. <u>Maternity</u> The Trust has reviewed the Ockenden report into the maternity concerns at the Shrewsbury and Telford Trust, and reviewed the recommendations. Some audit work is required to provide assurance

ACTION REQUIRED				
Approval	**Information**	**Discussion**	**Assurance**	**Review**

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to?				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

TRUST PRIORITIES - which Trust Priority does this link to?					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	This is linked to the Quality Strategic Risk on the BAF. Members of CoG are asked to note this report.

PURPOSE

This paper, written on behalf of the Medical Director and Chief Nurse, outlines the key issues relating to clinical risk/ harm, and the mitigating actions, with significant pressures relating to Covid-19 The areas considered are:

• Staffing	• Waiting Lists	• Cancer
• Complaints	• CQC actions	• IPC & Outbreaks
• PPE	• 12 hourbreaches	• Black Ambulance Breaches
• Mortality	• End of Life	• Serious Incidents
• Lateral Flow TestinQ	• Maternity	•

Prior to the Covid-19 Pandemic, the Trust had a plan in place to improve quality and safety in a number of areas. Given the challenges of the pandemic, this report pulls together the key areas of concern both prior to and arising during the pandemic which impact on the quality and safety of our care to our patients.

New areas in this months paper are Lateral Flow Testing, and Maternity, notably the position against the Ockenden report recommendations and CQC action risk areas.

STAFFING

The Trust bed base needs to support management of outbreak principles where the outbreak is contained in the smallest possible footprint and is scalable whilst minimising risk of cross infection. The staffing for these areas has been reviewed and set by the Chief Nurse as wards are reconfigured to meet the changing needs of Covid admissions. Safe Care Live is in place to record and manage nurse staffing levels and is utilised daily as a tool to provide oversight and aid decisions about deployment of staff to support the delivery of safe care.

As the availability of staff has been affected by Covid, minimum acceptable nurse staffing levels have been determined to support decision making out of hours, however work continues to fill shifts to established levels.

Risk	**Mitigation**

Safe care of patients on the in-patient wards as the availability of staff decreases - in excess of the sickness target level of 4.1% due to the requirements for staff to self-isolate if they test positive or if alerted through the Track and Trace system. This is likely to increase as lateral flow testing is introduced.	Safe Care Live provides information regarding patient acuity, dependency and staffing in real time to support decision making regarding deployment of staff to maintain patient safety. Daily safe staffing meeting supported by the Deputy Chief Nurse and staffing reviewed at 3 times daily operations meetings. Morning huddle by Matron with shift leaders to review staffing and enact redeployment. Retraining for staff who can be redeployed to clinical areas and deployment managed by the Workforce Resource Centre. Use of bank staff with 20% incentive scheme. Use of agency staff with revised tier and authorisation framework. Forward review of rosters with early escalation. Super Surge Plan in place. IPC practices to reduce risk of transmission at work. Health and wellbeinQ support for staff.ta
Safe care of patients requiring ventilation (Critical Care)	1:1 plus 1 buddy levels in Critical care 2 hour breaks for staff to change PPE Redeployment of theatre staff to ITU. Training for redeployed staff Critical Care Matron just focused on critical care Psychological care for Critical Care staff
Staff stress due to pressures of Covid-19	MH Lead Nurse availability to wards to provide support Care for Each Other Hub site NAVIGO practitioner to support staff Clinical Psychologist sessions available for staff Wobble rooms Vivup and Headspace apps available to all staff 24 hour staff helplines Mindfulness sessions available Remploy support Professional Voice email address introduced by the Chief Nurse to allow staff to raise concerns and share ideas.

WAITING LISTS*

A trajectory of improvement had been in place for waiting lists prior to Covid-19, to deŕ1ver on 3 kev tarQets b,v March 2021

Target	**Current Position on 31 October 2020**
Overall RTT waiting list not to exceed 23,000	26858 patients on the RTT incomplete waiting list
No 78 week tarQet	11 patients waitinQ in excess of 78w
No patients waiting in excess of 52w for treatment	476 waiting in excess of 52w

No patients waiting in excess of 40w for treatment	2545 waiting in excess of 40w
Maximum of 9000 patients on the Out-Patient follow-up waiting list	14459 patients on the Out-Patient Follow-up waiting list

Mitigation

Each specialty has a plan on a page detailing individual trajectories and targets to improve the waiting list position, this includes narrative of; the current position, potential issues, plans to recover and any required escalations.

Further to the National Contract for the Use of Independent Sector Providers, discussions are ongoing with external providers to support the Trust with admitted as well as non-admitted RTT patients and overdue follow-ups, particularly Medinet to support with a number of medicine specialties and ENT within Surgery.

As expected during November, all elective and daycase activity was below plan, however out-patients for both Surgery and Family Services have increased as clinicians have shifted their activity to this area whilst theatre capacity has been unavailable. Unfortunately, the Outpatient overdue follow-up position remains off trajectory.

To help minimise the risk to patients who are due or overdue a follow-up appointment, we have agreed with our local GP's to work collaboratively with the Trust to clinically validate/risk stratify their patients. We have received a sum of money from NHSEI to support this work.

Opportunities to maximise capacity available across HCV continues to be explored;

In line with the National Clinical Validation Programme, the Trust will write to all patients on the elective inpatient waiting list to establish patient's wishes regarding their treatment, before the end of December, 2020. This will be in the form of digital communication for the majority of patients.

Assessment

Area	Risk	Mitigation
Radiology	CT colon capacity remains a risk across both sites Shortfall in core capacity to accommodate all urgent, routine and follow up patients in CT and MRI within desired timescales. Independent sector central contract terminated from 24th December 2020 Lack of capacity to undertake risk stratification / clinical harm on entire diagnostic waiting list	CT colon waiting list has been risk stratified. Capacity being flexed as much as possible - plans being worked up for Jan/Feb when new scanner is live. Additional vans from NHSEI and independent sector capacity being utilised to minimize impact Working with contracting team to ensure contracts in place to continue additional capacity Using agreed referral priority Awaiting feedback from central waiting list validation team for next steps
Endoscopy	Delays in Endoscopy impact diagnostics and therefore waiting lists, particularly in cancer.	79% activity levels achieved during November 2020 compared with Nov 2019 - reduced scoping capacity due to social distancing constraints & clinicians being redeployed to ward areas. Cancer diagnostics continuing as priority
Clinical Sciences	Gap in SMT cover for Clinical Sciences until new GM in post	Recruitment in progress, start date for GM 5/1/21 Cross cover being provided by the team

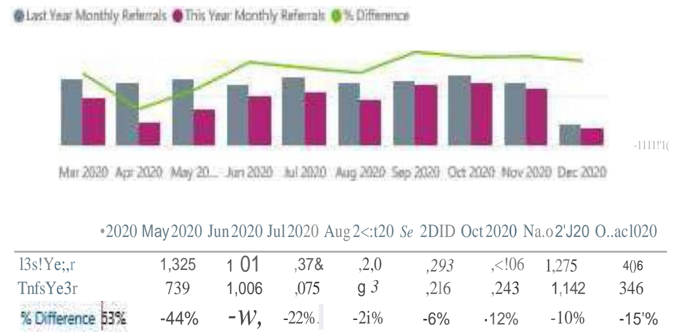
CANCER*

The key risks for Cancer during COVID-19 for NLAG are as follows:

Risk	Mitigation
2ww referrals: 2ww referrals fell by 70% during Phase 1 of the pandemic.	Since July 20, there has been recovery to 94% of pre-COVID levels in Sept (in line with Phase 3 recovery trajectory). This has fallen to 90% (end Nov) and is currently at 85% (at 15/12). The planned care board (which includes primary and secondary care) regularly receive the Cancer Highlight Performance report which sets out recovery for 2ww.

Monthly Positions vs Last Year

2ww Referrals and Treatments

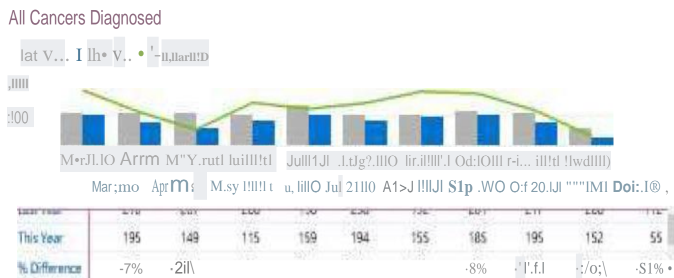


Diagnostics:

Cancers Diagnosed :
The volume of cancers diagnosed during the 1st wave of the pandemic was significantly reduced as a result of the reduction in 2ww referrals (-70%).

The peak in cancers diagnosed via emergency admissions was approx.. 10% higher than the same month(s) in 2019. Those diagnosed via emergency admissions in 2020 had a high mortality rate (circa 48%), and were predominantly late stage (Stage 3 or 4) cancers

All Cancers diagnosed: cumulatively this had returned to pre-COVID levels almost returned to pre-COVID levels Sept 92%/Oct 90%.



In November the volume of cancers diagnosed (all tumour sites) has dropped to 74% of pre-covid levels and 51% (at 15/12). Some Clinical teams have highlighted an increase in late-stage cancers which is being investigated.

Cancers diagnosed from emergency admissions - the Trust saw a spike in June/July and again in October. The analysis has been shared internally and is being sent to the relevant CCG for further discussion.

Cancers Diagnosed from Emergency Admissions

Treatment

Surgery
Cancer Treatments (Drugs). Some chemotherapy is given for alliative care/s m tom control.

<u>All Cancer treatments (combined)</u>: this had achieved 99% of pre-COVID levels at end September but has reduced to 83% October, 62% November and is at 56% (at 15/12)

Surgery has been affected by Wave 2 of the pandemic and the need to cancel elective surgery during the first 2 weeks of November. This has led to a decrease in recovery.

Discussions across the Cancer Alliance are taking place between COO's to establish an elective care surgical hub which will include Cancer.

Cancer Treatments(AlOvs Same Peiiod Last Year

	\pr 2020	May 2020	Jun 2020	Jul1020	Aug 2020	Sep 2020	Oct 2Ml	NOY 2020	Dec 2020
lastY era	230	m	mi	2:28	'229	235	2A3	U6	83
lrJs Ye3r	234	1	g1	226	90	23,5	202	1s,	47
';truts-ence	1.7%	-2M %	-19.1%	-0.9%	- 7.ff!e	0.0%	- 6.9%	-37,8%	-43.4%

Surgery : At end Sept surgery (NLAG/tertiary) achieved 100% of pre-COVID levels, however this slipped to 63% in October and 40% in November. Elective surgery (including cancer) has been cancelled due to COVID surge in the first 2 weeks of November. It is currently at 40% for December (at 15/12)

Cancer Trcatmer:ts (Surgery) v,Same Period Last Year

	•2010 May	2.020 Jun	202.0 Jul	1020 A g	2020 Sep	2020 Oct	2020]_'/OII	2'02ll D,?(	2020
L3sr Year	73	79	8J	8	39	7ll	79	gs	3S
This Year	54	41	Q4	72	69	?8	SO	$0	ii
% Difference	30.8%	-4$.1%	-22.9%	-7.7%	-22.,%	0.0-:	-Y.i.i'%	-o8i1%	-W.0%

Cancer treatments (Drugs):: this includes systemic anti-cancer therapy (SACT - chemotherapy), hormone therapy, and other drug regimens. At end Sept this achieved 92% of pre-COVID levels, but reduced to 79% in October, 82% in November and is currently at 96% (15/12)

Can(er Treatments(Drugs) vs.Same od Last Year

	• 2010 I.lay	2010 Jun	2020 Jul	1020 Atig	2020 Sepe	2ll20 Oct	Z02lJ N<W	2ll20 Da<l.020	
LastYear	10	ll	0	1(13	94	100	17	106	27
Tnis Year	106	B5	79	gs	,O	!!os	92	87	2o
%[iiff...,,,e	5.0%	-.6%	-MO;f	-7.8%	-255%	-9..!%	-21A%	-17.9%	-3.7%

COMPLAINTS*

Current review of the KPI's within the Complaint and Pals service are in progress to enable the implementation phase of the new complaints process and transition out of the old complaints process to be completed. The aim of this will be to have all old

process complaints closed by February 28th 2021. The new complaint process went live from 2nd November.

Risk	Mitigation
Timescales for complaints responses will increase due to clinical staff having reduced capacity.	Increased resource in central complaints team to focus on old process complaint closures. Weekly monitoring through Complaints Support and Challenge Meeting of longest open complaints and all new process complaints. Plan for individual complaints greater than 120 days and progress continues as seen below Reviewed the escalation process (detailed in new policy). Senior Nurse involvement in clinical validation of information to support process. Dedicated Project Manager providing additional support in divisions whenever necessary.
Increase in new complaints which may impact on capacity to manage caseloads effectively given increased volume	Use of electronic caseload tool to identify risks at facilitator level and assign appropriate actions Use of new complaints process to manage these within timescale by ensuring constant movement through process Monitoring of complaint numbers through Pals & Complaints Manager daily Tracking , weekly Support and Challenge meeting and monthly reporting

CQCACTIONS

Priority areas from the CQC Improvement plan are discussed elsewhere in this document, in those topics marked with an asterisk (*).

The Trust on 26th October undertook Urgent and Emergency Care Provider Collaboration review with the CQC, based on the Patient First guidance published in October 2020. No feedback is expected from the session but the responses feed into an app which will help inform when the next inspection will occur. The CQC have been invited to join the Divisional meetings again over the next 6 weeks to introduce the new Relationship Inspector.

Overall summary of grogress with CQC actions

	Se t	October	November		Chane
Number of actions	143	144	144		t
Blue		11% 16	22)	11.6% (14	↓
Green		45% 65	58)	62.5% (75	↑
Amber		15% 22	16)	5.0 % (6)	↓
Red		26% (38)			H
Need u date	0.7% (1)	0.7% (1)	0%		
On hold	1.4%		2		

Month by month comparison is more difficult this month as in all but Community and Therapies, the Improvement plans have been refreshed. Actions have been combined or if signed off in the previous month removed. This allows more focus on the work remaining. The action plans are becoming more streamlined. In addition, more sub-actions have been added to help achievement of the overall action and timescales refreshed to reflect the second wave of COVID 19. Areas that are red are largely due to activity performance, Mandatory training and PADRS, some slow progress and areas where additional resources are required to meet the standards. In the latter case position papers are being written to detail the mitigatory actions and any proposed plans to work differently.

Risk	Mitiaation
Delay in completing actions due to operational challenges	Maintaining Divisional meetings with reduced attendance Divisions continuing with Divisional Governance meetings
Delay in sign off and submission to CQC due to operational pressures and establishing a new process. Documents sent to the CQC which do not provide assurance.	Providing additional support to the Divisions to complete assurance templates Establishing a robust system which allows executive oversight and robust information to be submitted to the CQC First documents have been shared with the CQC awaiting feedback.

IPC including Outbreaks

The aim 1s to m1rnm1se the nsk of cross in ect1on within Trust premises.

Risk	Mitigation
COVID outbreaks risk will occur due to poor infrastructure, surge of admissions and laboratory turn-around time and asymptomatic staff.	Following national guidance in relation to Covid-19 Companies were asked to review the feasibility of erecting additional single rooms / PODS. These won't be in place until January 2021 at the earliest and likely a phased approach; as a result an alternative approach is being adopted. The Trust ordered x30 Redirooms to act as additional isolation capacity to nurse yellow and Red patients. In addition the Trust is looking to place an order for Cubiscreen, which is plastic curtain that will provide a shield between patients and especially useful where

	Redirooms cannot be used due to space restrictions e.g. HASU. The lateral flow testing is now up and running with over 3500 kits distributed and currently a low positive prevalence of approx. 1-3%. This testing should reduce the impact of asymptomatic staff spread. The Trust is following the key actions document released on 17th November and has introduced day 3 swabbing. There have been some technical issues with the WebV flags, however the IPC team are producing a list of patients that require a reswab, managed via the ICC. The Key actions 10 bullet points released has been received with mixed views nationally, e.g. not moving patients until 2 negative swabs. This would clog up the patient flow hence patients in NLAG are moved due to clinical rationale. The other actions mentioned are already well established and covered off in the IPC BAF and COVID secure recommendations.

PPE

The overall aim has been to ensure adequate and resilient supply of the necessary items of PPE across all sites and for all individual staff requirements, with the capacity to respond to fluctuations in demand driven by different factors, e.g. new guidance or changes in patient numbers.

Risk	Mitigation
Availability of key PPE products nationally has been placed under extreme pressure due to the nature of the pandemic	Availability of key products has improved significantly over recent months, helped by a move towards manufacturing and supply being more UK focused as well as an increased capacity in production of PPE globally. National distribution has become more sophisticated and is able to respond effectively to daily usage rates to deliver PPE in the necessary quantities. This 'Managed Inventory System' works on information provided by all Trusts on a daily basis. Its aim is to provide a more even approach to deliveries and provide buffer stocks to minimise the risk of critically low levels, which were regular features in Wave 1 of the pandemic. NLAG continues to play an active role within the STP PPE group which meets remotely 3 times per week to offer mutual aid on PPE stock where required. This enables the Trust to receive urgent supplies as and when required and to vice versa. As a Trust we have moved to reusable respirators to help reduce usage on single use FFP3 masks. This has been a priority for RED areas. However due to the IAAU project and ward moves this has resulted in a loss of momentum and staff that were previously fit tested with these masks are no longer working in the same location.

12 Hour Breaches

The overall aim is to have zero 12 hour trolley breaches within the Trust. 12 hour breaches are when a patient within the Emergency Department has had a decision to admit made and accepted by the relevant specialty but there is a delay of 12 hours or more for a bed to be made available for their admission. There were 58 declared OTA breaches in November 2020 (DPOWH: 45, SGH:13). Validation has shown that continuing care was provided to patients during their prolonged stay within the Emergency Department. An apology is provided to the patients at the time of their breach by the senior clinical staff in the department.

The average time patients were in ED before a decision to admin was made during November 2020 was 160 mins at DPOWH and 168 mins at SGH.
The longest trolley wait for a patient awaiting admission during November 2020 was 29 hours at DPOWH and 22 hours at SGH.

Risk	Mitigation
There is a risk of 12 hour breaches occurring due to a lack of bed availability and patient flow out of the Emergency Department.	Daily operational meetings to review and amend the ward zoning and patient movements to enable bed availability for the patients requiring admission. Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital. Review of the 12 hour escalation process to support early exploration of radical options to support prompt patient admission and 12 hour OTA breach avoidance. Development of a '10 is the new 12' initiative to treat 10 hours as the new OTA trolley breach deadline to be rolled out however, awaiting new national guidance on admission targets before release. Validation of all 12 hour breaches to identify themes and lessons to be learned to avoid future breaches.
Risk of harm to patients kept in ECC for more than 12 hours	Increased staffing to ECC 2 hourly board round with EPIC (Emerg. Physician in Charge) and Band 7 coordinator to identify risk Nursing care needs monitored through Care Round document (risk assessments for pressure ulcers, falls, nutrition, hydration and comfort) Alternatives to trolleys - beds, recliner chairs Red mattresses provided where needed Choice of meals including hot meals Medication and observations as required

Black Ambulance Breaches

The overall aim is to have zero black ambulance breaches within the Trust. A black ambulance breach is when a patient arrives at the Emergency Department by ambulance and the period of time for the ambulance handover to be completed exceeds one hour. The target time for an ambulance handover is 15 minutes. Black breaches have increased over the past three months with November 2020 resulting in 284 (DPoWH: 171, SGH: 113). Patients waiting in the ambulances are registered on the Emergency Department Symphony system and are included in the clinical board rounds to ensure ongoing safety and clinical escalation. An apology is provided to the patient by the clinical team at the time of the breach.

Risk	Miti ation
Black ambulance breaches occurring due to lack of available clinical cubicles within the Emergency Department. This has been impacted by the covid-19 implications and a lack of patient flow out of the Emergency Department. The chart below shows the link in hospital bed occupancy levels to ambulance handover 60mins+ black breaches: Bed Occupancy and A&E Breaches durin& the COVID pandem ic Produced: 02/12/2020 SGH Week Commencing 60 Min Breaches 12hr DTAs Bed Occupancy (Available Beds Estimated from Daily SitRep Data) Bed Occupancy DPOW Week Commencing 60 Min Breaches 12hr DTAs Bed Occupancy (Available Beds Estimated from Daily SitRep Data) Bed Occupancy	Ambulance Handover Task and Finish Group chaired by Medicine Division involving EMAS and YAS. UTC moved out of the ED footprint at SGH to restore the Ambulance handover bay. Ambulance handover improvement plan. New ambulance handover process implemented on 9th December 2020 which improves efficiency and clinical safety of handover and moves to paperless triage. ED Matrons validation all black ambulance breaches to identify themes and lessons to be learned to avoid future breaches. Additional actions added to ambulance handover action plan which identifies fast track option for paediatric patients and records assessments of patients being held in ambulances awaiting capacity in ED to commence handover.

MORTALITY

At the outset of the pandemic, there was a concern about monitoring the increased deaths for learning with the aim to maintain the Trust target for 2020/21 of screening 50% of deaths and undertaking subsequent Structured Judgement Reviews.

Risk	Mitigation
Mortality will increase	Mortality Improvement Group monitors mortality performance including the impact of Covid-19 mortality. Clinical Ethics Committee and Clinical Reference Group re-established During Wave 2 not all Covid-19 deaths will be reviewed. A sample of deaths will be reviewed to seek understanding of

	current quality matters and to seek assurance that actions taken in response to learning from Wave 1 were effective. The latest SHMI data covers up to July 2020. There is a lag between Wave 2 pressures, where the Trust has been impacted by Covid-19 much more than during Wave 1. Whilst Covid-19 is excluded by SHMI, the impact of altered activity and increased number of deaths cannot be fully projected. The latest mortality crude mortality data for the month of November will be available towards the end of December.
Co-morbidities will not be fully recorded leading to an increase in the SHMI	Grant Thornton reviews have continued with Trust coding team members. During the Summer, Divisional lead clinicians have been nominated to expand clinician led coding. This will continue following Grant Thornton's time with the Trust on this project ending in December 2020. In Division of surgery, engagement plans have been delayed due to the DPoW lead being unavailable due to illness. This is planned in during December 2020.
Inability to progress with mortality reviews within divisions resulting in a reduction in the proportion of deaths being reviewed for learning lessons purposes	In Wave 1 the Trust used shielding clinicians to review all Covid-19 deaths and BAU activities were maintained meeting the Trust's Quality Priorities. For Wave 2 the shielding criteria has changed resulting in fewer clinicians being available to support mortality reviews. Those are shielding have been contacted and are supporting urgent reviews first. 29% of SJRs required for October deaths had been completed as at the end of November. This has been added to the risk reQister.

Mortality related reviews of priority:

Area	Risk during Pandemic	Action /Mitigation
Liver Disease, alcohol related	Limited progress due to staff shortages in Gastroenterology. This is an externally notified (Dr Foster) outlier alert which will be followed up	Mitigated using shielding clinicans during wave 1. Review work concluded and discussed at collaborative meeting with CCG. Formal report being prepared for assurance
Sepsis mortality	Sepsis mortality has been identified as increasing, with a rise in February noted. There is likely a connection with data quality given the latest report from Grant Thornton to MIG that identified an over recording of pneumonia deaths and the reassignment of these to other chapters, including sepsis, to ensure data accuracy and quality. The GT work commenced in February 2020 so likely this is linked to an increase seen in sepsis related mortality.	Review work has been undertaken and links to deteriorating patient and sepsis group. Outcome data not yet analysed. Formal reporting and feeding back to MIG will be required.
Mortality reviews	The Trust are at risk of not meeting their quality priorities around mortality reviews (50% of deaths reviewed; 100% of priority cases reviewed).	Successful pilot completed linking coding reviews with quality of care screening (quality priority). Expansion of aooroach

	Agreed at MIG to add to the risk register.	to cover all Medicine deaths which will equate to equal >50% of Trust deaths to be taken forward with Grant Thornton during November 2020. Expansion of approach commenced in Surgery and Family Services. Roll-out in Surgery delayed due to absence of nominated clinician. To recover during December 2020. SJR reviews to utlise Wave 2 shieldinq clinicians is underwav.

End of Life*

The Trust's last CQC report identified themes and challenges in relation to end of life care. Some of the work required was for the Trust to lead on and others, to be successful in bringing about real improvement, required a wider system approach. The Trust is working with partners to strengthen the arrangements for governance and assurance for end of life services. The NLAG end of life group has been strengthened to include oversight of intelligence available from complaints, incidents, PALS, clinical audit and mortality reviews. From triangulation of these information sources, six key improvement themes were identified:

- Recognition that a patient is entering into the End of Life phase;
- Proactive and advanced care planning in preparation for end of life;
- Communication;
- Listening to the patient and family, involving them to develop personalised plans of care;
- Assessment of patient needs at EOL including pain assessment;
- Making best use of the care in the last days of life document

All key themes are within the improvement plan are progressing within time frame with the exception of those identified in the risk table below. In May 2020, with support from NHSE/1, a collective approach with a strengthened governance structure, with partners across Northern Lincolnshire driving a system wide approach has been agreed.

Risk	**Mitigation**
Current Trust Palliative care arrangements not optimal - SGH does not have 7 day service; DPoW service is not comparable **toSGH**	NHSE/1 Process mapping work to review/potential to streamline delivery of EOL services have been completed. Partner conversations ongoing around future EOL pathways and provision of services which have been identified as a priority project. Process mapping sessions set up for January and current scoping of best practice underway. EOL steering group looking at Specialist Palliative care cover/advice **24/7,** across Northern Lincolnshire , not specifically focused on consultant cover.
Improvements required on the identification, planning and communication of EOL care with	ReSPECT roll out has started and progressing. The work on EPaCCS has been accelerated to drive improvements across NLaG and partner

greater use of advanced care planning tools. There is a risk that the current pandemic surge will delay the accelerated work and training.	organisations. Continue to use video technology and virtual training but the uptake is problematic due to the current operational pressures.
Mandatory training levels and core competencies continue to have pockets not meeting the trust targets. There is a risk that the current operational pressures will affect the training.	Virtual training in place and on ward training to capture staff but the uptake is problematic due to the current operational pressures. EoI Core Competencies training continuing and staff being supported on the wards to care for patients
Delay in the launch of the pain assessment tool and updated guidelines	Clinician final approval required for the amendments to the guidelines to launch. Operational pressures have delayed the completion date. Currently the approval is being achieved by direct contact with clinicians, email consultation and improvement team support.
There is a risk that the care in the last days of life document will not be utilised to the full potential during the operational pressures	The EoI team have relaunched the Covid 1 page document as an alternative to the 15 page *Last day of life* document. The 1 page document was launched in Wave 1 and well received by the staff without any concerns. This reduces the time staff taken to document care provided whilst providing the quality framework to ensure that patients and their significant other, receive appropriate care. Audit will take place on this document and support is being offered to all staff providing the care.
Divisional engagement into the EoI meeting may be reduced due to operational pressures	The divisional engagement into the EoI meeting has started to pick up momentum with good engagement evident from the two largest divisions Medicine and Surgery. Continue with the virtual meetings and reducing the length of the meeting as appropriate.

SERIOUS INCIDENTS

The 60 day timeframe for SI investigations remains suspended due to Covid-19. The Quality Governance Team in the MD Office is working with clinical areas to ensure:

- Patient safety is not adversely affected by delays in implementing actions / learning from Sis
- Patients or families are not distressed by the increased delays.
- Training on investigations continues virtually

There are currently 57 Serious Incidents under investigation, 11 of these are 12 hour breaches. Following direction from NHSE/1, 12 hour breaches will no longer be reported immediately, but will be reported to StEIS if significant harm has occurred as a result, as identified through the 48 hour report.

Category	Number of Serious	Sign off	Risk of Dela

	Incidents		
Never Events	1 wrong implant	Medical Director	Low
Pressure Ulcers	14	Chief Nurse	High
Falls	8	Chief Nurse	High
Stop the Clock (confidential police investiqation)	1 (=)	Medical Director	None
Maior Incident, Oxyqen Suoolv	1	Medical Director	Hiqh
Maternity: • HSIB - Unexpected admission to NICU following NVD • Intrauterine Death • HIE Grade 2 • Unexpected admission to SCBU	4	Chief Nurse	High
Others	32 including 11 twelve hour breaches	Medical Director	High

At the start of Covid-19 Wave 1 there were 77 Serious Incidents under investigation; a total of 73 have been concluded and submitted to the CCG, leaving 4 remaining under investigation from pre Covid. Three of these reports are now at the final sign off stage and the remaining SI relates to a police investigation and is currently a 'stop the clock' investigation.

Investigations on Incidents of High Concern:

0,pen seriou.s mc1'dents mom·tored for potenf1al safetty concerns are:

Investigation	Action / Investigation Progress	Risk during Pandemic	Mitigation
Inadvertent Paracetamol Overdose	From 2018, had been under police investigation until January 2020. Highly complex with over 40 staff interviewed.	Medium- Priority to maintain timescales	HSIB were invited to investigate and are currently looking at a national report on the risks of paracetamol to those under 50kg. Prioritised to finish by December due date.
Paediatric Sis	An infant was brought in having suffered a significant dog bite; there were queries in regards to the fluid resuscitation. This is a multi-agency investiqation.	Medium Risk of investigation delay	The NLAG side was discussed in the ECC department
Information Governance	Inappropriate access to health care records. Investigation in progress.	Medium	Emails have been sent to all staff reminding them of their IG responsibilities
Never Event	Wrong Ophthalmology Implant undertaken by an NLAG surgeon at St Hughs	Priority investigation to maintain timescales	Immediate change in process for Ophthalmology at St Hugh's. Comparison review of other checklists and processes between

			NLAG and St Hugh's. This is a priority for completion on time.
MAJAX	A major incident was declared in relation to ensuring oxygen supply in regards to infrastructure. No patients came to harm.	Medium	Daily monitoring of oxygen pressure by ward. Increased portable oxygen to enable alternative delivery. External Investigator

Families are being kept informed of the delays to investigations.

Lateral Flow Testing

The aim of this national programme is to test all patient-facing staff twice weekly for SARS CoV-2. Participation in this screening process is not compulsory but we are encouraging all eligible staff to participate. Any staff member who has tested positive by PCR will NOT need to perform the LFDs for a period of 90 days after their positive PCR. This is because the LFD may give a false positive result resulting in unnecessary further testing and self-isolation for you and your household.

Progress to date (14/12/2020)
Total test kits distributed: 3601
Total results returned: 3047
Positive returns: 44
Neqat1ve return: 2996

Risk	**Mitigation**
The trusts runs out of tests are unable to order more.	An ordering schedule is in place with the supply chain however the Trust is limited by the national supply of tests.
Staff have kit but are not registered on result processing system or input the results incorrectly	Results processed those not registered to a user still enter the database and are followed up
Staff receive False positive	All positive result are followed up with PCR test - automated system informs line manager and swab team at time result inputted to ensure no delay in arranqinq PCR test
Staff receive False negative	They will be testing twice weekly and regular before work. PPE/cross infection rules have not changed and staff still expected to adhere to government guidance on social distancing. Self-testing is extra precaution in ensuring limiting spread of Codid-19 on top of existing measures in place.
Staff receive inconclusive result	After 2 inconclusive results staff must contact the Self testing team for further instruction. Further demonstration on self-administering test may be required.
Staff stop using testing kit	Data monitored any staff that stop using kit who have not had positive PCR will be followed up by self-testing team.
Staff loose/damage testing kits	Staff who stop using kit who do not have positive results will be followed up, Damaqed lost kits will be

	investigated further to assess reasoning for this. Replacements issued stock depending and when possible misuse determined.
Staff do not choose to take part	It is not compulsory, although we encourage and recommend, Stock permitting staff can opt in at any time. PPE/cross infection rules have not changed and staff still expected to adhere to government guidance on social distancinq.

Risk	Mitigation
The Trust will not achieve 100% participation in lateral flow testing of those who do not qualify for exclusions.	Communication continues to encourage all staff to participate
More staff will be absent due to false positives	Those testing positive self isolate immediately but are then sent for PCR tests This will reduce absenteeism due to contact with Covid positive patients or individuals

Maternity- Ockenden Report and CQC Actions

An independent review of maternity services was requested and undertaken at the Shrewsbury and Telford Hospital NHS Trust. The first report published 10 December 2020 follows 250 cases and forms seven immediate and essential actions. The aim of the actions is to improve safety in maternity services across England

Risk	Mitigation
Enhanced Safety - to strengthen partnerships between Trusts and local networks. Work collaboratively to ensure Si's have regional and LMS oversight	Current collaborative working is limited to CCG involvement and external input at the Trust request. To work with LMS in relation to Serious Incidents Perinatal Clinical Quality Surveillance is done in the Trust, known as PMRT.
Listening to Women and Families - women and their families are listened to and heard	Current involvement of Maternity Voices Partnership. To work with LMS to create an independent senior advocate role. Re-appointment to Non-Exec Director with oversight into maternity services following recent retirement
Mandatory Training and Staff training and working together	Multi-disciplinary training in place, to be evidenced by LMS. To work with staff to ensure percentage compliance meets Trust requirements, 88% for core at the end of November and 81% for specific training.
'Live' skills training	Further simulations planned, report and action plan
Managing complex pregnancy - pathways and development of tertiary Maternal Medicine Centres	Women have named consultant lead locally. Development of maternal medicine specialist centres with 'hub & spoke' model. Trust already meets requirement for regional integration of maternal mental health services.

Risk Assessment throughout pregnancy	Risk Assessments undertaken locally - to audit
Monitoring Fetal Wellbeing	Already meet requirement for midwife fetal monitoring lead, but a Medical Lead is to be identified Do not currently meet Saving Babies Lives Care Bundle v2 (elements, smoking and CO2 monitoring, element 2 on fetal growth restriction and element 5 on reducing pre term births for trans vaginal cervix scanning) The progress on this is addressed in the paper which goes to Quality & Safety Committee
Informed Consent	Process in place To audit information qiven to women
24/7 theatre access, maternity SGH	Working with S&CC to commence 24/7 cover by the end of January 2021

CONCLUSION

In summary, the most significant risks are:

- Impact of the increased clinical pressures with Wave 2 of Covid-19 on waiting lists, risk stratification, cancer, 12 hour breaches and ambulance delays with the resulting slowing of some patient safety work as evidenced in the CQC action plan.

Mitigations are in place, including redeploying central staff and using central Governance staff to try to pick up some of the patient safety assurance work (for those not redeployed) where possible to alleviate the impact on clinical areas, however it is not possible to entirely remove the impact as evidenced in the 12 hour breaches. Steps have been taken in discussion with the CCG to minimise the post Covid impact of assurance on these.

Progress continues to be made in addressing CQC actions, and in monitoring for external reports for learning, such as the Ockenden report, which has been welcomed and reviewed with speed.

RECOMMENDATION

The Quality & Safety Committee is asked to

- note the key risks identified and mitigation work

CoG (01/21) Item 2.2.2

DATE	19th January 2021
REPORT FOR	Council of Governors (CoG) (Public)
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Dr Peter Reading, Chief Executive
SUBJECT	Integrated Care System Partnership Working Update
BACKGROUND DOCUMENT (if any)	Letter from the Humber Coast and Vale (HCV) Humber Care Partnership (HCP), regarding the Integrating Care: Next Steps for Integrated Care Systems (ICS) and legislative proposals (Appendix A).
PURPOSE OF THE REPORT	To note the update
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Letter has been circulated to members of the Trust Board.
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	To provide the Council of Governors with an ICS Partnership Working update including the supplementary views from the geographic partnerships within HCV. The letter in Appendix A on Integrating Care: Next Steps for ICSs, was prepared by the HCV HCP, following consultation with all partners, and subsequently submitted to NHSE/I on Friday 8 January 2021. The letter presents shared views on the document that was published on the 24th November 2020 on Integrating Care: Next Steps for ICSs and the proposed legislative changes aimed at removing barriers to integration across health bodies and with social care. The views represent the collective response from the partner organisations of the HCV HCP which already holds integrated care system status. The letter explains that the partnership supports the direction of travel and the opportunity to build on and make the appropriate adjustments that need to be made to reflect the policy changes. Partners agreed that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future. The agreement from partners was broad, and a preference through the discussions to option 2.

	Further detail from each of the geographic partners can be viewed from page 6 (Annex One).

ACTION REQUIRED				
Approval	**Information**	**Discussion**	**Assurance**	**Review**

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to?				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

TRUST PRIORITIES - which Trust Priority does this link to?					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	**Strategic Risk 9:** Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment.
CoG Action Required	The Council is asked to note the report.

Kindness·Courage·Respect

January 2021

Humber, Coast and Vale Health and Care Partnership
Partnership Office
NHS Hull Clinical Commissioning Group
2nd Floor, Wilberforce Court
Alfred Gelder Street
Hull, HU1 1UY

Email: hullccg.hcvstppmo@nhs.net

Dear Colleagues

RE: Integrating Care: Next Steps for Integrated Care Systems

Thank you for the opportunity to share our views on the document you published on the 24th November 2020 on Integrating Care: Next Steps for Integrated Care Systems (ICSs) and the proposed legislative changes aimed at removing barriers to integration across health bodies and with social care.

The following views represent a collective response from the partner organisations of the Humber, Coast and Vale Health and Care Partnership which already holds integrated care system status.

As a partnership that has been and continues on a development journey, we are very supportive of the direction of travel set out in the document and welcome the opportunity to build on and make the appropriate adjustments that need to be made to reflect the policy changes set out.

We agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future. There has been broad agreement and a preference through our discussions to option 2.

We believe this model will provide greater encouragement for collaboration and flexibility to establish arrangements that suit the needs of our population, alongside strengthening lines of accountability most importantly, to our patients.

We welcome the clarity of purpose rooted in creating health and care systems that will be better placed to:

- Improve population health
- Improve access and address health inequalities
- Drive better quality and value
- Directly engage the NHS with wider social and economic development.

The partners in Humber, Coast and Vale also felt we needed to ensure that other proposals in the document were drawn out as key tests for a successful integrated care system, these include:

- Operating as an equal partner with local government and the voluntary and community sectors
- Co-producing strategies, plans and outcomes with patients, citizens and their representatives.

On improving population health and health inequalities we would like to see a strengthening of strategic planning to support this and feel a longer term outlook (5-10 years) is required to make changes to population outcomes.

Place

The emphasis on 'place' in the document is universally seen as positive and we will ensure decisions and resources are devolved as close to communities as possible. It remains a main focus for strengthening local leadership, increasing integration and developing primary care in its broadest sense as both a foundation and as an equal partner in transforming services. We see 'place' as the key enabler to continuing to improve the overall health and wellbeing of people living in our area in equal partnership with local government.

Having said that, for a large geographical area such as Humber, Coast and Vale there is logic to an approach that brings a number of places together on a footprint which is smaller than the ICS, but is through the functions of the ICS. This would enable partnership working, strategic leadership and planning of integrated care to meet the needs of populations greater than a single place, to drive better value, address health inequalities and the wider determinants. In doing so, we would not envisage additional formal governance or accountability of the ICS, but instead flexible and dynamic arrangements for the practical delivery of outcomes and services across 'places'. The partnership arrangements already established in Humber, Coast and Vale are demonstrating this through the strength and depth of the managerial, clinical, professional and lay leadership. They have contributed complementary views as set out in annex one.

We feel the approach set out in the document is permissive and pragmatic enough to enable governance arrangements to be established that make sense in the context of our geography and arrangements we already have in operation but also to develop further ways of working and developing clear accountabilities with arrangements such as Health and Wellbeing Boards, we welcome this. We would encourage in any further considerations this flexibility remains so that ICSs are able to strengthen integration and reduce bureaucracy.

Provider Collaboration

We are supportive of the changes proposed for provision, based on duties of collaboration at place within provider collaborations and across an ICS within provider collaboratives, where patient pathways need to rely on services of more than one trust or organisation due to the specialist nature of treatment. We acknowledge for the sector specific collaboratives the value is in designing and delivering specialist and other services at scale that meet the needs of our population, where it makes sense to do so. There are some highly specialised services where we feel it might be beneficial to still consider whether they should be delivered on a multiple ICS or even a national basis e.g. Deaf Services for CAMHS to ensure patient safety is maintained and workforce expertise is available.

We also need to continue to recognise the value of diversity in our providers particularly for areas such as Humber, Coast and Vale where we have a vibrant Voluntary, Community and Social Enterprise Sector that focus on delivering care closer to home as we increasingly shift resources into the community. They also play an important strategic role at an ICS and multi-ICS level, with many community providers working across systems and in at scale provider collaboratives. This is an important point for community providers as the landscape of provision varies greatly across the country. While some ICSs have large community providers, others such as Humber, Coast and Vale will have a more mixed collection of varying sized providers delivering a myriad of services. The proposals also only reflect community providers' relevance at

place which we fully support, however, there is a role at an ICS level where they bring together primary and community care into a collaborative network, developing plans to deliver more care at home and in the community to improve population health outcomes. We feel it is important that the leadership role that community providers' play at place and system level is emphasised and the changes need to ensure parity of esteem across mental and physical health, and care in the community and in hospital.

As providers, Ambulance Trusts are an important part of our provider collaboration both at place and across the ICS. We recognise that this is significantly challenging for them as they tend to span multiple ICSs. Therefore, we feel it would be beneficial for consideration to be given to ambulance collaboratives being coterminous with wider regions ensuring alignment to ICSs within that region to enable them effectively work with systems and places.

What must not be underestimated is the balancing for all providers between place and sector and that they are supported appropriately to do both. Whilst there is some acknowledgement of their role as anchor institutions this could be strengthened to include more around their social and economic value and not just a focus on fair and equal access.

As mentioned above Primary Care is the foundation of delivering better outcomes for the population and specifically the role of Primary Care Networks within this. Whilst there is recognition through development funding that they need to be supported to grow, they are all at different levels of maturity. It would be helpful if further consideration could be given to the capacity and support needs to enable them to be an equal partner alongside the other provider organisations.

Partnership with local government

Whilst our existing arrangements are and any changes to these arrangements will be mindful of the potential reforms to local government and allow for greater alignment and integration in the future, we propose that should there be any further consideration of the model to ensure the flexibility between health, public health and social care is maintained and enables places within systems to build on existing established arrangements between the NHS and local government and create the equal partnership that can address the needs of a population. With the proposed changes to Public Health England and the impact of reduced funding to local authorities on community services and clinical aspects of health improvement / public health services, we also feel there needs to be greater consideration with local authorities of the roles of ICSs in this area.

Clinical and Professional Leadership

There is clear message about the clinical and wider professional community being a powerful force for leadership and governance at every level, as well as the voluntary and community sector and citizens and this has been collectively acknowledged by partners in Humber, Coast and Vale as a positive direction. A specific response from the Clinical and Professional Group is set out in annex two.

Workforce

We are also supportive of the direction in relation to our people as creating a sustainable workforce is key to the delivery of our ambitions. It is vital that there is engagement with other stakeholders, such as Health Education England, Universities, Further Education providers and schools and other public sector organisations to ensure we maximise the opportunities.

Finance, transformation and digital

Whilst we recognise there is further detail to be developed, we welcome the proposals around the financial arrangements set out in the document. This will enable us to ensure resources are more effectively linked through to our places to address health inequalities and improve outcomes for our people and communities and are also available to support delivery of national programmes and transformation change as a system. We also welcome the focus on connecting health and social care, using digital and data to transform care and put the person at the centre of their care. Annex three provides a further response to the digital and data proposals.

Changes to commissioning

The proposals will lead to significant change for commissioning and the document refers to absorbing Clinical Commissioning Group (CCG) functions as core ICS business. We believe to have a successful integrated care system this will only be a small part and that to deliver on the purpose described in the document we will need to ensure the functions are appropriately deployed to place, providers and the system. As we are sure you will be aware, this causes concern for colleagues in our organisations particularly in CCGs. The document suggests 2021/22 will be a transitional year and central to this will be the redeployment of staff with guarantees of employment as we transition to new roles, ways of working are reshaped and changes are made to the current system to enable the new one to be formed and we welcome this. This will be an unsettling time and will cause significant uncertainty and anxiety for all colleagues who have been and continue to work exceptionally hard in response to COVID-19. Whilst as a collective group of leaders we will manage this change and transition, expediency in our requests for support / further national guidance, so that we can give staff the certainty they are looking for would be appreciated.

Link with NHS England and Improvement

The North East and Yorkshire (NEY) region was the first region in England to have 100% ICS coverage, and as a result we believe the ICSs are in a very strong position to take on the statutory role and responsibilities outlined in the proposals. Building on the firm foundations, as ICSs in NEY we work closely with the regional team as part of a "four plus one" approach, with collective leadership from ICS leaders and the Regional Director. Many regional staff are already embedded within, or aligned to, the ICS. NHSEI Locality Director works directly to ICS leader, playing a key role and working as a bridge between the region and the ICS. Working in this "four plus one" way has proved highly effective in managing the response to Covid, in service planning, performance management and development of a commonly agreed framework for deploying staff. This puts the ICS and the region in a strong position to manage any transition process.

To ensure as an ICS, that we have the coherence and capacity to deliver, we would be supportive of an approach that would see the devolution and/or delegation of central and regional NHSEI functions along with the appropriate resources. Recognising that we will work together with the other ICSs in the region, through lead ICS arrangements and building on our "four plus one" approach, we feel that this would put all the ICSs in region in the strongest position to succeed.

We are keen to see an evolutionary approach rather than nationally driven reorganisation, agreeing with the expressed wishes of the Secretary of State that this should be avoided, and learning from previous NHS reorganisations.

Finally, we would like to reiterate our thanks for the opportunity to share our views, we welcome the direction of travel and should you wish to follow up on any points raised then please do get in touch.

On behalf of the Partner Organisation Members of the Humber, Coast and Vale Health and Care Partnership (ICS)

Prof. Stephen Eames CBE
HCV Independent Chair and System Lead

Amanda Bloor
Accountable Officer,
of North Yorkshire & York System Leaders

Emma Latimer
Accountable Officer, Chair
Chair Humber Partnership

Andrew Burnell
Chief Executive of City Health Care Partnership,
HCV Community Collaborative Chair

Chris Long
Chief Executive of Hull University Teaching Trust,
HCV Acute Collaborative Chair

Michele Moran
Chief Executive Humber Teaching Foundation Trust,
HCV Mental Health Collaborative Chair

Nigel Wells
GP, Chair of Vale of York CCG,
HCV Clinical Lead

Annex One – Supplementary Views from the Geographic Partnerships within Humber, Coast and Vale

Humber

The Humber Partnership is a diverse health and care system comprised of 17 Primary Care Networks, four Local Authorities, four Clinical Commissioning Groups, seven NHS providers and three Community Interest Companies.

Together we work on behalf of the approximately 1 million residents of the Humber to achieve sustained improvements in the health, wellbeing and inequalities experienced by our people and communities through the four places that are aligned with each of the local authorities in the Humber.

We are supportive of the direction of travel set out in the document and agree with the approach to move ICSs to a statutory footing from 2022 (Option 2). We agree that these proposals will provide greater encouragement for collaboration to address health inequalities and improve population health. Whilst we acknowledge that option 2 will provide a longer-term solution to achieving this integration agenda compared to option 1, we have concerns that the arrangement may provide clarity of accountability for Parliament, the clarity of accountability to patients is less evident and more further consideration needs to be given to governance and public accountability.

As a partnership we recognise the potential for the proposals to really strengthen our approach to key enablers, for example:

- *System workforce planning in partnership with Further and Higher Education*

Greater system level workforce planning will enable providers to share expertise, support engagement with further and higher education, and support the development of more flexible training and career choices which encourage people to live, learn and stay local.

- *System intelligence*

True system working will require system intelligence built around individuals, communities and population groups. We recognise the need to bring all organisations and PCNs with us in order to make available linked data sets connecting primary and secondary care data with 999, NHS111, and Local Authority data, to understand and predict service utilisation, identify gaps in provision and target high risk groups.

- *Place at the heart of system health and care provision*

As a partnership we identify PCNs, neighbourhoods and place as key drivers for change. We are looking to align CCG management expertise and clinical leadership to support the rapid development of PCNs and neighbourhood service offers for populations of 30-50,000, which formalise relationships between health, social care and community assets. It is our intention to rapidly develop primary care to form a strong foundation, which is evident through every level of the ICS, and which has the capability to deploy resources at neighbourhood level differentially and disproportionately.

There are areas which are underrepresented in the document where further clarity would be helpful – particularly with regards to accountability (question 2 posed by the document) and governance arrangements (question three) including but not limited to:

- *Discharging quality functions and statutory responsibilities under new arrangements*

Quality (Safety, Outcomes, Patient Experience) should be a clearly defined function within the ICS. We welcome a shift in the focus of Quality Assurance, from individual provider monitoring and improvement, to cross-provider accountability for population outcomes and pathways of care. This should be reflected in a system interface with the CQC. There is opportunity to establish clarity through a Quality Framework which operates at multiple levels, from neighbourhood through to system level, with the ability to establish joint oversight with Local Authorities. We would want to harness the significant expertise of leadership for quality of care, quality assurance, quality improvement, and advocacy for patient experience which exists in CCGs to ensure that those multiple layers, especially at place, feel the benefit and the independence from providers that this brings.

CCGs have statutory responsibilities (alongside other statutory partners) for safeguarding, child death review arrangements, research and the requirement for a SEND Designated Clinical Officer. These responsibilities could be aligned through new legislation to the ICS, with strategic leadership supporting delivery of responsibilities through partnerships operating models. For safeguarding and child death review this could operate effectively through geographic partnerships, and for research through provider collaboratives and PCNs. The SEND DCO role closely aligns to place, defined by Local Authority boundaries. We welcome the opportunity to draw on our local expertise to define accountability and delivery arrangements which fulfil statutory responsibilities through the transition period and beyond.

- *There is a degree of ambiguity in systems shaping their own governance arrangements, particularly given the potential introduction of new geographically-based and sector-based collaborations, and potential implications for individual organisations in managing system performance.*

We welcome the opportunity to develop local financial rules but recognise there is a risk that financial systems will be determined by historic behaviours and practice, which traditionally 'lock-in' resource to sectors and tend not to prioritise preventive and proactive interventions which offer solutions to system problems. This approach cannot continue, particularly when set against the disproportionate impact of Covid-19 on people who are already experiencing disadvantage and discrimination, and will only contribute to rising costs of health and care in the long term.

We welcome the capability as a partnership to target our collective resources to where we have the greatest potential to address inequalities and improve outcomes for our people and communities, although disruptive financial mechanisms are required to support the shift in mindset.

However, it should be noted that in developing existing joint working structures care has been taken to work closely with local government, to establish arrangements through which decisions can be taken together (for example in East Riding, Hull, North and North East Lincolnshire through CCG/Local Authority Committees in Common / place based collaborations). This has enabled

services to be designed and commissioned in collaboration and by the most appropriate local government and / or health partner with a wide range of provider organisations in an integrated contractual form. It is not clear how integrated decision making will be facilitated within the revised arrangements. The focus of the consultation document appears to be primarily upon organisations which are formally part of the NHS. It is not apparent how private sector organisations or the voluntary sector, commissioned by local government to provide much of the integrated delivery chain for the provision of health and social care services, will be integrated into the delivery model.

While the consultation document recognises the importance of the footprint of Health and Wellbeing Boards, there is little reference to their future role. Health and Wellbeing Boards have enabled commissioners and providers to be brought together with other public and key organisations, for example the Police and Crime Commissioner, to provide the framework for development of a co-ordinated response to the wider determinants of health.

The opportunity exists to build on existing structures at place based on the knowledge developed over recent years. Decision making structures will need to respect the role of local government to allow integration with social care to continue and recognise local democratic accountability and wider social care commissioning requirements.

- *Priorities should be set by partnerships with strong clinical, lay member and elected member involvement, enabling disproportionate allocations which target those with the poorest health and support a recurrent shift in resources between sectors and geographies.*

The role of elected member, lay members and foundation trust governors has brought a wealth of experience, professional expertise and objective focus on decision making about local population health priorities. This voice will become distanced in a larger footprint and system governance arrangements will therefore need to reflect the role of place and provide the framework for democratic and community accountability, together with an understanding of people, communities and populations and how this is applied to decisions about priorities and resource allocations.

We are broadly supportive of an approach whereby services currently commissioned by NHSE transfer to ICS bodies. We welcome the opportunity to bring all available resources together to deliver population health care from cradle to grave, across whole cycles of care. We also recognise that there needs to be a multi-layered approach to ensure that value in terms of outcomes and resources is maximised.

There is benefit in moving elements of primary care commissioning to work more locally with PCNs, whilst other primary care services such as performer action lists should continue at scale.

The same is true of specialised services which require a larger population footprint beyond ICSs to maintain service quality and sustainability. Mechanisms will be needed whereby ICSs work through collaborative or hosting arrangements to preserve capacity and capability.

More broadly there are services and strategies which require a regional coordinated approach, for example Yorkshire and Humber Integrated Urgent and Emergency Care Strategic Commissioning and the Yorkshire and Humber Care Record.

As a Humber Partnership we have strength and depth by virtue of our partners and active involvement of managerial, clinical, professional, lay and elected members. The pace of change required to get us to April 2022 presents a significant challenge, recognising the scale and scope of proposed change and the level of ambiguity that remains.

In order to respond to the challenge we are mobilising our local leaders and subject matter experts; to develop and test new arrangements through 2021, learn from and share with other ICSs across the region, and support our members of staff – particularly those in CCGs and NHS EI – to play active roles in our system as it emerges.

North Yorkshire and York

North Yorkshire and York (NY&Y) Partnership has a diverse population of approximately 775,000 residents. It comprises of 76 GP Practices in 19 Primary Care Networks, two Local Authorities (North Yorkshire County Council and City of York Council), two Clinical Commissioning Groups and five NHS providers.

The NY&Y Partnership leaders are supportive of the direction of travel set out in the consultation document and support the approach to move Integrated Care Systems to a statutory footing from 2022 (Option 2). We agree that these proposals will provide greater encouragement for collaboration and will maximise the contribution the NHS makes to the social, economic and environmental conditions that shape good health.

As a partnership we recognise the potential for the proposals to really strengthen our approach to key enablers, and have the following key points to make:

A Strategic and Collaborative Approach to Economic and Social Recovery
We welcome the opportunity to come together as experts to greater influence economic and social recovery, particularly due to the impact of COVID-19 pandemic. We believe that a single, more powerful, voice to represent our regions working closely with other geographic partners will create a sustainable future for our population and our significant workforce. In short, we will work together more effectively so that the people of North Yorkshire and York get the health and social care system they deserve.

System workforce planning in partnership with Further and Higher Education
As detailed within the People's Plan and already embedded within our organisational development plans, we understand the importance of workforce planning, talent management and succession planning through further and higher education and are committed to greater system level workforce development. A flexible approach to workforce planning across wider sectors and geographies will enable a greater level of shared expertise and will encourage talented individuals to come into and remain in the area.

System Intelligence
We support the importance of a strong collaborative approach to system intelligence and for the system to understand how it can aggregate collective effort together at differing levels in the system to make sense of, and deliver on, the specific issue we are addressing. A strong intelligence function

is crucial for the ICS to deliver improved population health and needs to be flexible enough to support local 'place' requirements.

Primary Care at the Heart of System Health and Care Provision
We recognise that PCNs form a key building block of the NHS long-term plan. Bringing general practices together to work at scale is already a priority. We agree that the local voice of our clinicians is paramount in the successful development of PCNs and their sustainability. We agree with our clinicians that we must continue to develop PCNs at pace and for their voice to be heard in order to: improve the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

Improving Health Outcomes and Reducing Health Inequalities across a Wide Geographical Footprint
We understand the challenges of working across a wide geographical footprint and recognise that the size, scale and reach of the NY&Y Partnership means it can influence the health and wellbeing of the population by aligning core functions to improve health outcomes of local communities. We strongly believe that the notion of place needs to be a flexible concept working closely with communities in order to enable an agile response to improving heath and care outcomes and reducing health inequalities.

Governance Arrangements
As a system that has worked even more closely together over the previous months in response to the pandemic, we have a greater understanding of how our governance models can flex and adapt in light of statutory changes. We have taken the opportunity to embed strong links and working arrangements with our local authorities and would want to see this continue to be strengthened.

As a recently merged CCG, North Yorkshire CCG understands the complexities of joint governance arrangements of multiple statutory organisations. We would therefore welcome decisive authority to act to bring organisations together to act on behalf of consolidated populations and lay aside organisation sovereignty through the transition period towards a single ICS.

We support our ICS formation of two strategic geographical partnerships each with common issues, population needs and aims as a cornerstone of collaborative working both locally and strategically.

We recognise the important principle of subsidiarity and would want to promote the important decisions about health and care being made as close to our local communities as possible.

System Financial Management
We welcome the opportunity to develop local financial rules but recognise there is a risk that financial systems will be determined by historic behaviours and practice. The COVID-19 financial regime has allowed our geographical partnership to have constructive conversations about how to use growth funding which has been refreshing and enabled constructive collaboration across sectors. A return to the previous financial regime could see us return to the requirement of very high levels of efficiency requirements of 3% per annum due to historic recurrent deficit positions of partner organisations. We would like to see recognition of the need for longer term financial recovery period of up to 5 years (setting trajectories locally) to allow challenged financial systems to

make real progress in meeting the financial challenge while also being able to invest in collaborative transformation.

A recognition of the real cost of smaller remote hospitals would also be welcome through national allocations, in particular the hospitals recognised by ACRA.

We would also welcome the continuation and scaling of system performance management and financial performance measures which aid collaboration rather than organisational sovereignty

Annex Two – Humber, Coast and Vale Clinical and Professional Group Response

The following views represent a response from the clinical & professional group of the Humber, Coast and Vale Health and Care Partnership. The clinical and professional group was set up in the response to Covid 19 in April 2020 but has developed over the last 9 months into a wide inclusive group that looks at all areas of health strategy and response.

As a group, we are very supportive of the direction of travel set out in the document and welcome the opportunity to build on the areas we have highlighted over the past months. We have secured agreement across the partnership for a set of principles that establish a focus on shared ownership of care, transparency in communication, shared health demand lists, health access equity, integrated health and care pathways, the prevention agenda and allocation of resources to community solutions.

We agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future and will allow us to build on the principles outlined above. We believe option 2 in the document will provide greater encouragement for collaboration and flexibility to establish arrangements that suit the needs of our population, alongside strengthening lines of accountability most importantly, to our residents.

The group welcomes the clarity of purpose rooted in creating health and care systems that will be better placed to:

- Improve population health
- Improve access and address health inequalities
- Drive better quality and value
- Directly engage the NHS with wider social and economic development.

There is clear message about the clinical and wider professional community being a powerful force for leadership and governance at every level, as well as the voluntary and community sector and citizens and we welcome this. We feel that this approach needs to be underpinned by a commitment to a longer term strategy around improving population health and reducing health inequalities. We would like to see a population health management approach embedded in every work stream and strategy going forward.

Primary care networks within our places will be key drivers of integration and collaboration; resource and capacity needs to be liberated for them. We feel option 2 could allow significant resources to flow to place and neighbourhood and drive positive impacts. As key partners within anchor networks and settings we all need to encourage employment in the health and care sector with emphasis on wellbeing and prevention. It is clear that we need to mobilise social justice to build a wellbeing movement and economy.

We are supportive of the changes proposed for provision, based on duties of collaboration at place within provider collaborations and across an ICS within a sector provider collaboratives (acute and mental health). We acknowledge for the sector specific collaboratives the value is in designing and delivering specialist and other services at scale that meet the needs of our population, where it

makes sense to do so. This needs however to be truly cross sector collaboration and we need to recognise and encourage the contribution of the primary care and the VCSE sectors to these forums. All networks and collaboratives within the emerging ICS will need to acquire or grow expertise and provide the people with the skills for 'whole pathway' commissioning and whole pathway quality improvement. This will require some organisational development to be built in across all areas.

We truly agree with and encourage reduction in bureaucracy and hierarchy and understand the need for high trust partnerships and relationships across all sectors; we would not want additional layers of governance and assurance built in via this change for Integrated Care Systems.

Annex Three – Humber, Coast and Vale Digital Response

We welcome the focus on connecting health and social care, using digital and data to transform care and put the citizen at the centre of their care.

We have already completed significant work to join up patient records across our places, for example through the establishment of the Yorkshire & Humber Care Record, with developed capabilities to extend the sharing of patient records via a standard approach across the ICS and wider Yorkshire and Humber. This builds upon our previous success of deploying shared record access to where it's most needed and developing a culture of record sharing as standard rather than by exception e.g. strategic use of the NHS Digital Summary Care Record product, Clinical Systems, GP systems TPP SystmOne and EMIS integration, and use of the Medical Interoperability Gateway solution.

We are invested, at both 'place' and system in building a population health management capability underpinned by more joined up data sets, allowing for improved commissioning and targeted care delivery. This should continue to ensure intelligence-led approaches are the foundation for population planning and improve health outcomes, whilst improving the use of data for research across the system.

We are embracing a "design at system, deliver at place" ethos, via the development of shared strategies, a region wide Digital Charter and a successful Yorkshire and Humber Digital Delivery board. This recognises the continuing importance of all places, but seeks opportunities for further collaboration efficiency gains through working across ICS footprints as we have successfully done over previous years.

We will continue to work in partnership with our peers across Yorkshire and Humber, designing solutions at a system level with delivery at place.

CoG (01/21) Item 3.1

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	19 January 2021
REPORT FOR	Council of Governors (CoG) (Public)
REPORT FROM	Helen Harris, Trust Secretary
CONTACT OFFICER	Alison Hurley, Membership Manager & Assistant Trust Secretary
SUBJECT	Revised Governor Assurance Group Report
BACKGROUND DOCUMENT (if any)	Review of CoG Sub-groups and Briefings
PURPOSE OF REPORT	To seek approval of the revised Governor Assurance Group Terms of Reference and Annual Work Programme
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) & OUTCOME	Approved by current Governor Assurance Group Members
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Following approval to subsume several CoG sub-groups into the existing Governor Assurance Group (GAG) at the October 2020 CoG meeting, this report presents the revised Terms of Reference and Annual Work Programme. The Appointments and Remuneration Committee will be maintained as a separate group as agreed. The GAG meetings will be held on a bi-monthly basis, with a briefing held prior to each meeting for all Governors who can remain for the GAG meeting as observers if they are not GAG members. Governors are reminded that they can also attend the bi-monthly virtual public Trust Board meetings in an observer capacity, which will take place in the intervening months of the GAG meetings and briefings.

ACTION REQUIRED				
Approval	Information	Discussion	Assurance	Review

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to? Highlight the box this refers to				
1. To give great care	2. To be a good employer	3. To live within our means	4. To work more collaboratively	**5. To provide strong leadership**

TRUST PRIORITIES					
Leadership and Culture	Workforce	Quality and Safety	Access and Flow	Finance	Service and Capital Investment Strategy

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	11 - Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) – capacity and capability.
COG ACTION REQUIRED	The CoG is asked to consider and approve the revised GAG Terms of Reference and Annual Work Programme.

Northern Lincolnshire and Goole
NHS Foundation Trust

Revised Governor Assurance Group (GAG) Terms of Reference and Annual Work Programme

January 2021

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1. Executive Summary

Following approval to subsume several CoG sub-groups into the existing Governor Assurance Group (GAG) at the October CoG meeting, this report presents the revised GAG Terms of Reference and Annual Work Programme. The Appointments and Remuneration Committee will be maintained as a separate group as agreed.

The GAG meetings will be held on a bi- monthly basis, with a briefing held prior to each meeting for all Governors who can remain for the GAG meeting as observers if they are not GAG members.

Governors are reminded that they can also attend the bi-monthly virtual public Trust Board meetings in an observer capacity, which will take place in the intervening months of the GAG meetings and briefings.

2. Strategic Objectives, Strategic Plan and Trust Priorities

This proposal will support Strategic Objective 5 - To provide strong leadership.

3. Introduction / Background

It was agreed to review the CoG sub-groups following Governor requests at the last GAG meeting. This resulted in approval of the recommendation to subsume the following groups into the existing GAG at the October 2020 CoG meeting:

- Membership and Patient Engagement Group
- Quality Review Group
- Staff Governor Working Group.

The Trust Constitution only requires the Appointments and Remuneration Committee (ARC) and GAG Governor groups, and these will remain as separate groups as agreed.

GAG meetings will be held on a bi-monthly basis, with a briefing held prior to each meeting in addition to the briefings to be covered within the quarterly CoG business meetings. This will mean there are six pre-GAG briefings and a further four Governor briefings within the CoG business meetings per year. It is anticipated that GAG meetings and pre-GAG briefings will be held virtually utilising available meeting technologies as appropriate. An overview of the proposed CoG and GAG meeting schedule is detailed at Appendix A together with Trust Board meetings.

4. Discussion / Issues

In order to implement these changes, the GAG Terms of Reference and Annual Work Programme have been reviewed and revised to take into account any key details from the CoG sub-groups now incorporated into the GAG. The revised Terms of Reference are detailed at Appendix B and the revised Annual Work Programme is detailed at Appendix C. Amendments are highlighted in yellow or

scored out for ease of reference.

GAG Governor members have been increased from six to eight (including the Lead Governor Chair and Deputy Lead Governor), in order to reflect the nine current Governor members of the sub-groups to be subsumed within the GAG.

GAG members will be elected as per the process detailed in the GAG terms of reference, and other Governors are welcome to attend in an observer capacity. Governors are also welcome to attend the bi-monthly virtual public Trust Board meetings in an observer capacity, which will take place in the intervening months of the GAG meetings and briefings.

The GAG with be aligned with all of the Trust Board Assurance Committees and receive highlight reports from the Non-Executive Directors, who are the Chairs of these committees at each GAG meeting. The committee highlights reports will include the relevant Board Assurance Framework (BAF) elements to allow effective challenge and assurance. They will also incorporate any issues on deep dives for Care Quality Commission (CQC) issues.

Governor attendance in an observer capacity at upcoming committee meetings will be determined within the GAG meeting for the intervening period, and dates of upcoming Committee meetings will be added to the GAG agenda for ease of reference.

5. Quality and Patient Safety

Governor oversight, appropriate challenge and holding to account of NEDs will be managed within the GAG meeting. This will be escalated as required in the GAG Highlight Report to the CoG Business meetings.

6. Consultation / Engagement

The Trust's Vice-Chair, Lead Governor and current Governor Assurance Group members were consulted and have all supported these proposals and revisions.

7. Conclusion

Following approval at the October CoG meeting to subsume the CoG sub-groups into the GAG as detailed above, the GAG Terms of Reference and Annual Work Programme have been reviewed and revised and approval is being sought as per the usual protocol.

8. Recommendation

The CoG is asked to consider and approve the following documents and the proposed changes detailed within them:

- Revised GAG Terms of Reference
- Revised GAG Annual Work Programme.

Compiled By: Alison Hurley, Membership Manager & Assistant Trust Secretary
Date: 19 January 2021

APPENDIX A

GOVERNOR BRIEFINGS AND TRUST BOARD MEETINGS OVERVIEW

JANUARY
- Council of Governors' Business Meeting – with Governor Briefings included
- GAG meeting and Governor pre-briefing

FEBRUARY
- Public Trust Board meeting

MARCH
- GAG meeting and Governor pre-briefing

APRIL
- Public Trust Board meeting
- Council of Governors' Business Meeting - with Governor Briefings included

MAY
- GAG meeting and Governor pre-briefing

JUNE
- Public Trust Board meeting
- Council of Governors' Annual REVIEW Meeting

JULY
- Council of Governors' Business Meeting - with Governor Briefings included
- GAG meeting and Governor pre-briefing

AUGUST
- Public Trust Board meeting

SEPTEMBER
- Council of Governors' Annual MEMBERS' Meeting
- GAG meeting and Governor pre-briefing

OCTOBER
- Public Trust Board meeting
- Council of Governors' Business Meeting - with Governor Briefings included

NOVEMBER
- GAG meeting and Governor pre-briefing

DECEMBER
- Public Trust Board meeting

NHS
Northern Lincolnshire
and Goole
NHS Foundation Trust

Trust Secretary

GOVERNOR ASSURANCE GROUP

DRAFT 1.3

Membership and Terms of Reference

1.0 Introduction and Purpose

1.1 The role of the Governor Assurance Group (GAG) is to have oversight of areas of Trust governance and assurance frameworks in order to provide added levels of assurance to the work of the Council of Governors (CoG).

1.2 The Group will work closely with the Trust Board's Assurance Committees, sharing findings, concerns and requests for additional information with the committee chair and vice-chair, monitoring the progress of resolution and provision of assurance by the Trust Board relating to these areas, and reporting progress to the CoG.

1.3 As a Foundation Trust, the CoG is responsible for regularly feeding back information about the Trust, its vision and performance to the constituencies/classes and stakeholder organisations. The GAG provides a mechanism through which the CoG can seek assurance on this key matter for staff and public members.

1.4 The group will monitor the effectiveness of the Membership Strategy which incorporates oversight and scrutiny of the Trust's engagement with patients and carers. It will undertake this role on behalf of the CoG, whilst being mindful of the national, regional and local service transformation agenda.

1.5 One of the Trust's key goals is to create a supportive, developmental and listening environment for its staff so they are able to excel and contribute to the success of the organisation. The GAG will monitor and assist as appropriate in staff engagement, recruitment and retention and staff morale.

2.0 Authority

2.1 The GAG will have delegated authority on behalf of the CoG to consider and progress specific agenda items, as directed, and report back to the full Council as required.

2.2 The Group will share information and work closely with the Chair/Vice-chair of the Trust Board assurance committees but will have the authority to request information from Non-Executive and Executive Directors, in seeking assurance around areas of concern or areas where further clarification is required by Governors. This may include issues around quality, finance, performance, strategic development or staffing.

2.3 The Group will have the authority to ask relevant members of the Trust's staff, specifically, Executive Directors and / or their Deputies, to attend meetings of the Group and provide such information or assurance as may be required to enable the Group to fulfil its role.

2.4 The Group will meet six times per year and have the authority to hold extraordinary meetings as the Group deems appropriate.

3.0 Accountability & Reporting Arrangements

3.1 The group is directly accountable to the full CoG and the Chair of the GAG will submit a brief Highlight Report to each quarterly CoG Business meeting.

3.2 All meetings of the Group will be minuted by the Membership Manager's staff.

3.3 The Group will maintain close working relationships with the Trust Board Assurance Committees so that any concerns and/or assurance can be addressed.

4.0 Responsibilities

4.1 General

4.1.1 The Group will nominate a public or staff Governor from the Group to attend each of the Trust Board Assurance Committee meetings in an observer capacity, together with a deputy for the nominated attendee.

4.1.2 The Group will provide input to the process of determination of the Trust's quality priorities and contribute to the identification and development of quality and safety measures to be included within the Trust's Integrated Performance Report and annual Quality Account.

4.1.3 On behalf of the CoG each year, the Group will select a local quality indicator for scrutiny by the Trust's appointed external auditors as part of the annual Quality Account audit process.

4.1.4 Provide support to the CoG with regards to the Trust's performance against the NHS Constitution

4.1.5 The group will seek to undertake periodic patient and/or public consultations in line with Trust strategy and any proposed service changes in line with our Constituted Foundation Trust status.

4.1.6 The group will commission such research on the composition of the trust membership as it requires, to understand whether that membership is representative of the population served. The group will utilise these results to devise and implement recruitment strategies to ensure a representative membership is maintained. Normally such research will be led by the Membership Manager & Assistant Trust Secretary.

4.1.7 Act as a forum for sharing ideas, best practice and investigate alternative methods of delivery of identified staff and public engagement as required.

4.2 Oversight of the Trust Audit Processes

On behalf of the CoG, the group will monitor Northern Lincolnshire and Goole NHS Foundation Trust's performance against the Terms of Authorisation and Strategic Direction. This specifically relates to seeking assurance from the Trust Board Finance & Performance Committee and the Audit, Risk & Governance Committee.

4.3 External Audit

The CoG is responsible for the appointment of the Trust's external auditors and the task of assessing prospective candidate firms is delegated to a panel of Governors drawn from the GAG, supported by a member of the Audit, Risk & Governance Committee (normally the chair thereof).~~The CoG will seek advice and assistance from the Trust Board Audit, Risk & Governance Committee relating to their appointment of the external auditors.~~ The GAG will therefore oversee and approve recommendations to the CoG on the appointment of external auditors.

4.4 Internal Audit

To receive highlight reports from the Chair of Audit, Risk and Governance Committee, relating to progress against the internal audit programme.

~~**Maintaining Oversight of the Trust Governance Framework and Board Assurance Framework (BAF)**~~

~~Take receipt of regular reports relating to developments of the Trust governance frameworks and changes to the BAF, covering governance, risk and controls.~~

~~**4.5 Fit & Proper Persons Standards**~~

~~To provide CoG assurance relating to the application of effective systems and processes for ensuring its Board of Directors meet the required Fit & Proper Persons Standards.~~

4.6 Responsibility for ensuring appropriate and effective Governor Development Processes

4.6.1 Identify and develop training and development plans for Governors.

4.6.2 Receive feedback on the Annual Governor Developmental Reviews from the Trust Chair and identify areas for action to be incorporated into the development plans.

4.6.3 Monitor performance against the thematic Governor Development Plan requirements and ensure effective delivery methods are identified.

4.6.4 Act as a forum for sharing ideas, best practice through benchmarking and investigate alternative methods of delivery of identified training and development.

4.6.5 Assist in the induction, development and training of Governors to facilitate the discharge of their responsibilities in line with the requirements of the Health and Social Care Act 2012.

4.7 Providing support to the CoG with regard to amendments for Policies and Procedures as they apply to the full Council or its' sub-groups

4.7.1 Review and make recommendations to the full CoG for amendments to other relevant policies and procedures.

4.7.2 Ensure sufficient communication amongst Governors and between the CoG and the Trust Board and, in this regard ensure the three year review of the 'Council of Governors Engagement Policy' and make recommendations to the full CoG in respect of any required changes.

4.7.3 Review the need for and effectiveness of the sub-groups which report to the CoG

4.8 Providing support to the CoG in order to ensure the effective application of the required democratic processes for Governor Elections (as per the Trust Constitution)

4.8.1 To oversee the search process for suitable prospective Governors and encourage their nominations in the Governor Elections Process, recommending changes to process as required.

4.8.2 To identify and engage with potential prospective governors, encouraging a commitment to the Trust and roles and responsibilities of Trust Governor through their nomination into the Governor elections.

5.0 Membership

5.1 Core Membership:

- The Trust Vice Chair~~man~~ (ex officio)
- The Lead Governor (ex officio)
- The Deputy Lead Governor, and ~~five~~ six other Governors elected following the process described in paragraph 5.3 below, a minimum of one to be a staff Governor.

5.2 Other Persons Attending Meetings:

- Non-Executive Director (NED) Chair or Deputy Chair of the Trust Board Assurance Committees as follows:
  - Audit, Risk & Governance Committee
  - Finance & Performance Committee
  - Quality & Safety Committee
  - Workforce Committee
- The Chief Executive, directors and senior managers shall attend meetings by invitation ~~only~~
- The Trust Chair will attend meetings on an intermittent basis
- Other Governors who are not GAG members can attend as observers
- The Trust Secretary and/or the Membership Manager & Assistant Trust Secretary shall attend meetings in an advisory and non-voting capacity, as required/the agenda dictates
- Attendees either from within or outside the Trust (e.g. from Clinical Commissioning Groups Healthwatch, regulators or Integrated Care Partnership representatives) may be invited if deemed appropriate by the Group Chair or Vice-Chair, Trust Board Assurance Committee Chairs or specifically requested by Group members or the CoG.

5.3 Governor Assurance Group Elections

5.3.1 Members of the GAG shall be elected for the remainder of their term of office (although will be entitled to express an interest in standing for re-appointment if they are re-elected as a governor). When elections are required they shall be held at the first meeting of the CoG in the calendar year. All Governors shall be entitled to vote, and all Governors except the Lead Governor (who is an ex officio member of the group) shall be entitled to stand.

5.3.2 At least one calendar month before the date of the meeting of the CoG the Trust Secretary or their Deputy shall contact all Governors to invite expressions of interest. Ballot papers showing the names of all the nominated candidates shall be distributed with the papers and a secret ballot shall be conducted at the meeting (or electronically). The Trust Secretary, or their nominee, shall act as returning officer and shall announce the results of the election before the close of the meeting when completed ballot papers will be made available for scrutiny by Governors as required.

5.3.3 Alternatively, expressions of interest will be sought by the Membership Manager & Assistant Trust Secretary via e-mail and all Governors will be invited to vote with a set timescale. The results of the election will be announced via e-mail and an update will be provided at the next GAG Meeting. This will be included in the GAG Highlights Report to the next CoG meeting.

5.3.4 To ensure equitable representation, an electoral constraint shall be applied which requires that at least one staff governor and at least two public governors are elected to the group. Where there are no nominations from either of these groups, however, it is clear that it will not be possible to apply the constraint.

5.4 Other Provisions

Should the core membership of the GAG fall below the number specified in paragraph 5.1 then the remaining members shall have the authority to co-opt additional governors to serve on the committee provided that the total core membership is not exceeded. It is expected that the selection of co-opted members will be by consensus: where a vote is required this shall be determined by a simple majority of a show of hands. Such co-opted members shall serve until the next scheduled election to the Governors Assurance Group.

6.0 Procedural Issues

6.1 Frequency of Meetings

The frequency of meetings shall be as determined by the group, but there shall be at least six meetings of the GAG in any calendar year.

6.2 Chairperson

The Chairperson of the GAG shall be the Lead Governor. In the absence of the Chairperson the Deputy Lead Governor will Chair the meeting. ~~the governors present will choose one of their number to chair the meeting~~.

6.3 Secretary

Secretarial support will be provided by the Membership Office.

6.4 Attendance

6.4.1 Governors are required to attend in person and no deputies are permitted. The Trust Secretary or Membership Manager & Assistant Trust Secretary may nominate a deputy to attend in his/her absence as required.

6.4.2 It is expected that members will attend all meetings of the group. The minimum acceptable attendance is 50%; the Chairperson of the group will report attendance levels below this to the Trust Chair.

6.4.3 Where a member's attendance is below the acceptable attendance, the Chairperson may discuss the reasons for this with the individual Governor in order to ensure that their continued membership of the Group is in the best interests of the Group, the CoG and the member.

6.4.4 Where concerns about acceptable attendance levels cannot be resolved within the Group, then this matter will be referred to the next CoG business meeting for discussion and resolution.

6.5 Quorum

Four Governors shall form a quorum for the group. This provision shall not apply to any meeting immediately following a reduction in the number of core members, for whatever reason, when those present shall constitute a quorum. The co-opting of additional Governors to make up the full complement of members, as described in paragraph 5.4 above, shall be an item on the agenda at any such meeting.

6.6 Minutes of Meetings

Draft minutes will be submitted to the Chairperson for approval within ten working days of the meeting. On approval they will be distributed to all members of the group and forwarded to the Trust Chair's office for inclusion for information with the papers for the next CoG meetings

6.7 Reports to be Provided to Meeting Members

6.7.1 Trust Board Assurance Committee Highlight Reports from the following committees:

- Audit, Risk & Governance Committee
- Finance & Performance Committee
- Quality & Safety Committee
- Workforce Committee

6.7.2 Board Assurance Framework as an item for information

6.7.3 Take receipt of the Trust Board approved Annual Financial Plan

6.7.4 Annual National Staff Survey Results

6.7.5 Inspection reports and updates from regulators (Care Quality Commissioners (CQC), NHS England & Improvement (NHSE&I))

6.7.6 This list is not exhaustive but provides a basis for the regular flow of information for consideration by the Group

~~Take receipt of the quarterly performance information in the Integrated Performance Report~~

~~Take receipt of the Improving Together Improvement Plan on behalf of the CoG~~

6.8 Review

These terms of reference will be reviewed every three years or sooner should the need arise.

7.0 Equality Act (2010)

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

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

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

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

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

Appendix C - revised Annual Work Programme

Governor Assurance Group (GAG) Annual Work Plan – Draft 1

NHS Northern Lincolnshire and Goole NHS Foundation Trust

January 2021

Annual GAG Work Plan			
Months	**MAY**	**JUL**	**SEP**
Events	• Approval of final draft Quality Account	• Evaluation of GAG (using template)	• Governor Development Plan Review (inc thematic outcomes from Governor Development Reviews)
Standing Agenda Items	• Action Log • Board Committee Highlight Reports (to include Board Assurance Framework (BAF) elements, and allow for challenge and Board assurance, and updates from deep dives for CQC issues): - Audit Risk & Governance - Finance & Performance - Quality & Safety - Workforce • Governor and Trust Engagement • Governor Training/Development/Support • Review of Governor CoG Attendance	• Action Log • Board Committee Highlight Reports (to include Board Assurance Framework (BAF) elements, and allow for challenge and Board assurance, and updates from deep dives for CQC issues): - Audit Risk & Governance - Finance & Performance - Quality & Safety - Workforce • Governor and Trust Engagement • Governor Training/Development/Support • Review of Governor CoG Attendance	• Action Log • Board Committee Highlight Reports (to include Board Assurance Framework (BAF) elements, and allow for challenge and Board assurance, and updates from deep dives for CQC issues): - Audit Risk & Governance - Finance & Performance - Quality & Safety - Workforce • Governor and Trust Engagement • Governor Training/Development/Support • Review of Governor CoG Attendance
MONTH	**NOV**	**JAN**	**MAR**
Events	• Review of attendance at GAG Meetings		• Review GAG Annual Work Plan
Standing Agenda Items	• Action Log • Board Committee Highlight Reports (to include Board Assurance Framework (BAF) elements, and allow for challenge and Board assurance, and updates from deep dives for CQC issues): - Audit Risk & Governance - Finance & Performance - Quality & Safety - Workforce • Governor and Trust Engagement • Governor Training/Development/Support • Review of Governor CoG Attendance	• Action Log • Board Committee Highlight Reports (to include Board Assurance Framework (BAF) elements, and allow for challenge and Board assurance, and updates from deep dives for CQC issues): - Audit Risk & Governance - Finance & Performance - Quality & Safety - Workforce • Governor and Trust Engagement • Governor Training/Development/Support • Review of Governor CoG Attendance	• Action Log • Board Committee Highlight Reports (to include Board Assurance Framework (BAF) elements, and allow for challenge and Board assurance, and updates from deep dives for CQC issues): - Audit Risk & Governance - Finance & Performance - Quality & Safety - Workforce • Governor and Trust Engagement • Governor Training/Development/Support • Review of Governor CoG Attendance

DOCUMENTS FOR REVIEW	DATE OF REVIEW
Review any updates for Trust Constitution	June 2022
Review GAG Terms of Reference	January 2022
Review of Engagement Policy	June 2022

CoG (01/21) Item 3.2

DATE	19 January 2021
REPORT FOR	Council of Governors (CoG) (Public)
REPORT FROM	Helen Harris, Trust Secretary
CONTACT OFFICER	Alison Hurley, Membership Manager & Assistant Trust Secretary
SUBJECT	Governors' Annual Declaration of Interests
BACKGROUND DOCUMENT (if any)	
PURPOSE OF THE REPORT	For Assurance
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report provides the updated Register of Governors' Interests as at January 2021

ACTION REQUIRED				
Approval	**Information**	**Discussion**	**Assurance**	**Review**

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to?				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

TRUST PRIORITIES - which Trust Priority does this link to?					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	11 - Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) – capacity and capability.
CoG Action Required	The Council is asked to: Note the report

Northern Lincolnshire and Goole NHS Foundation Trust

REGISTER OF GOVERNORS' INTERESTS

January 2021 (v1)

GOVERNOR NAME	INTERESTS	DATE
PUBLIC GOVERNORS - EAST & WEST LINDSEY		
Jeremy Baskett	➢ National Committee Member of Managers in Partnership (MIP) Trade union ➢ Trade Union Representative on behalf of MIP in NHS Organisations ➢ Staff Side Chair for Humber SPF for the CCGs ➢ Elected Town Councillor - Louth, Lincolnshire ➢ Working for NHS Hull CCG (on behalf of Humber CCGs) ➢ Working for NHS Harrogate and Rural District CCG (on behalf of the North Yorkshire CCGs) on HR projects.	04.09.2020
Gorajala Vijay	➢ None	06.11.2020
PUBLIC GOVERNORS - GOOLE & HOWDENSHIRE		
Tony Burndred	➢ Chair of Men in Sheds (Goole)	30.11.2020
Rob Pickersgill	➢ Fellow, Chartered Institute of Public Finance and Accountancy (CIPFA) ➢ Chair – Asselby Parish Council, Howden, East Yorkshire ➢ Member of Howden Medical Practice PPG ➢ Managing Director and 50% shareholder at W Hallam Castings Ltd, Thorne, Doncaster (private company) ➢ Member of the Yorkshire and Humberside Regional Advisory Board, MAKE UK (UK Manufacturers Organisation)	30.11.2020
Stephen Price	➢ None	01.12.2020

PUBLIC GOVERNORS - NORTH LINCOLNSHIRE		
Kevin Allen	➢ Volunteer worker at SGH ➢ Have applied to North Lincolnshire Council to be a school governor – under consideration	15.10.2020
David Cuckson	➢ None	14.10.2020
Maureen Dobson	➢ None	04.11.2020
Vince Garrington	➢ Operations Director for Cairn Hotel Group and responsible for a hotel next to the Nightingale Hospital in Harrogate which has/will tender for NHS business	30.11.2020
Paul Grinell	➢ Board member of DN Colleges Group (formerly North Lindsey College) ➢ Director of Kingsway Consulting Limited (subsidiary of DN Colleges Group) ➢ Director of DC Teach Limited (subsidiary of DN Colleges Group)	04.11.2020

PUBLIC GOVERNORS - NORTH EAST LINCOLNSHIRE		
Diana Barnes	➢ None	30.11.2020
Brian Page	➢ Sole Trader trading as BP Training ➢ Currently contracted to deliver Health & Wellbeing training for Care Plus	03.12.2020
Ian Reekie	➢ Member of the National Institute of Health & Care Excellence (NICE) Quality Standards Advisory Committee	17.11.2020
Liz Stones	➢ Chairman of Cleethorpes Golf Club (1894) Ltd	10.11.2020
Vacancy		

STAFF GOVERNORS		
Ahmed Aftab	➢ Director of Sazin Eyecare Limited	30.11.2020
Tim Mawson	➢ United Kingdom Accreditation Service ➢ Voluntary ISAS technical Assessor since October 2014	05.11.2020
Joanne Nejrup	➢ None	15.10.2020

STAKEHOLDER GOVERNORS		
Vacancy - East Riding of Yorkshire Council	➢	
Eddie McCabe - North East Lincolnshire Clinical Commissioning Group	➢ None	04.11.2020
Alex Seale - North Lincolnshire Clinical Commissioning Group	➢ Chief Operating Officer at North Lincolnshire CCG	21.12.2020
Stan Shreeve - North East Lincolnshire Council	➢ Elected member and portfolio holder for Finance and Resources NEL council. ➢ NEL Stakeholder Trustee of NEL Citizens Advice Bureau. ➢ Stakeholder Director of Humber Bridge Board. ➢ Trustee of Harbour Place ➢ Stakeholder representative of NEL on EY Pension Committee	30.11.2020
Vacancy - North Lincolnshire Council		
Vacancy - Lincolnshire Council		