NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 2 August 2022, Forest Suite, Forest Pines, Ermine Street, Broughton, DN20 0AQ
Time – 9.00 am – 12.45 pm
(Lunch – 12.45 pm – 1.15 pm)
For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Introduction**			
1.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:00 Hrs	Verbal
1.2	**Apologies for Absence** Sean Lyons, Chair			Verbal
1.3	**Patients' Story and Reflection** Sara Wood, Quality Matron	Note		Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:15 hrs	Verbal
2.2	**To approve the minutes of the Public meeting held on Tuesday, 7 June 2022** Sean Lyons, Chair	Approve		NLG(22)115 Attached
2.3	**To approve the minutes of the Trust Board Self-Certification Event held on Monday, 30 May 2022** Sean Lyons, Chair	Approve		NLG(22)116 Attached
2.4	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.5	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(22)117 Attached
2.6	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:25 hrs	NLG(22)118 Attached
2.7	**Integrated Performance Report (IPR)**	Note		NLG(22)119 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Key Issues – Quality & Safety** Mr Kishore Sasapu, Deputy Medical Director & Ellie Monkhouse, Chief Nurse	Note	09:35 hrs	NLG(22)119 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:45 hrs	NLG(22)120 Attached

3.3	**Ockenden Update** Jane Warner, Associate Chief Nurse - Midwifery	Note	09:50 hrs	NLG(22)121 Attached
3.4	**Complaints Annual Report** Ellie Monkhouse, Chief Nurse & Melanie Sharp, Deputy Chief Nurse	Note	10:00 hrs	NLG(22)122 Attached
3.5	**Nursing, Midwifery & AHP Strategy Annual Report** Ellie Monkhouse, Chief Nurse & Di Hughes, Associate Director – Special Projects	Note	10:10 hrs	NLG(22)123 Attached
3.6	**Key Issues – Performance** Shaun Stacey, Chief Operating Officer	Note	10:15 hrs	NLG(22)119 Attached
3.7	**Finance & Performance Committee Highlight Report and Board Challenge – Performance (including Action Plan as a result of F&P Self Assessment)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:25 hrs	NLG(22)124 Attached
BREAK – 10.30 hrs – 10:40 hrs				
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Key Issues – Workforce** Christine Brereton, Director of People	Note	10:40 hrs	NLG(22)119 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	10:50 hrs	NLG(22)125 Attached
4.3	**Workforce Race Equality Standards Annual Report (WRES)** Christine Brereton, Director of People	Note	10:55 hrs	NLG(22)127 Attached
4.4	**Workforce Disability Equality Standard Annual Report (WDES)** Christine Brereton, Director of People	Note	11:05 hrs	NLG(22)128 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Key Issues – Finance – Month 03** Lee Bond, Chief Financial Officer	Note	11:15 hrs	NLG(22)129 Attached
5.2	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:25 hrs	NLG(22)130 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Key Issues – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:30 hrs	NLG(22)131 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – July 2022** Neil Gammon, Chair of the HTFTC	Note	11:40 hrs	NLG(22)132 Attached
6.3	**Executive Report – Digital Strategy** Chris Evans, Associate Director of Information Services	Note	11:45 hrs	NLG(22)133 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	None			

8.	**Governance**			
8.1	**Audit Risk & Governance Committee Highlight Report & Board Challenge – June 2022** Gill Ponder, Non-Executive Director	Note	11:55 hrs	NLG(22)134 Attached
8.2	**Board Assurance Framework (BAF) – Quarter 1** Helen Harris, Director of Corporate Governance	Note	12:00 hrs	NLG(22)135 Attached
8.3	**Trust Management Board (TMB) Terms of Reference** Dr Peter Reading, Chief Executive	Note	12:05 hrs	NLG(22)138 Attached
9.	**Approval (Other)**			
9.1	**Fire Annual Report** Bill Parkinson, Associate Director of Safety & Statutory Compliance and Simon Tighe, Deputy Director of Estates & Facilities	Approve	12:10 hrs	NLG(22)136 Attached
9.2	**LSMS Annual Report & Workplan and Security Annual Report** Bill Parkinson, Associate Director of Safety & Statutory Compliance and Simon Tighe, Deputy Director of Estates & Facilities	Approve	12:20 hrs	NLG(22)137 Attached
10.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:30 hrs	
11.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Public & Private Meeting** Tuesday, 5 October 2022, 9.00 am – TBC **Board Development** Tuesday, 1 November 2022, 9.00 am	Note		Verbal

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

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – April & May 2022** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(22)140 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – May and June 2022** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(22)141 Attached
10.3	**National Inpatient Survey** Melanie Sharp, Deputy Chief Nurse & Jo Loughborough, Senior Nurse – Patient Experience	NLG(22)161 Attached
	Workforce Committee	
10.4	**Workforce Committee Minutes – May 2022** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(22)142 Attached
10.5	**Medical Appraisal & Revalidation Annual Report (AOA)** Dr Kate Wood, Medical Director	NLG(22)143 Attached
10.6	**Freedom to Speak up Guardian Quarter 1 Report** Liz Houchin, Freedom to Speak up Guardian	NLG(22)144 Attached
10.7	**Guardian of Safe Working Hours Quarter 1 Report** Dr Liz Evans, Guardian of Safe Working Hours	NLG(22)145 Attached
	Audit, Risk & Governance Committee	
10.8	**Audit, Risk & Governance Committee Minutes – April 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)146 Attached
10.9	**Audit Committee Annual Report 2021/22** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)147 Attached
	Health Tree Foundation Trustees' Committee	
10.10	**Health Tree Foundation Trustees' Committee Minutes – May 2022** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(22)148 Attached
	Other	
10.11	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(22)149 Attached
10.12	**Documents Signed Under Seal** Dr Peter Reading, Chief Executive	NLG(22)150 Attached

NLG(22)115

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 7 June 2022 at 9.00 am, UCNL, Ashby Road, Scunthorpe, DN16 1BU

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Chair
Dr Peter Reading	Chief Executive
Lee Bond	Chief Financial Officer
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Simon Parkes	Non-Executive Director
Gillian Ponder	Non-Executive Director
Michael Proctor	Non-Executive Director
Michael Whitworth	Non-Executive Director

In Attendance:

Adrian Beddow	Associate Director of Communications
Christine Brereton	Director of People
Kerry Carroll	Deputy Director of Strategic Development (for item 6.1)
Neil Gammon	Independent Chair of the Health Tree Foundation Trustees' Committee
Stuart Hall	Associate Non-Executive Director
Liz Houchin	Freedom to Speak up Guardian (for item 4.3)
Jug Johal	Director of Estates & Facilities
Angie Legge	Associate Director of Quality Governance (for item 3.4)
Jo Loughborough	Senior Nurse – Patient Experience (for item 1.3)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Fiona Osborne	Associate Non-Executive Director
Raj Purewal	Healthcare
Ian Reekie	Lead Governor
Mr Kishore Sasapu	Deputy Medical Director (representing Dr Kate Wood)
Maneesh Singh	Associate Non-Executive Director
Emma Watts	Learning Disability and Complex Transition Specialist Nurse (for item 1.3)
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Introduction

1.1 Chair's Opening Remarks

Sean Lyons welcomed everyone to the meeting and declared it open at 9.00 am. Neil Gammon, Independent Chair of the Health Tree Foundation Trustees' Committee (HTFTC) was welcomed to the meeting along with Ian Reekie, Lead Governor. Sean Lyons welcomed Raj Purewal from Healthcare to the meeting.

1.2 Apologies for Absence

Apologies for absence were received from Linda Jackson, Helen Harris, Dr Kate Wood, represented by Mr Kishore Sasapu, Deputy Medical Director.

1.3 Patients' Story and Reflection

Jo Loughborough advised the patient story was around pain and Emma Watts, Learning Disability and Complex Transition Specialist Nurse was in attendance to share Chloe's story a patient with pain during pregnancy. Emma Watts went through the patient story presentation with the board. Sean Lyons thanked Emma Watts for the story and recognised the support that had been offered to Chloe during the pregnancy and after the birth.

Mike Proctor referred to the point raised in the presentation in respect of Chloe being referred at 24 weeks but then not being seen until 33 weeks and whether this was reflective of Emma Watts' current workload. It was advised Emma Watts was the only person in this role at the moment, however, interviews were due to take place that week for an additional nurse. Dr Peter Reading asked Emma Watts to highlight the importance of the role in supporting patients with learning disabilities and the seriousness of patients not having the support. Emma Watts confirmed there were a number of patients that had learning disabilities and struggled with everyday activities. Patients that have learning disabilities need to attend hospital for various reasons including in-patient and out-patient appointments which could mean the need for additional support. The patients visit areas where staff have not experienced or had the necessary training in how to deal with patients that have a disability. Emma Watts currently covered all three sites which included supporting patients in all specialties. There had been occasions when two patients required support at the same time and this then impacted on no support for one of those patients. There was also a need to train Trust staff in better communication with those patients to offer more support.

Ellie Monkhouse wanted to say thank you as Emma Watts had gone above and beyond in this particular to ensure Chloe had the additional support required, this had meant working longer hours than expected. Sean Lyons also noted thanks on behalf of the Trust Board.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 5 April 2022 – NLG(22)077

The minutes of the meeting held on the 5 April 2022 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Lee Bond referred to page 10, item 3.5. The wording should be changed within the first paragraph to read "The work required had been included in the 2022/23 Financial Plan and the work would be completed by the next inspection in October 2022".
- Lee Bond referred to page 11, item 4.1. The word target near the end of the paragraph should be changed to "rate".
- Lee Bond referred to page 11, item 4.3. The wording should be changed to add the Gender Pay Gap Report.
- Mr Kishore Sasapu referred to page six, item 3.1. Dr Kate Wood had asked for the wording to be changed within the final paragraph in respect of the Palliative Care Consultant appointment and this should state, "key roles had been sent to the College for approval". It was noted this had not already been completed but once approval had been received this would be advertised.

2.5 Urgent Matters Arising

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

2.6 Trust Board Action Log – Public by exception NLG(22)078

Sean Lyons invited Board members to raise any further updates by exception in relation to the Trust Board Action Log. It was noted those highlighted in green would be moved to closed actions for the next meeting.

2.7 Chief Executive's Briefing – NLG(22)079

Dr Peter Reading advised of three items to be highlighted within the report. One item related to the national incident which had been stood down as of the 1 June 2022. Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) had made the decision to put this in place and this was confirmed later the same day by National Guidance.

Dr Peter Reading advised of the Consultation NHS England had launched which would be concluded on the 8 July. This related to two key governance documents which would impact on NLAG. Dr Peter Reading referred to the changes this would mean detailed within the report. Dr Peter Reading felt there was not a need to respond to the recommendations made. Trust Board members agreed with the proposal of not responding.

Dr Peter Reading asked the board to note the final point within the briefing in respect of the latest developments of the Humber & North Yorkshire Health & Care Partnership.

Gill Ponder queried how going forward the board would feel assured on the NLAG contribution to the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) objectives and various collaboratives due to the complexity of this. Reflecting this within NLAGs Board Assurance Framework (BAF) would be an interesting exercise to work through going forward to ensure this was in place. Dr Peter Reading advised one of the Strategic Objectives related to working collaboratively so this would feed into this. There would be an expectation that once the ICB became legal from the 1 July it would rapidly put expectations on organisations in the patch. Sean Lyons felt this was a good point that both Sean Lyons and Dr Peter Reading should respond to in order to agree a timetable. It was agreed to provide a further update in three months' time to provide a proposal of how this would fit within NLAGs assurance frameworks. There was also a need to align communication as this was also not clear at the moment. It was felt there would be a need to align both NLAG and Hull University Teaching Hospital (HUTH) boards to enable messages received to be the same.

Action: Sean Lyons and Dr Peter Reading

2.8 Integrated Performance Report (IPR) – NLG(22)080

Sean Lyons advised the IPR was for noting and would be used to support the Executive Reporting for Quality & Safety, Workforce and Performance. It was noted it was now a well developed document and would become more effective going forward.

3. Strategic Objective 1 – To Give Great Care

3.1 Key Issues – Quality & Safety - NLG(22)080

Mr Kishore Sasapu referred to mortality as there had been improvements made in respect of Summary Hospital Mortality Indicator (SHMI), however, there were still issues in respect of Out of Hospital Mortality, work in this regard continued.

Sean Lyons queried whether it was best to have a high Out of Hospital SHMI as it indicated people had passed away in the desired place. Mr Kishore Sasapu advised it was taken in this way. Patients that had died in the right place was the main focus of NLAG. There would be certain people that would require NLAG to be the secondary place of care. In respect of Out of Hospital SHMI it should be considered that the patient was discharged appropriately and whether they should have been cared for outside of the hospital in the first place. There had been more engagement due to the Mortality Improvement Group (MIG) which also reviewed deaths and highlighted themes. Deaths were also reviewed in other forums within North and North East Lincolnshire and themes were discussed.

Sean Lyons referred to the connection between NLAG and HUTH and queried whether there was confidence that the sharing and learning lessons continued or whether further review was required. Mr Kishore Sasapu advised there was more

joint working in respect of coding, however, learning from deaths was not a process that happened at the moment. There was a willingness to look at this going forward. Dr Peter Reading wanted to note as a Board that the SHMI figure was a month out of date within the report, this was now at 104.41 as of the end of December 2021. This was the lowest figure ever recorded for NLAG. It was noted the Trust had been put in special measures in 2013 and at the time was in the top 14 worst Trusts in the country.

Shaun Stacey referred to the performance of NLAG and how this linked to how hospital care was managed. There continued to be close working with primary care and social care colleagues. Admissions continued that were not necessarily needed due to there not being accessible resources in respect of care in the community. Maneesh Singh queried how robust the data shared at the Quality & Safety Committee (Q&SC) was in respect of Out of Hospital SHMI as the data shared did not state whether the person had been a cancer patient; or a patient with another cause of death. Mr Kishore Sasapu advised the systems did not presently link together to enable this information to be provided. However, going forward any community death would be reviewed by the medical examiners if they had been discharged from hospital. Any patient who had visited the hospital more than twice in the three months prior to death would also be reviewed. Shauna McMahon advised the lead of a BI Intelligence Group within the Integrated Care System (ICS) was trying to put a Strategy in place on how all the data would be collated. Going forward this would mean there would be one place to obtain and collate data, however, this was in the early stages of being discussed.

Dr Peter Reading referred to sepsis and queried what was in place due to this being raised as an issue for concern. Mr Kishore Sasapu advised this linked into the National Early Warning Score (NEWS) and whether this was being recorded correctly. This also included any changes being recorded to enable them to be acted on. It was noted the Trust were currently reporting scores correctly. One of the second aspects was whether an alert was being triggered to the correct source when it was more than five. The current issues with workforce meant there could be concern for the Critical Care Outreach team to respond to an alert. There were also issues when the alerts are received out of hours due to workforce.

Sean Lyons raised concern as to how the 67 unestablished escalation beds were being managed. Shaun Stacey advised there was currently 64 escalation beds and they were not routinely staffed, dependent on staffing recommendations this model would change going forward. The driver for the beds being open was due to NLAG having 150 patients that had no right to reside in hospital. Those patients had to be cared for until a care provision became available for the patient to be discharged, safety checks for those patients were in place. The beds being kept open had meant an increase in the number of agency nurses. Ellie Monkhouse advised the detail of this was monitored and discussed at the Q&SC through the Nursing Assurance Report which was added as an item for information for the Trust Board.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(22)081

Mike Proctor referred to the SHMI comments discussed earlier in the meeting and added that when a patient passed away if the information the Trust had was expected this reflected well in NLAGs SHMI. The work completed internally did put a better emphasis on the fact that the Trust were more confident it was recorded.

Mike Proctor referred to the highlights within the report shared. One point to raise was that the committee had reviewed cancer performance. With support from Shaun Stacey the Q&SC had been looking at particular cancer pathways to enable the committee to understand the patient experience within the pathway. The Q&SC had also reviewed complaints and PALS received and some appeared to be linked to workforce shortages, particularly in respect of nursing. There had been concern raised that whilst the patient was being kept safe the staff had unfortunately not been able to deliver the quality of care liked and that this would continue.

The current risk rating in respect of Strategic Objective 1.1 relating to quality of care was currently at 15, there had been discussion this may need to be increased in the future. The risk target for next March on this area was 10 and this would be unachievable due to the workforce issues not improving. Mike Proctor was assured that despite the issues NLAG faced everything possible was being put in place. Ellie Monkhouse felt the risk appetite did not reflect where the Trust had been working over the past year. Dr Peter Reading supported the target being changed as this was more realistic.

Dr Peter Reading work had been undertaken on the Board Assurance Framework (BAF) with Christine Brereton in respect of splitting the workforce section to make it more reflective of the issues faced. It was noted there was a need to maintain staff morale going forward.

Ellie Monkhouse highlighted the various ways staffing was monitored and explained how safe care live allowed staff to be moved when required. One of the issues for NLAG was the more complex patients with high acuity as this care was more demanding on individuals.

Sean Lyons referred back to staff morale and queried whether anything further could be put in place. Ellie Monkhouse felt visits by the board would need to be to places of purpose, one option would be to hold them on board days to enable the board to then discuss visits together. It was agreed to discuss this further at the Q&SC.

Action: Mike Proctor / Dr Kate Wood / Ellie Monkhouse

3.3 Ockenden Progress Update

Jane Warner provided background in respect of the Ockenden Report shared on the 30 March 2022. There had been 15 immediate and essential actions and over 90 subsequent actions. There was currently no expectation to highlight compliance until the East Kent Maternity Service Report was published. It was

noted NLAG had almost completed the baseline review. The day after the report had been received NLAG had been asked to review the continuity of carer provision within the service. There was a requirement that every patient had no more than eight midwives to provide maternity care during pregnancy.

NLAG had undertaken a full review and spoken to the three teams. The review looked at whether suspending one of the continuity of carer teams would support the safe staffing of NLAGs units. After some discussion it was agreed by the executive team to suspend the Scunthorpe General Hospital (SGH) team. Ellie Monkhouse advised that prior to the decision being made it had also been agreed through an Extra-Ordinary Maternity Transformation Board and Trust Management Board (TMB). The suspension would be from Monday, 13 June 2022 for a period of six months.

3.4 Annual Quality Account – NLG(22)082

Angie Legge shared the Quality Account and advised this had to be published by the deadline of the 30 June 2022. The board were advised of the process undertaken as detailed within the paper. Stakeholders had been asked to comment on the Quality Account but not all comments had been received.

Sean Lyons thanked Angie Legge for attending the meeting and felt the report was an excellent overview of the Trust story. As some comments had not been received by Stakeholders it was proposed a small group of the Q&SC would review any late comments received, it was agreed this would include Dr Peter Reading and Sean Lyons. In response to a query regarding comments received Angie Legge advised if comments received back were factually inaccurate this could be challenged but all other comments and views would be required to be published. Dr Peter Reading asked for board approval to sign the document once the comments were received and reviewed by the sub-group. It was agreed to approve the paper as some board members would have oversight of the changes made at the sub-group.

Angie Legge wanted to formally note thanks to Hayli Garrod for the work undertaken.

3.5 Volunteer Strategy – NLG(22)083

Ellie Monkhouse advised the Volunteer Strategy had been approved through the correct processes with final approval at the Q&SC, this was now shared with the board for information. Gill Ponder was supportive of the Strategy and felt it was easy to read. It was noted the document would need to be proof-read due to some errors.

Action: Ellie Monkhouse

3.6 Key Issues – Performance – NLG(22)080

Shaun Stacey advised the four hour emergency care standard continued to be a challenge and the demand on the service was again significantly high. The Trust had sustained circa 60% performance against the standard so had remained in a

good place. The 12 hour delays had also increased due to the high numbers of attendees with Accident & Emergency (A&E). One positive in respect of urgent care was that the service had seen 3,000 patients in the month within four hours. NLAG continued to deliver on the 21 day stay patients. The team continued to look at opportunities to improve the flow through A&E.

In respect of electives, month one had missed the trajectory this was mainly due to ill health with clinicians, along with mutual aid support and a higher than expected number of trauma patients. There was a plan to mitigate this by the end of July, although the report suggested the end of June this had now changed.

With regard to cancer there continued to be further work around 28 day faster diagnosis. The challenge continued regarding cancer care within the system but the Trust Board had previously been sighted on this and the work with partners continued. As NLAG had provided mutual aid within the ICS this would impact on the Trust Patient Tracking List (PTL) in month two.

Shaun Stacey wanted to note thanks to the diagnostic teams for all the work undertaken to ensure there was significant improvement in month one whilst supporting other requests.

Lee Bond queried whether the report would start to highlight the exact timings for patients that had waited over 12 hours. Shaun Stacey advised this was not mandated at the moment but would be from September. This was currently reported on the daily SIP Report but was not required from a governance perspective in any other way. After further discussion it was agreed Shauna McMahon would check if this could be reported within the IPR.

Action: Shauna McMahon

Simon Parkes referred to the cancer performance and queried whether there was any further that could be put in place to achieve the targets. Shaun Stacey advised there was a lot of change in how to manage patients on a cancer pathway to enable an early decision of diagnosis. Shaun Stacey highlighted that the Statistical Process Charts (SPC) showed NLAG did not very often achieve the national position. Mr Kishore Sasapu advised two aspects that had to be looked at, one was what was being referred and the other was how NLAG dealt with this. If too many inappropriate referrals were received this did impact on diagnostic services. The numbers of treated cancers have not increased over the past few years, however, the number of referrals had. One way of supporting this would be to undertake fit testing before the patient was referred but this required engagement with the primary care.

3.7 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(22)084

Fiona Osborne advised the board of three highlights from the meeting held. In respect of cancer it was noted the committee was working with the Q&SC to look at the patient experience along with pathways, procedures and performance. In respect of the waiting lists the committee had been concerned that patients

transferred from Hull University Teaching Hospital (HUTH) could not be identified from NLAG patients unless this was undertaken manually.

Ellie Monkhouse referred to the deep dive on ventilation and air conditioning that had been undertaken, it was noted this was a concern in the organisation due to the impact on quality and safety. It was felt the deep dive should be shared with the Infection Control Committee. Gill Ponder advised the deep dive had been undertaken from an estates perspective and agreed this could be shared.

Action: Gill Ponder

4. Strategic Objective 2 – To Be a Good Employer

4.1 Key Issues - Workforce – NLG(22)080

Christine Brereton highlighted some themes around recruitment and retention. Staff that had left over the last year had been asked to share some experiences of reasons why. Some emerging themes had been around career development, culture and behaviours. In response to this the recruitment and induction process had been looked at for Health Care Support Workers (HCSW). A quality improvement methodology was being looked at for those staff to identify the areas of improvement that would be required. This would be supported by the Quality Improvement Team and NHS England / Improvement (NHSE/I).

In respect of sickness absence some trends of short-term absence had been identified which had impacted on the service. The management of this was now being addressed and would be monitored. In terms of core statutory and mandatory training this had been slightly above target, however, there had been some hot spots around specific roles so this would be addressed. A review of staff training was also being undertaken.

Maneesh Singh queried whether a way to retain HCSW would be for the individual to undertake taster sessions in different areas to understand which area was preferred before committing to the role. Christine Brereton advised the Trust had pushed the role due to the requirement of 0% vacancies. Some individuals appointed had not previously worked in this type of role so had struggled to adapt, this had then meant individuals leaving those roles. The recruitment process would now take prospective candidates through the process enabling them to leave at any point. Part of the process had been to show the individuals videos to enable them to experience what the role was like. Ellie Monkhouse added recruitment in this area of work was a national concern and related to the pay not being enough. The role also had no robust career pathway for individuals that wanted to progress. Work continued to recruit to this role including changing the onboarding process.

Christine Brereton advised there may be the introduction of nursing associate roles going forward but this was something that would be discussed. The career development pathway would also support progressing some HCSW roles into nursing roles.

Dr Peter Reading highlighted the decision NLAG had previously made in respect of the balance of trained nurses and HCSWs, this had meant NLAG were now able to recruit trained nurses more easily. As it was thought NLAG would struggle to recruit HCSWs in the future should there be consideration to review the balance and reverse the previous decision. Ellie Monkhouse advised there was still a high number of skilled professionals undertaking non-clinical tasks so would not be keen to go back to how this had previously been. From the establishment review the ideal skill mix was 60/40 and NLAG were around this number.

Stuart Hall queried whether NLAG reviewed staff that had left to ensure a personal development appraisal had been completed and whether a mentor had been in place to support the individual. A further query was to whether a "cooling off" process was in place in case the staff member wanted to withdraw the resignation at a later date. Christine Brereton advised focus had been around hot spot areas and NLAG were undertaking focus work to address whether anything could have been put in place. Two key themes identified around this work had been around behaviours and career development. There may be an option for a more one on one conversation to take place to see if this may improve the situation.

Simon Parkes referred to the increase in overseas students in the last year and queried whether student spouses may be look for roles in the NHS whilst here. The Trust could look at connecting with Universities in the area to review this. After further discussion it was agreed Christine Brereton would discuss this further with Simon Nearney at HUTH.

Action: Christine Brereton

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(22)085

Michael Whitworth referred to the highlight report and advised the meeting had been positive, the committee had looked at work completed over the previous year. The Trust board were advised of highlights within the report shared.

4.3 Freedom to Speak up Guardian (FTSUG) Annual Report – NLG(22)086

Liz Houchin referred to the detail within the report shared and highlighted key themes. It was noted that although behaviours were the highest concern raised this was not unique to NLAG. It was noted there had been an increased awareness of the guardian role with nurses and administration staff being the highest to report concerns.

Gill Ponder had been interested in the case study included in the report but had found this alarming as the staff member had left due to this. It was questioned as to whether there was an issue of discrimination in this work area. Gill Ponder queried whether there had been any follow up with departmental staff to try and educate them in understanding the impact the behaviour had had on the individual, this would also ensure this did not happen again. Liz Houchin advised there had been links with the operational lead and feedback had been shared afterwards. It was not known if anything was undertaken by the department following this. Christine Brereton advised issues had been identified in respect of international nurses and work had been undertaken in respect of this. Discussions had taken

place which had included Union Staff. Workshops had been put in place for international and other nurses and other work was also ongoing following this particular case study.

Stuart Hall referred to the staff survey results shared in the paper and queried how the gap would be closed in staff feeling confident to approach managers and the FTSUG with concerns. It was advised Liz Houchin would continue to raise awareness and create a safe environment with staff, there was also a need to highlight that staff were able to report concerns to other staff. There would be a need to develop the comms further for staff to highlight this. Christine Brereton advised this would also be fed into the leadership work to enable managers to understand behaviours with staff that were line managed. Liz Houchin added that one way forward was to also develop a support leaflet for managers to ensure there was no defensive approach. Sean Lyons referred to an approach the FTSUG at HUTH had adapted in having an area where staff could go for support, for example the Chapel. Liz Houchin agreed this was another option being considered.

Sean thanked Liz Houchin for the work undertaken. The Board were advised a Self-Assessment of the Trust would be undertaken at a further Board Development session in respect of FTSU.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 01 - NLG(22)087

Lee Bond referred to the report and advised NLAG was currently £500,000 behind the plan that had been set. This was due to two major issues, one being activity as referred to earlier the meeting. The second was around the pay position in respect of medical and nursing staffing as this had been above budget.

Shaun Stacey advised there had been a high level of trauma during April which had meant routine work had been delayed. The second issue was in respect of a decision that had been taken in respect of levelling up, this had meant offering other providers sessions which had then impacted on NLAG performance, particularly in orthopaedics. This issue would be discussed further at the next F&PC and actions would be taken in respect of this.

5.2 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(22)088

Fiona Osborne referred to the highlights within the report. The committee had noted concerns in respect of workforce issues. No queries were raised in respect of the report.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(22)089

Kerry Carroll referred to the highlights in the paper shared. Fiona Osborne queried whether the Ockenden Report had influenced the draft models of care and whether

anything had changed significantly due to this. Kerry Carroll advised a specific workshop had focussed on this in terms of longer-term models and these would be worked through.

6.2 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – May 2022 – NLG(22)090

Gill Ponder referred to the highlight report and advised the committee had approved two wishes at the last meeting.

Sean Lyons questioned whether staff were aware of how to access the committee funds. Gill Ponder advised there was a simple form available to be completed, however, it may be beneficial to communicate the process to staff. Dr Peter Reading agreed it would be helpful to communicate this to staff and advise what funding could be applied for. It was agreed Ade Beddow would communicate this to staff.

Action: Ade Beddow

6.3 Humber Acute Services Development Committee Highlight Report & Board Challenge (CIC) - NLG(22)091

Sean Lyons referred to the highlight report and advised programme one had struggled in terms of decisions being made. This had resulted in a conversation at the Joint Development Board and was now being worked through. This would be reported at the Committees in Common (CIC) meeting in June.

Dr Peter Reading advised the Joint Board Development Terms of Reference had been reviewed and as a result Chris Long, Chief Executive at HUTH and Dr Peter Reading co-chaired the meeting. The recent meeting held had been well attended by Directors of both Trusts. The board were advised the CIC minutes would be shared at the Private Board going forward as an item for information.

6.4 Strategic Development Committee (SDC) Highlight Report & Board Challenge – NLG(22)092

Simon Parkes referred to the highlights within the report. In respect of the hospital building programme there were risks if the funding was received as this would impact on workforce. If the funding was not received a meeting had been held with Ivan McConnell to see how this would be worked through. Further updates on this would be provided later in the year.

In respect of the digital update Shauna McMahon advised the ICS were looking at a single electronic patient record (EPR) system but this was currently being worked through. This had been escalated and advice given that if this decision was not made soon NLAG and HUTH would join up and have a joint EPR. The Lorenzo system continued to be supported but was under a new supplier that had advised Lorenzo Clinicals would not be supported. Discussions in respect of this were to take place to find out what this would mean. An information technology review was being undertaken across both Trusts. Shauna McMahon agreed to escalate any issues going forward to the board.

Dr Peter Reading advised Ivan McConnell had briefed the Executive Team and following this further work was to be completed. At the July Joint Board Meeting there would be an understanding for both boards to understand the risks and how those risks would be managed. The Health Service Journal had published that the Hospital Programme was on track according to Sajid Javid, however, it was felt the decision would not be made by July as anticipated.

7. Strategic Objective 5 – To Provide Good Leadership.

7.1 There were not items to discuss under this section.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – NLG(22)093

Simon Parkes referred to the report and shared highlights from the committee. Ellie Monkhouse referred to point five and asked if the report could be shared with Executives. Simon Parkes referred to the report and advised the questionnaires had been more positive from the Executives on the usefulness of the BAF whereas the Non-Executive Directors (NEDs) had been less favourable. It was agreed the report would be shared with the Executive Team.

After further discussion it was agreed the BAF and the Internal Audit Progress Report should be discussed at a future board development session.

Action: Dr Peter Reading

Lee Bond referred to the internal audit opinion and advised the number of overdue recommendations had reduced since the last meeting and this would feature in the final opinion.

8.2 Board Assurance Framework (BAF) – Quarter 4 - NLG(22)094

Dr Peter Reading advised the report was for noting. No issues were raised in respect of the report.

9. Approval (Other)

9.1 Health & Safety Policy Statement – NLG(22)095

Jug Johal shared the Health & Safety Policy Statement and advised of one minor amendment from the previous year, this was highlighted within the statement.

The Trust Board approved the Health & Policy Statement.

9.2 Finance & Performance Committee Terms of Reference – NLG(22)112

Gill Ponder provided an overview of the changes made.

The Trust Board approved the revised Terms of Reference.

10. Items for Information

The following items were shared at the June 2022 meeting:

- F&PC Minutes – February and March 2022
- Q&SC Minutes – March & April 2022
- Nursing Assurance Report
- Workforce Committee Minutes – March 2022
- AR&GC Minutes – February 2022
- HTFTC Minutes – March 2022
- Communications Round-Up
- Documents Signed Under Seal

In relation to the AR&GC minutes shared Christine Brereton advised there were some factual inaccuracies. After some discussion it was agreed Christine Brereton would advise Simon Parkes outside of the meeting on any changes required.

Action: Christine Brereton

11. Any Other Urgent Business

There were no items of any other business raised.

12. Questions from the Public

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

13. Date and Time of the next meeting

Formal Trust Board Meeting

Tuesday, 2 August 2022, Time: 9.00 am

Board Development

Tuesday, 1 November 2022, Time: TBC

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

Sean Lyons closed the meeting at 12:23 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	2	2	Ellie Monkhouse	2	2
Dr Peter Reading	2	2	Fiona Osborne	2	2
Lee Bond	2	2	Simon Parker	2	2
Christine Brereton	2	2	Gillian Ponder	2	2
Stuart Hall	2	2	Michael Proctor	2	2
Helen Harris	2	0	Maneesh Singh	2	2
Linda Jackson	2	1	Shaun Stacey	2	2
Jug Johal	2	1	Michael Whitworth	2	2
Ivan McConnell	2	1	Dr Kate Wood	2	1
Shauna McMahon	2	2			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PRIVATE) – SELF CERTIFICATION

Minutes of the Private Meeting held on Monday, 30 May 2022 at 1.30 am
By MS Teams

For the purpose of transacting the business set out below

Present:

Sean Lyons	Chair
Linda Jackson	Vice Chair
Dr Peter Reading	Chief Executive
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Simon Parkes	Non-Executive Director
Gillian Ponder	Non-Executive Director
Michael Whitworth	Non-Executive Director

In Attendance:

Chris Boyne	Deputy Director, Internal Audit
Christine Brereton	Director of People
Alison Hurley	Assistant Director of Corporate Governance (representing Helen Harris)
Matt Clements	Assistant Director of Financial – Financial Management (representing Lee Bond)
Stuart Hall	Associate Non-Executive Director
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Fiona Osborne	Associate Non-Executive Director
Maneesh Singh	Associate Non-Executive Director
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

Business Items

1. Chair's Opening Remarks

Sean Lyons welcomed Board members to the meeting and declared it open at 1.30 pm.

2. Apologies for Absence

Apologies for absence were received from Lee Bond, represented by Matt Clements, Adrian Beddow and Helen Harris, represented by Alison Hurley.

3. Declarations of Interest

Sean Lyons sought any declarations of interest in relation to the business to be transacted. None were received.

4. Minutes of the previous event held on the 25 May 2021 – NLG(22)075

The minutes of the last meeting held on the 25 May 2021 were approved as an accurate record and would be duly signed by the Chair.

5. Introduction to and Purpose of the Event

Alison Hurley advised the meeting was held annually to ensure the Trust complied with the requirements of the Provider Licence. Thanks were expressed for support received in respect of the updates provided.

It was noted that the Annual Governance Statement (AGS) looked back over the previous year, however, the Self-Certification process looked forward. The Trust Board, therefore, needed to be confident in making the required self-certifications to ensure robust plans were in place to mitigate risks identified.

The document was designed to support the Trust Board's deliberations and outlined the risks of certification and mitigated actions. Board members would be required to note and consider the areas that were detailed as 'not confirmed'.

6. Internal Audit (Audit Yorkshire) Assurance in Support of the Self Certification

Chris Boyne advised an independent review of the self-certification process had been undertaken and evidence had been checked to support the statement.

A presentation was provided to Board members detailing the process undertaken. The outcome of the process was awarded 'significant assurance'.

7. Self-Certification Review – NLG(22)076

Alison Hurley took Board members through the document, addressed the areas noted as 'not confirmed' and sought comments.

Dr Kate Wood requested the Single Oversight Framework be amended to System Oversight Framework. Ellie Monkhouse advised that the Nursing Assurance Report is not currently received at the Trust Board as referred to on page 16, and sought an amendment.

Post Meeting Note: Following the meeting it was agreed the Nursing Assurance Report would be shared at the Trust Board meeting as an item for information.

The Trust Board agreed to the statements and approved the paper.

8. Date and Time of next meeting

Public & Private Meeting
Tuesday, 7 June 2022, Time TBC

Board Development
Thursday, 7 July 2022, Time TBC

The meeting closed at 13:54 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	3	3	Ellie Monkhouse	3	2
Dr Peter Reading	3	3	Fiona Osborne	3	3
Lee Bond	3	2	Simon Parkes	3	3
Christine Brereton	3	3	Gillian Ponder	3	3
Stuart Hall	3	3	Michael Proctor	3	2
Helen Harris	3	0	Maneesh Singh	3	3
Linda Jackson	3	3	Shaun Stacey	3	3
Jug Johal	3	2	Michael Whitworth	3	3
Ivan McConnell	3	3	Dr Kate Wood	3	3
Shauna McMahon	3	3			

NLG(22)117

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2022/2023

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
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NHS Foundation Trust

Trust Board Public Meeting
2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
2.7	07.06.2022	CEO Briefing		Update to be provided on how collaboratives would fit within NLAGs Assurance Frameworks.	Sean Lyons & Dr Peter Reading	04.10.2022	Update to be provided at the October Trust Board meeting.			
3.2	07.06.2022	Quality & Safety Committee Highlight Report & Board Challenge		Update to be provided from the Q&SC regarding board visits.	Mike Proctor, Dr Kate Wood, Ellie Monkhouse	02.08.2022	Update to be provided at the August Trust Board meeting.			
3.5	07.06.2022	Volunteer Strategy		Volunteer Strategy to be updated following proof reading	Ellie Monkhouse	02.08.2022	Update to be provided at the August Trust Board meeting.			
3.6	07.06.2022	Key Issues - Performance		Update to be provided on whether the IPR could include exact timings patients had waited over a 12 hr breach.	Shauna McMahon	02.08.2022	Update to be provided at the August Trust Board meeting.			
3.7	07.06.2022	Finance & Performance Committee Highlight Report & Board Challenge		Deep Dive on ventilation and air conditioning to be shared with the Infection Control Committee.	Gill Ponder	02.08.2022	Update to be provided at the August Trust Board meeting.			
4.1	07.06.2022	Key Issues - Workforce		Christine Brereton to look at opportunites with Universities in terms of recruiting family members of overseas students. Joint discussion to take place with Simon Nearney.	Christine Brereton	02.08.2022	Update to be provided at the August Trust Board meeting.			
6.2	07.06.2022	HTFTC Highlight Report & Board Challenge		Communication to be sent to staff on the process for accessing Health Tree funds.	Ade Beddow	02.08.2022	Update to be provided at the August Trust Board meeting.			
8.1	07.06.2022	ARG Highlight Report & Board Challenge		BAF Session to be added to the Trust Board Development Session timetable	Dr Peter Reading / Helen Harris	02.08.2022	Update to be provided at the August Trust Board meeting.			
10	07.06.2022	Items for Information		Christine Brereton to advise of factual accuracies in specific ARG Minutes	Christine Brereton		Update to be provided at the August Trust Board meeting.			

Key:

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

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting

2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
2.5	07/12/2021	Mortuary & Board Store Assurance - Trust Board response to NHS England / Improvement		It was agreed the Audit, Risk & Governance Committee would be responsibility for the oversight of actions being undertaken.	Simon Parkes	Feb-22	An update was to be provided at the February 2022 meeting. It was confirmed at the February 2022 meeting this would be added to the AR&GC workplan.		AR&GC workplan	
3.5	07/12/2021	Executive Report - Performance		It was agreed more focus would be included within the report going forward to highlight actions for specific areas.	Shaun Stacey	Feb-22	An updated report would be provided at the February 2022 meeting. An updated report was shared at the February 2022 meeting.		Minutes - February 2022 Board Meeting	
4.1	07/12/2021	Executive Report - Workforce		Update to be provided on the current position in respect of mandatory Covid vaccines for staff within the Executive Report - Workforce.	Christine Brereton	Feb-22	An update was to be provided at the February 2022 meeting. An update was provided at the February 2022 meeting.		Minutes - February 2022 Board Meeting	
8.2	07/12/2021	Board Assurance Framework (BAF)		A meeting to review the requirement of sub-categories within Strategic Objective 2 was to be held.	Helen Harris / Ellie Monkhouse / Christine Brereton	Feb-22	An update was to be provided at the February 2022 meeting. Item closed, update provided at April 2022 meeting.			
3.2	01/02/2022	Quality & Safety Committee Highlight Report & NED Challenge		Update to be provided on Governor Engagement in respect of the Quality Priorities approval process.	Helen Harris / Dr Kate Wood / Mike Proctor	Apr-22	An update was to be provided at the April 2022 meeting. Item closed, update provided at April 2022 meeting.			

Key:

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

NLG(22)118

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	2 August 2022
Director Lead	Peter Reading, Chief Executive
Contact Officer/Author	Peter Reading, Chief Executive
Title of the Report	**Chief Executive's Briefing**
Purpose of the Report and Executive Summary (to include recommendations)	To brief the Board on major issues of interest, nationally and locally
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Both the Messenger Review and the Trust's Culture Transformation programme may be expected to have positive impact on equality, diversity and inclusion
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ☐ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Chief Executive's Briefing

1. CQC Inspection

NLaG had a two and half day on site inspection by about 40 CQC inspectors from 28th to 30th June 2022. The inspectors visited all three hospitals (but not Community Services) and the following services:

- Diagnostics
- End of Life
- Maternity
- Medicine
- Outpatients
- Surgery

The Trust's Well Led Inspection took place from 26th to 28th July, and on these dates both A&Es were also inspected.

2. Development of Humber & North Yorkshire Health & Care Partnership

Following the Health & Care Act gaining Royal Assent, integrated care systems (ICSs) such as the Humber & North Yorkshire Health & Care Partnership (HNY) have been incorporated statutorily with effect from 1st July 2022.

NLaG continues to participate actively in the development of the three Place Partnerships and two Collaboratives of which it is a member, together with relevant professional or specialist for a within the HNY structure. Place Directors have now been appointed for all three of the Place Partnerships of which NLaG is a member. A development session was also held for the Collaborative of Acute Providers on 15th July.

3. National Covid-19 Pandemic Inquiry

This independent public inquiry has been set up to examine the UK's response to and impact of the Covid-19 pandemic, and learn lessons for the future. The Inquiry is Chaired by Baroness Heather Hallett, a former Court of Appeal judge. The Inquiry was officially launched on 21st July 2022, with preliminary hearings starting this year, and the first witnesses to be called next spring.

Terms of Reference have recently been published and these set out the aims of the Inquiry, namely to examine the COVID-19 response and the impact of the pandemic; to produce a factual narrative account in relation to central, devolved and local public health decision-making and its consequences; the response of the health and care sector across the UK; the economic response to the pandemic and its impact, including government interventions; and to identify the lessons to be learned from the above, thereby to inform the UK' preparations for future pandemics.

The Trust Lead for the Inquiry is Helen Harris. The Trust has established an internal Inquiry working group, made up of key individuals which would meet on a regular basis to discuss and action the information coming from the national team, with the regional steering group meeting monthly.

4. Messenger Review

The review of NHS leadership by Sir Gordon Messenger and Dame Linda Pollard, commissioned by the Secretary of State last autumn, was published on 8 June 2022, entitled Leadership for a collaborative and inclusive future. Generally, it has been well received by NHS leaders. A link to the report is below.

https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future

I had the opportunity to feed into the review in three separate Roundtable meetings convened by Sir Gordon, one about the leadership needs of challenged, rural and remote trusts, one about equality and diversity, and one about disability and leadership. It is satisfying to see each of these themes featuring strongly in the report.

Board members may also be interested in the recommendation about NED recruitment and development.

The recommendations of the report are:

i. *Targeted interventions on collaborative leadership and organisational values*
A new, national entry-level induction for all who join health and social care. A new, national mid-career programme for managers across health and social care
.

ii. *Positive equality, diversity and inclusion (EDI) action*
Embed inclusive leadership practice as the responsibility of all leaders.
Commit to promoting equal opportunity and fairness standards.
More stringently enforce existing measures to improve equal opportunities and fairness.
Enhance CQC role in ensuring improvement in EDI outcomes.

iii. *Consistent management standards delivered through accredited training*
A single set of unified, core leadership and management standards for managers.
Training and development bundles to meet these standards.

iv. *A simplified, standard appraisal system for the NHS*
A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

v. *A new career and talent management function for managers*
Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

vi. *More effective recruitment and development of non-executive directors*
Establishment of an expanded, specialist non-executive talent and appointments team.

vii. E*ncouraging top talent into challenged parts of the system*
Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

5. Culture Transformation programme

The first meeting of the Trust's Culture Transformation Board took place on 6th July 2022, and on 4th August, the first of five planned Culture Transformation launch events will be held at Forest Pines Conference Centre. There is an exciting agenda of events scheduled, including the introduction and launch of our partnership with Clever Together to deliver our Big Conversation on engagement across the Trust this summer. Attendees will be exploring, through table conversations and presentations, how we will build and deepen a values-based employee experience with Kindness, Courage and Respect at its heart.

Peter Reading
Chief Executive

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 02 August 2022
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
Contact Officer/Author	Shauna McMahon, Chief Information Officer
Title of the Report	**Integrated Performance Report (IPR)**
Purpose of the Report and Executive Summary (to include recommendations)	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page 4. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page 6. **4. Workforce** The executive summary of the Workforce section is provided over on page 8. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR (February Data) Quality and Safety – IPR (January/February Data) Workforce – IPR (February Data)
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

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

*Board Assurance Framework (BAF) Descriptions:

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

IPR EXECUTIVE SUMMARY	Date: July 2022

1. ACCESS & FLOW – Shaun Stacey

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

- Cancer – Two Week Wait – 95.1% June 2022
- % of Extended Stay Patients 21+ Days (Weekly) – 9.24% June 2022
- Inpatient Non Elective Average Length of Stay – 3.8 June 2022

Lowlights: (share 3 areas of challenge/struggle)

- Emergency Department Waiting Times (4 Hour Performance) – 63.3% June 2022
- Number of Decision to Admit (DTA) 12 Hour Waits – 502 June 2022
- Cancer Waiting Times – 62 Days GP Referrals – 52.5% June 2022

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Emergency Department Waiting Times (4 Hour Performance)	Bid submitted for funding for Virtual Ward Development across Northern Lincolnshire which will provide an alternative to urgent care attendance and acute care if successful	Less patients attending ED will allow the clinical focus to be on the patients who require it.
Number of Decision to Admit (DTA) 12 Hour Waits	Work with Community Services/NEL & NL CCGs to improve patient pathways and alternative community pathways	Patients can be discharged to community care earlier, freeing up beds for ED patients
Cancer Waiting Times – 62 Days GP Referrals	Production of process maps for booking of patients to ensure optimum list utilisation	Optimum Utilisation of Clinics will potentially allow for an increased number of cancer slots available for patients

1. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- Performance of PEWS and NEWS undertaken/recorded within the specified time periods are now in line/above the target.
- VTE risk assessment completion is in line with the 95% target for the first time.
- The number of emergency admissions for people in the last three months of life has reduced from 214 in May 2022 to 165 in June 2022.
- The Trusts' rolling 12-month SHMI (January 2022) recorded the lowest SHMI on record for the second month running at 104.1. The Trust's HSMR for April 2022 remains below 100.

Lowlights: (share 6 areas of challenge/struggle)

- Continued low compliance in recording an actual weight for patients on EPMA or WEB V – 20% for May 2022. The audit highlighted 1 patient at DPOW was prescribed Paracetamol 1g (when required PO/IV, Maximum 4g in 24 hours) despite their actual weight being recorded as 45kg.
- One NQB structured judgement review remains outstanding for 2021 (Surgery & Critical Care division).
- The Trust's rolling 12 month out of hospital SHMI remains higher than the target (134) for February 2022.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Number of patients with an actual weight recorded on admission to IAAU.	Escalation to Associate Chief Nurse and Divisional Clinical Director for Medicine Division. Associate Chief Nurse to look at sourcing more suitable equipment to aid weighing of acutely ill patients.	Increase in the number of patients with a weight recorded.
Out of hospital SHMI remains higher than the target.	A pilot is in development to implement a NEWS2 type system in care homes, which will help the PCNS monitor patient deterioration. Early identification of palliative care, frailty index and standard palliative resources being rolled out across NEL care homes, with training to upskill staff on palliative management.	Reduction in the number of avoidable admissions to hospital.

1. WORKFORCE – Christine Brereton

Highlights:

- The Core Mandatory Training position overall currently stands at 91%, Compliance continues to be above the Trust target of 90%
- The Medical vacancies position is 14.1% this continues to be below target of 15%
- Sickness absence has reduced 1.4% from April to May

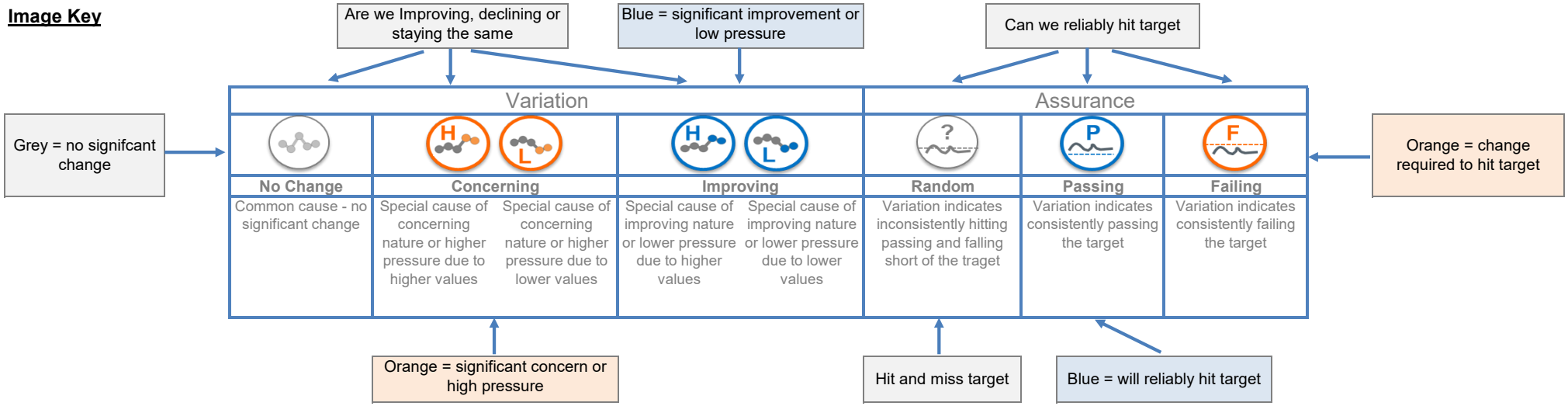
Lowlights:

- Hotspot areas of low compliance for Statutory /Mandatory training in medical workforce
- Turnover continues to be above target. The latest turnover data point 12.3%
- Registered Nursing vacancy positions continues to increase to 13.7% against a target of 8% (the sharp increase in the vacancy factor from due to 6.38% increase in substantive establishment from April 22)

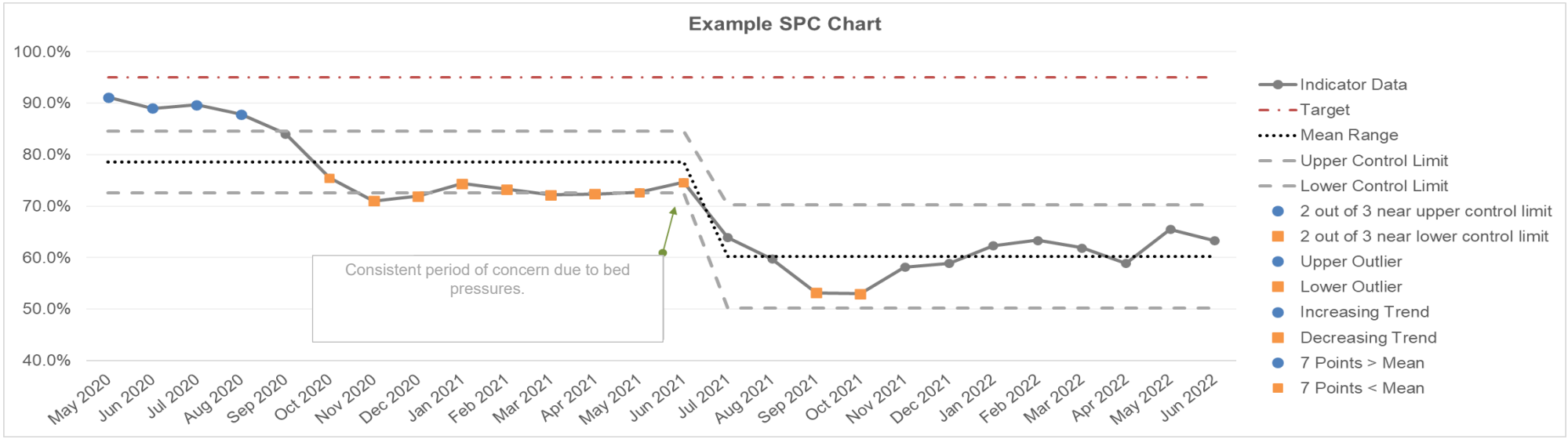
Unregistered Nursing vacancy positions continues to increase to 18.6% against a target of 8% (the sharp increase in the vacancy factor from due to 9.49% increase in substantive establishment from April 22)

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
To address the spike in Unregistered vacancies mass recruitment events for unregistered nursing and in the planning stage. The rescheduled for September 2022, with an aim to recruit circa 120 new HCA staff to start between October 21 and March 22. Continue to utilise funding from NHS/e for international nurse recruitment. Additional support available for recruitment of midwives is currently being explored. The trust is implementing the revised Covid-19 terms and conditions back to pre covid-19 procedures. The trust is working with managers, trade unions and employees to revert these practices in line with national guidance.	Recruitment Plans are being produced detailing forecasts and will be circulated to operational groups. Ongoing engagement with Chief Nurse's Office and Operational Groups through regular task and finish groups for registered and unregistered nursing. An increased emphasis on prevention of avoidable leavers by improving culture (mid to long term goal) and strengthening leadership capability and behaviours where required. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround.	An improved vacancy position is anticipated to reduce turnover rates and support staff retention alongside Nursing career frameworks and introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term. Improvement/steady position on turnover

Image Key



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



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

Notes on Process Limits Re-Calculation

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

This might be shown as:-

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

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

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

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

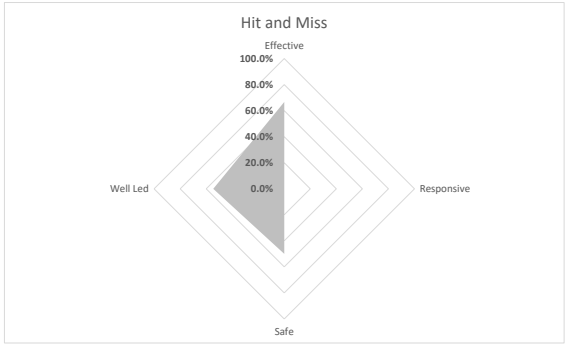
Consistently Passing

Total: 2

Core Mandatory Training Compliance Rate
Total Inpatient Waiting List Size

Hit and Miss

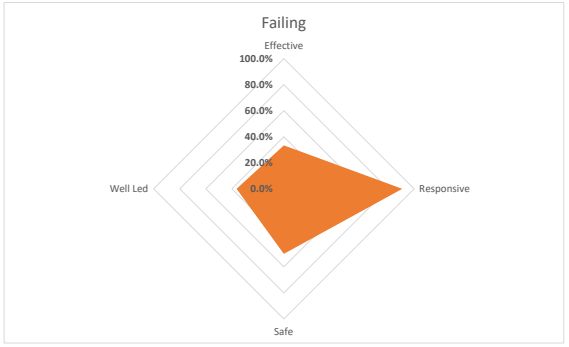
Total: 13



% Discharge Letters Completed Within 24 Hours of Discharge
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Role Specific Mandatory Training Compliance Rate
Turnover Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Complaints Responded to on time
Unregistered Nurse Vacancy Rate
Registered Nurse Vacancy Rate
Medical Vacancy Rate
Trustwide Vacancy Rate

Consistently Failing

Total: 18



% Inpatient Discharges Before 12:00 (Golden Discharges)
% Patients Discharged On The Same Day As Admission (excluding daycase)
Ambulance Handover Delays - Number 60+ Minutes
Cancer Request To Test In 14 Days*
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Emergency Department Waiting Times (% 4 Hour Performance)
Medical Staff PADR Rate
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
PADR Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Venous Thromboembolism (VTE) Risk Assessment Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Sickness Rate
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission
Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H		Inpatient Non Elective Average Length Of Stay	% Patients Discharged On The Same Day As Admission (excluding daycase) Number of Incomplete RTT pathways 52 weeks* Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Venous Thromboembolism (VTE) Risk Assessment Rate Medical Staff PADR Rate
		L			
	Common Cause		Core Mandatory Training Compliance Rate	% Discharge Letters Completed Within 24 Hours of Discharge % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay Complaints Responded to on time Duty of Candour Rate Medical Vacancy Rate	% Inpatient Discharges Before 12:00 (Golden Discharges) Number of Overdue Follow Up Appointments (Non RTT) Ambulance Handover Delays - Number 60+ Minutes Cancer Request To Test In 14 Days* Emergency Department Waiting Times (% 4 Hour Performance) Percentage Under 18 Weeks Incomplete RTT Pathways* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38* PADR Rate Sickness Rate
	Special Cause Concern	H	Total Inpatient Waiting List Size	Bed Occupancy Rate (G&A) Turnover Rate Role Specific Mandatory Training Compliance Rate Unregistered Nurse Vacancy Rate Registered Nurse Vacancy Rate Trustwide Vacancy Rate	Cancer Waiting Times - 104+ Days Backlog* Cancer Waiting Times - 62 Day GP Referral* Combined AfC and Medical Staff PADR Rate
		L			

Scorecard - Access and Flow

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Jun 2022	68.8%	92.0%	Alert		F
	Number of Incomplete RTT pathways 52 weeks*	Jun 2022	336	0	Alert	L	F
	Total Inpatient Waiting List Size	Jun 2022	11,083	11,563	Alert	H	P
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Jun 2022	24.5%	1.0%	Alert	L	F
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Jun 2022	29,478	9,000	Alert		F
	Outpatient Did Not Attend (DNA) Rate	Jun 2022	7.2%	No Target			n/a
	% Outpatient Non Face To Face Attendances	Jun 2022	28.2%	No Target	Alert	L	n/a
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Jun 2022	52.5%	85.0%	Alert	L	F
	Cancer Waiting Times - 104+ Days Backlog*	Jun 2022	51	0	Alert	H	F
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Jun 2022	0.0%	75.0%	Alert		F
	Cancer - Request To Test In 14 Days*	Jun 2022	85.4%	100.0%	Alert		F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Jun 2022	63.3%	95.0%	Alert		F
	Number Of Emergency Department Attendances	Jun 2022	12,899	No Target			n/a
	Ambulance Handover Delays - Number 60+ Minutes	Jun 2022	771	0	Alert		F
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Jun 2022	502	0	Alert		F
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Jun 2022	40.9%	40.0%	Alert	H	F
	% of Extended Stay Patients 21+ days	Jun 2022	9.2%	12.0%			?
	Inpatient Elective Average Length Of Stay	Jun 2022	2.1	2.5			?
	Inpatient Non Elective Average Length Of Stay	Jun 2022	3.8	3.9		L	?
	Number of Medical Patients Occupying Non-Medical Wards	Jun 2022	209	No Target			n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Jun 2022	90.2%	90.0%			?
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Jun 2022	16.8%	30.0%	Alert		F
	Bed Occupancy Rate (G&A)	Jun 2022	94.9%	92.0%	Alert	H	?
COVID	Number of COVID patients in ICU beds (Weekly)	Jun 2022	0	No Target		L	n/a
	Number of COVID patients in other beds (Weekly)	Jun 2022	44	No Target		L	n/a
	% COVID staff absences (Weekly)	Jun 2022	25.6%	No Target			n/a

Scorecard - Quality and Safety

Northern Lincolnshire and Goole NHS Foundation Trust

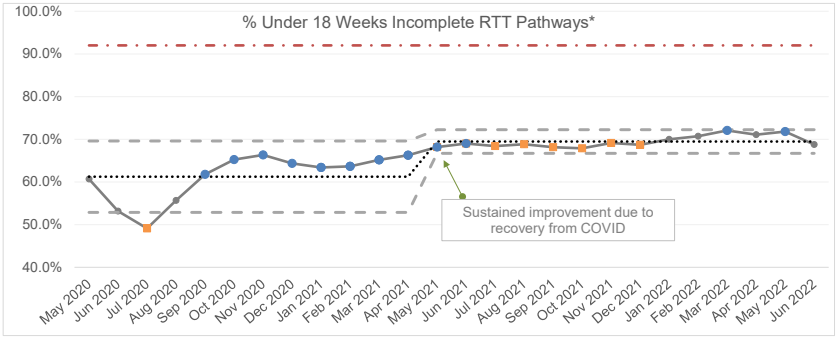
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	May 2022	0.00	No target			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	May 2022	0.30	No target			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	May 2022	0.10	No target			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	May 2022	0.15	No target			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	May 2022	0.50	No target			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Apr 2022	99.2	As expected		L	As expected
	Summary Hospital level Mortality Indicator (SHMI)	Jan 2022	104.0	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	May 2022	100%	100%			n/a
	Number of Serious Incidents raised in month	May 2022	7	No target			n/a
	Occurrence of 'Never Events' (Number)	May 2022	0	0		n/a	n/a
	Duty of Candour Rate	May 2022	100%	100%			?
	Falls on Inpatient Wards (Rate per 1000 bed days)	May 2022	5.4	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	May 2022	3.2	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	May 2022	95.3%	95.0%	**Alert**	H	F
	Care Hours Per Patient Day (CHPPD)	May 2022	8.1	No target	**Alert**	L	n/a
	Mixed Sex Accommodation Breaches	May 2022	0	0		n/a	n/a
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Apr 2022	6.6	No target			n/a
	Complaints Responded to on time	Apr 2022	72.0%	85.0%			?
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	May 2022	846 out of 892	No target		n/a	n/a
	Number of Positive A&E Scores	May 2022	582 out of 800	No target		n/a	n/a
	Number of Positive Community Scores	May 2022	144 out of 154	No target		n/a	n/a
	Number of Positive Outpatient Scores	May 2022	28 out of 31	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	May 2022	6 out of 6	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	May 2022	116 out of 128	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	May 2022	0 out of 0	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	May 2022	44 out of 46	No target		n/a	n/a

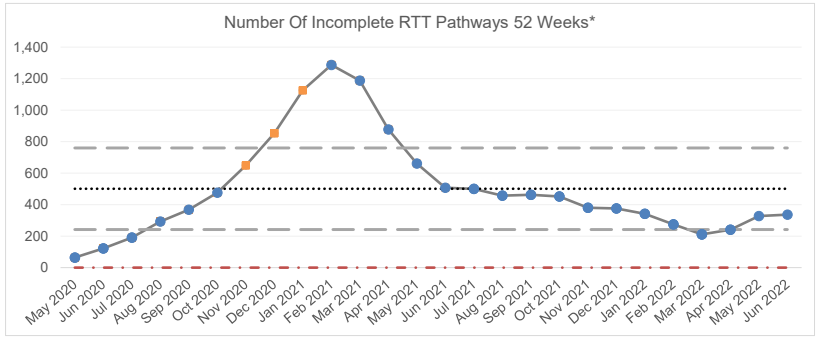
Scorecard - Workforce

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first
*Indicators marked with an asterix have unvalidated status at the time of producing the IPR.

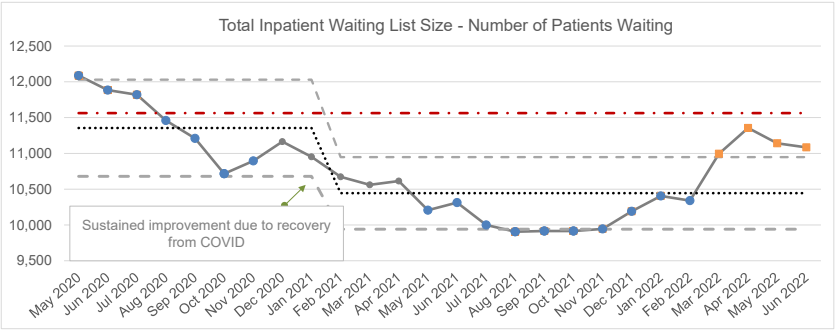
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	May 2022	18.6%	8.0%	Alert		
	Registered Nurse Vacancy Rate	May 2022	13.7%	8.0%	Alert		
	Medical Vacancy Rate	May 2022	14.1%	15.0%			
	Trustwide Vacancy Rate	May 2022	12.4%	8.0%	Alert		
Staffing Levels	Turnover Rate	Jun 2022	12.3%	10.0%	Alert		
	Sickness Rate	May 2022	5.4%	4.1%	Alert		
Staff Development	PADR Rate	Jun 2022	78.0%	85.0%	Alert		
	Medical Staff PADR Rate	Jun 2022	84.0%	85.0%	Alert		
	Combined AfC and Medical Staff PADR Rate	Jun 2022	77.5%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Jun 2022	91.0%	90.0%			
	Role Specific Mandatory Training Compliance Rate	Jun 2022	75.0%	80.0%	Alert		



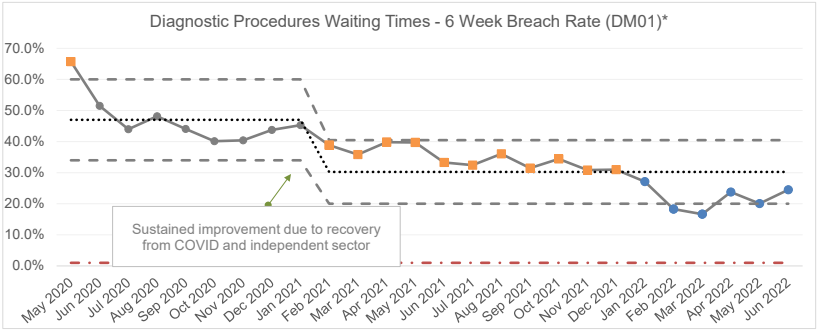
Jun 2022	Target	Variance	Assurance
68.8%	92.0%	Common cause - no significant change	Consistently falling short of the target



Jun 2022	Target	Variance	Assurance
336	0	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target



Jun 2022	Target	Variance	Assurance
11,083	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently passing the target



Jun 2022	Target	Variance	Assurance
24.5%	1.0%	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Note: Process limit re-calculation from May 21. Performance has stabilised over the past 12 months, this is reflected in the process limit re-calculation. However, the target of 92% will not be achieved without process re-design.
Incomplete 52 weeks*: The number of 52 week waits has decreased over recent months and shows improvement following the spike in 2020. The target will not be met without process redesign.
Inpatient waiting list: Note: Process limit re-calculation from Feb 21. There was significant reduction in waiting list size during the pandemic, although the most recent figures are high compared to 2021. Based on the data, the indicator can reliably be expected to achieve the target.
Diagnostics 6 Week Wait (DM01)*: Note: Process limit re-calculation from Feb 21. There has been a significant improvement in this indicator compared with 2020, based on the unvalidated latest figure. Process re-design is required in order to meet the target.

Challenges:
- Acceptance of Mutual Aid - 52+ week wait now stands at 282 for SCC&CS
- Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted
- Large fluctuations in Diagnostic demand, causing variations in total waiting list size - therefore impacting on DM01 performance
- Insuffieient established workforce in Ultrasound to meet demands on service
- Medicine vacancy rate; Gastroenterology: 33.3%, Cardiology: 75%, Dermatology: 28%
- Gynaecology Nursing capacity to support delivery of planned care
- Breast Consultant capacity due to substantive vacancy (now appointed to, start date of September 2022)
- Echo DM01 waiting times increased - insufficient capacity in core - secured IS provider, need to continue into 2022/23

Key Risks:
- Potential further COVID waves
- Carry over of annual leave - clinician availability and summer peak
- Ongoing management of high levels of acute activity impacting elective work
- Theatre nurse staffing vacancy, retention and high sickness rates
- Contracting agreements and funding for use of Independent Sector not yet agreed for 22/23
- Removal of Waiting List Initiative additional sessions by NLaG clinicians. Along with a reduction to 2% activity from external providers
- Aging Diagnostic equipment
- Funding not secured for EDCT at SGH - currently 1 3year old scanner covering unplanned care & 10 year old scanner supporting elective work
- Increasing CT colon demand & limited capacity in July/August due to consultant leave, will impact 2ww performance

Actions:
- Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position. July 2022
- Continue to utilise St Hugh's for new patients for Ophthalmology, ENT and Orthopaedics. - ongoing action.
- Robust recruitment plan for theatres with external company, options being presented to Exec - July 2022.
- Continual management of medical workforce, backfilling of vacancies with agency locum and immediate progress on any vacancies to reduce vacant positions. - ongoing action.
- Ultrasound Service review required to fully understand deficit in service - aim to complete by end of August
- Bid to be submitted for funding to support equipment replacement - bid deadline 14th July
- Review CT Colon requests to understand reason for increased demand, and review service delivery with a view to increasing capacity
- Production of process maps for booking of patients to ensure optimum list utilisation, by end of July 2022.
- Review of current processes for coding of activity, end of August 2022.
- Review of Demand and Capacity, end of August 2022.

Mitigations:
- Additional sessions still being undertaken by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment.
- Locum staff in place where able to secure
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
- Clinical risk stratifiation to ensure allocation of appointments, including pre-anaesthetic assessment is led by clinical priority of patients.
- Use of IS capacity to support delivery of diagnostic activity (currently MRI and Ultrasound)

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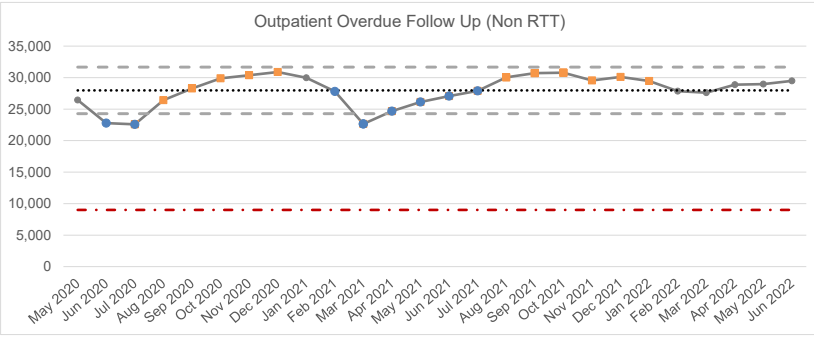
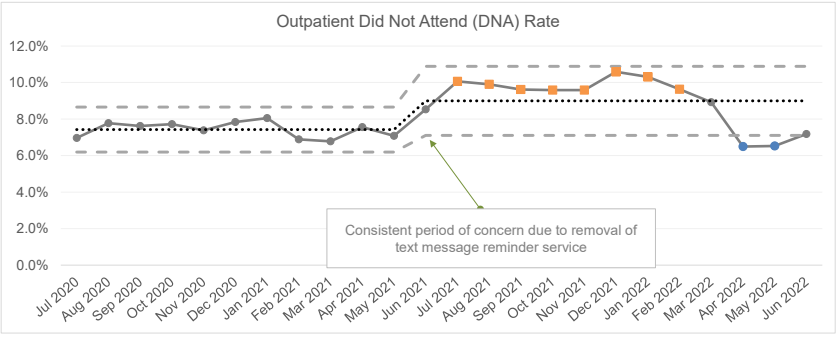
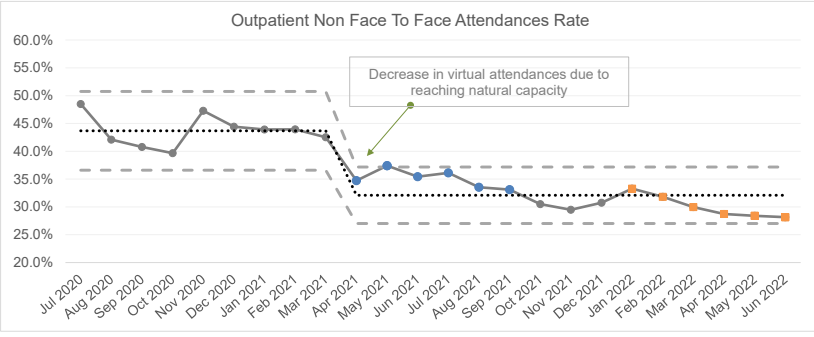


Jun 2022	29,478
Target	9,000
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Jun 2022	7.2%
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jun 2022	28.2%
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant

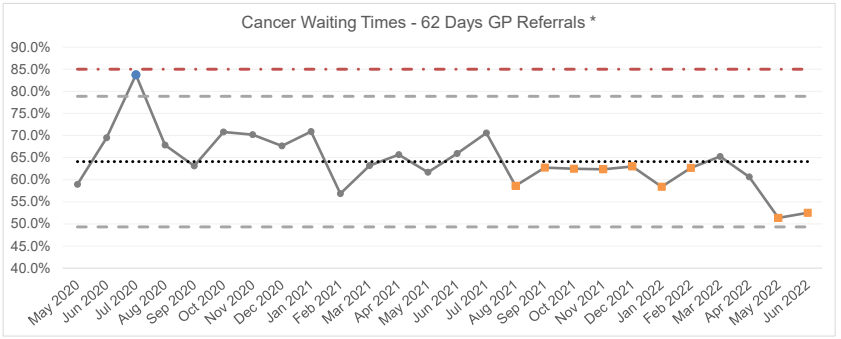
Data Analysis:
Outpatient Overdue follow up: For the past 2 years performance has been alternating between improvement and concern. Over this period the indicator has consistently failed the target of 9,000 by some margin and can be expected to continue to do so without process re-design.
Outpatient DNA rate: Process limits were recalculated from June 2020 to reflect the statistically significant shift in the behaviour of the data. The indicator has shown improvement over the course of 2022.
Non Face to Face Outpatient: Note: Process limit re-calculation from Apr 21. There has been a drop in the rate over the last 6 months, which has triggered special cause concern as the rate has fallen below the mean during this time.

Challenges:
- Further work is needed to sustain and improve the DNA rate
- PIFU is a key enabler to reduce the overdue follow-up list - this is sitting at around 1% - the challenges is to increase this to meet the 5% March target
- Roll-out of CHN continues to expand across the PCN's and into other specialties. This is transformational change that will take time to implement, the challenge is to keep the momentum going and the belief in outcomes of the programme
- Long term funding of the CHN model is proving to be a challenge. National focus is on current contracting models and the teams work separately across primary and secondary care, this model calls for a collaborative approach.
- Balance between providing overdue follow ups and reducing follow ups by 25%

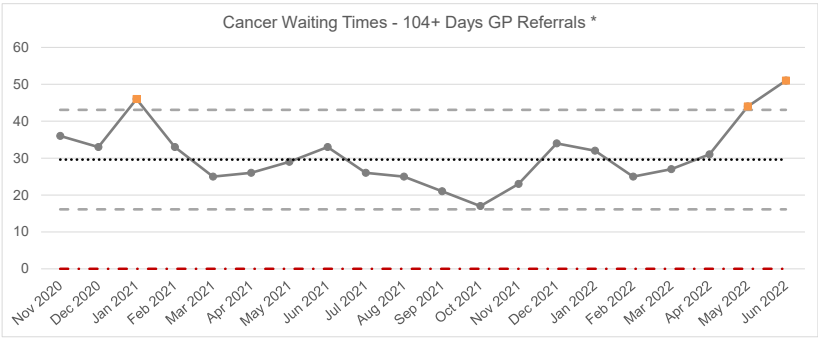
Key Risks:
- Clinical buy-in to PIFU is not supported and therefore not adopted as standard practice
- We are unable to secure a new model to finance CHN from March onwards (once the pilot funding runs out)
- The focus is on elective and new referrals in terms of performance and funding - OP follow-ups are not seen as a priority and therefore continue to rise

Actions:
- A deep dive into patients who persistently DNA or cancel their appointment is underway - ongoing
- There are plans to extend the text reminder service and digital letters into other services - ongoing
- The Trust is working closely with NHSEI and the ICB to review commissioning and funding approaches. A workshop is being organised for key individuals within the next 2 months (diaries permitting)
- Targeted work with specialties to increase the number of patients on a PIFU pathway in line with expected Trajectory. Expected implementation across all specialties except Elderly Medicine is Q1 2022-23.
- Further collaborative work with Primary Care Networks: Clinics being held by GPWSI in Rheumatology. Implemented in Rheumatology and ongoing.
- Clinicians engaged with following the access policy with regards to DNAs. Implemented and ongoing.

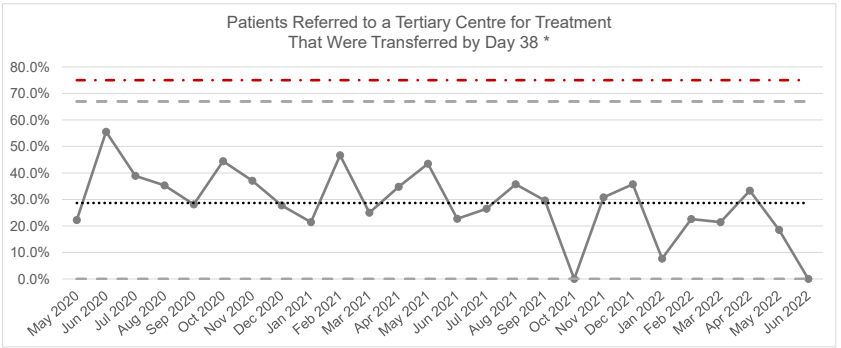
Mitigations:
- A clinical lead has now been appointed to support the Out-Patient Transformation work, which will help with clinical buy-in
- The Divisions continue to be monitored on reducing the backlog, whilst working on the longer terms objectives to prevent follow-up in the first place
- Weekly assurance meetings on the activity planning numbers - we continue to see a reduction in longer waiters and movement towards achievement of constitutional standards
- Risk Stratification of outpatient waiting lists.
- Mutually agree the majority of out-patient appointments, to minimise DNA rates.



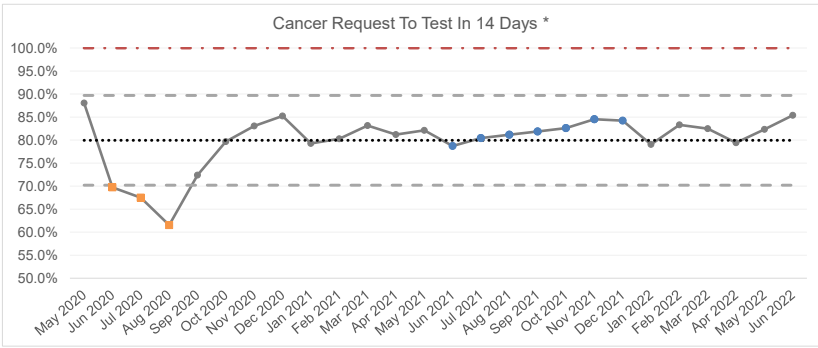
Jun 2022
52.5%
Target
85.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Consistently falling short of the target



Jun 2022
51
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target



Jun 2022
0.0%
Target
75.0%
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target



Jun 2022
85.4%
Target
100.0%
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target

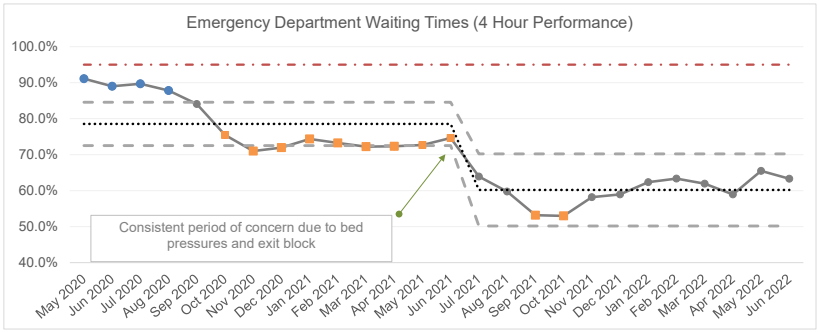
Data Analysis:
62 days GP referral*: Seven of the last ten months have triggered a cause for concern in terms of data variation. This target has not been achieved over the last 2 years and the indicator will fail to meet the target without process re-design.
104+ days GP referrals*: Behaviour is predominantly as expected, however the past four months have recorded an increasing trend with May and June plotting outside the expected range. The target of zero will not be met without process re-design.
Transferred by day 38*: The wide variation is due to very low numbers, often in single figures. Performance has not changed significantly over the past 2 years, and the target has not been achieved during this time. It will continue to fail the target without process re-design.
Request to test 14 days*: Performance is stable and as expected. The target of 100% has not been achieved for more than 2 years and the indicator will fail to meet the target without process re-design.

Challenges:
• Management of complex unfit patients requiring significant work-up are causing delays
• All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62 day pathways) resulting in increased breaches of 62 days
• Most tumour sites are unable to achieve 62 day standard due to multiple factors, including diagnostic and pathoogy turnaround times
• Colorectal is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required
• Notable increase in Urological Cancer referrals over last 3 months
• UGI is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required, we are reviewing the 28 day performance and RDC commencing at DPoW next week and SGH the week after
• Medicine UGI and Lung tumour site pathways for 28 day performance continue to be challenged
• Gynaecology Nursing capacity to support delivery of planned care
• Breast Consultant capacity due to substantive vacancy (now appointed to, start date of September 2022)

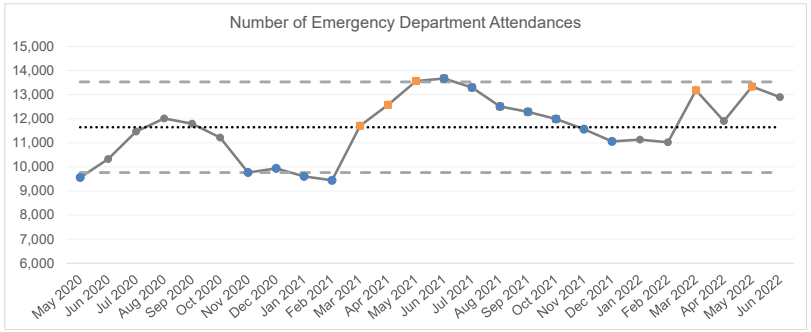
Key Risks:
• For Upper GI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
• Covid Positve Patients
• One Clinician at SGH running STT UGI service - manageable as small numbers but during leave and sickness leaves service vulnerable
• Urology cancer consultant taking extended period of leave from September 2022
• There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38
• Request to test (14 days) - in order to meet 28 day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days
• HUTH have relocated Urology oncologist to Breast, which is causing some risk to waiting times

Actions:
• Additional Consultant Led Endoscopy Clinics to enable decision making at time of procedure - September 2022
• Urology service review completed with additional one stop clinics being introduced from September 2022 in collaboration with Radiology.
• Additional consultants business case approved in Urology - recruitment of additional cancer consultant. September 2022.
• The Cancer Transformation team has completed a pathway analysis on 100 patient pathways for Lung. Outputs of this analysis have identified several areas for improvement and discussions are continuing with HUTH
• Production of process maps for booking of patients to ensure optimum list utilisation, by end of July 2022.
• Review of current processes for coding of activity, end of August 2022.
• Review of Demand and Capacity, end of August 2022.

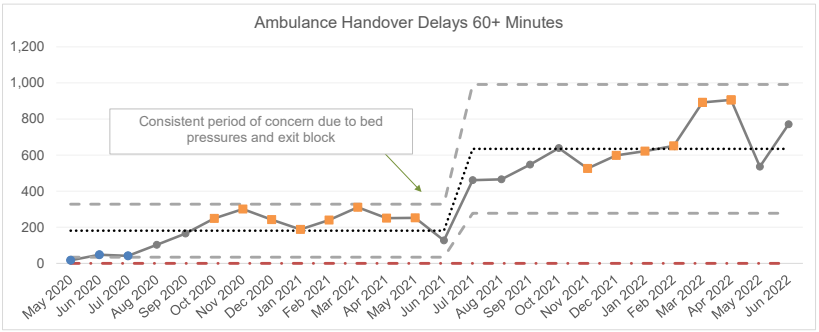
Mitigations:
• Increase RDC capacity to work alongside STT to streamline service in Colorectal
• Funding approved to recruit to Band 3 and Band 2 admin support
• RDC to be opened up to non site specific pathway from 1st May 2022 with minimal uptake
• 62 day performance is being reviewed and managed weekly - along with the 28 day performance.
• Urology agency consultant currently in post.
• The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved. Lung completed and fed back to clinical team - remedial actions being discussed.
• The joint transformation pathway work with HUTH will help with the transfer of patients between NLAG/ HUTH and to identify areas where the pathway can be accelerated
• Cancer Improvement Plans developed



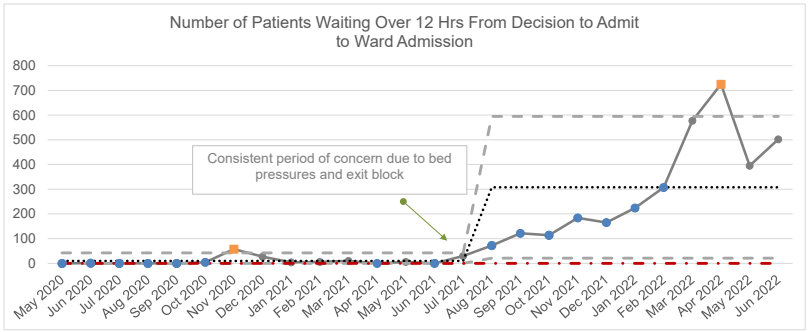
Jun 2022	Target	Variance	Assurance
63.3%	95.0%	Common cause - no significant change	Consistently falling short of the target



Jun 2022	Target	Variance	Assurance
12,899	No Target	Common cause - no significant change	There is no target therefore target assurance is not relevant



Jun 2022	Target	Variance	Assurance
771	0	Common cause - no significant change	Consistently falling short of the target



Jun 2022	Target	Variance	Assurance
502	0	Common cause - no significant change	Consistently falling short of the target

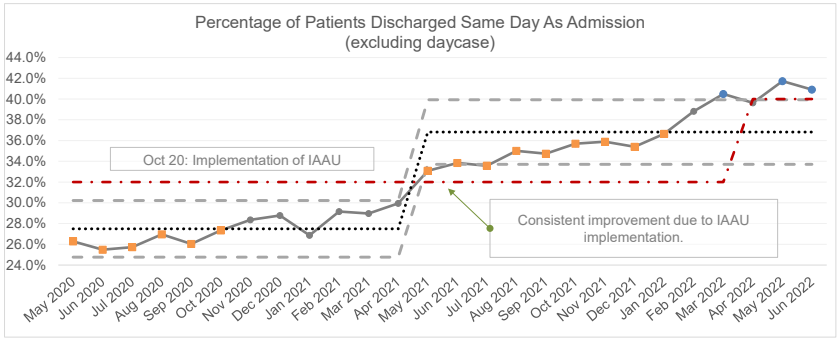
Data Analysis:
ED 4 hour waiting: There has been a significant deterioration in performance over the past two years resulting in a re-calculation of the process limits from July 21. Since then, the data is falling within the expected range, however the indicator will fail the target without process re-design.
ED Attendances: The number of attendances remains within the expected range but has moved closer to the upper range of the data in the past four months due to an increased number of attendances.
Ambulance handover 60+ minutes: Note: Process limit re-calculation from July 21. The number of 60+ minute ambulance delays remains elevated but within the expected range of the data based on the last 11 months performance. The target will not be met without process re-design.
DTA 12 hours: Note: Process limit re-calculation from Aug 21. This indicator continues to record very high levels compared with data prior to one year ago and April/May 2022 saw the worst performance for more than two years. The target will not be met without process re-design.

Challenges:
- Pressure within the community in relation to demand for ambulance attendances
- Sharp rise in the last two weeks of staff that are off sick with Covid-19
- Rise in the number of patients being admitted with Covid-19 (specifically at DPOW)
- High level of acuity with pressures within Resus

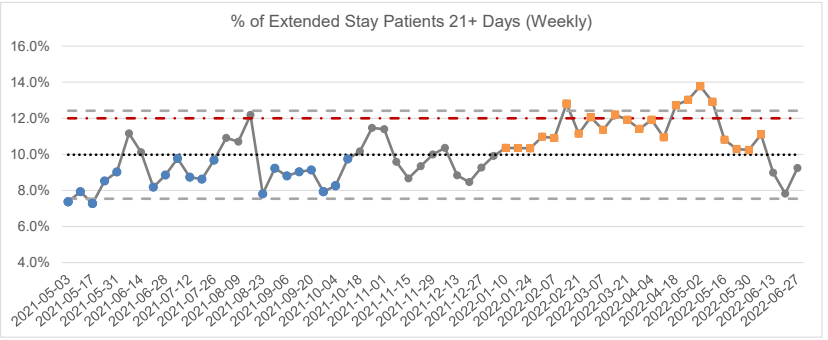
Key Risks:
- Staffing gaps in both medical and nursing
- High levels of agency and locum staff
- Inability to achieve Ambulance Handover targets due to patient flow within the hospital
- Inability to meet patient waiting times in ED
- Staff burnout

Actions:
- Daily review of medical and nursing staffing to ensure appropriate skill mix - ongoing
- Work continues on the new build for both sites to increase footprint (DPoW due to open at the beginning of September 2022)
- Discussions commencing in relation to funding of extra medical staff for the new build (DPoW due to open at the beginning of September 2022)
- Screen being installed in SDEC and SAU to enable "straight to" ambulance handover pathways to be implemented to support ED avoidance - ongoing
- Review of all Urgent Care Services across Northern Lincolnshire has commenced to look at reducing pressure across the system by ensuring that patients are seen at the right place, by the right person, first time - ongoing
- Bid submitted for funding for Virtual Ward Development across Northern Lincolnshire which will provide an alternative to urgent care attendance and acute care if successful, outcome anticipated in July 2022

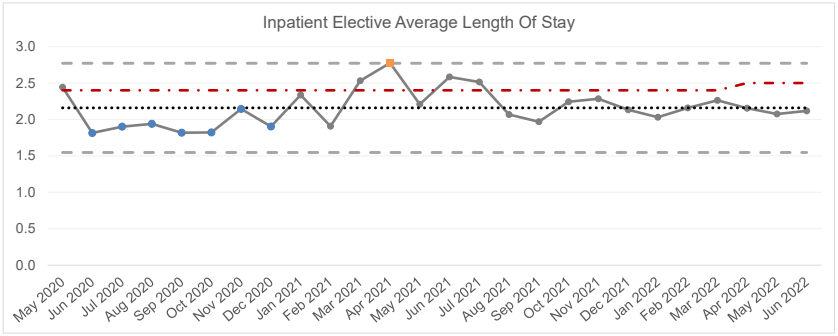
Mitigations:
- Urgent Care System continues to meet performance target and reduce the pressure on the Emergency Department
- Patients are triaged on the ambulances if there is a delay to ambulance handover to ensure patient safety
- New structure in place within ED with senior decision makers now identified on a daily basis for EPIC, Resus/Majors, Initial Assessment and Ambulance Triage
- Tier system is in place to ensure that escalation is taking place where appropriate to support patient flow to ensure a swift resolution to issues
- Fast track paediatric process in place
- 2 hourly board rounds with EPIC and Clinical Coordinator with nursing care needs monitored through care round document – risk assess for pressure ulcers, falls, nutrition, hydration, comfort
- Alternatives to trolleys – beds, recliner chairs. Choice of meals for patients during prolonged ED stays



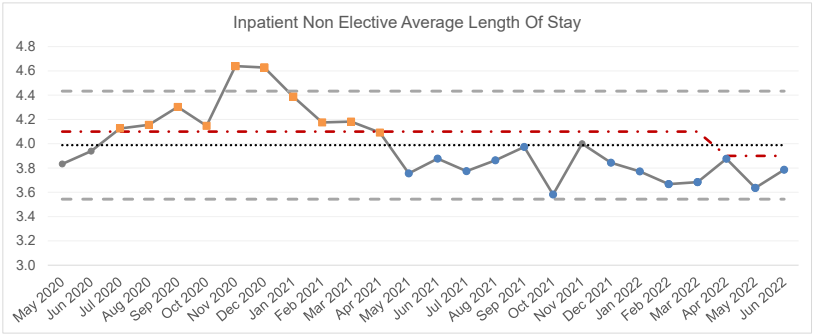
Jun 2022	Target	Variance	Assurance
40.9%	40.0%	Special cause of improving nature or lower pressure due to higher values	Consistently falling short of the target



Jun 2022	Target	Variance	Assurance
9.24%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Jun 2022	Target	Variance	Assurance
2.1	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Jun 2022	Target	Variance	Assurance
3.8	3.9	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target

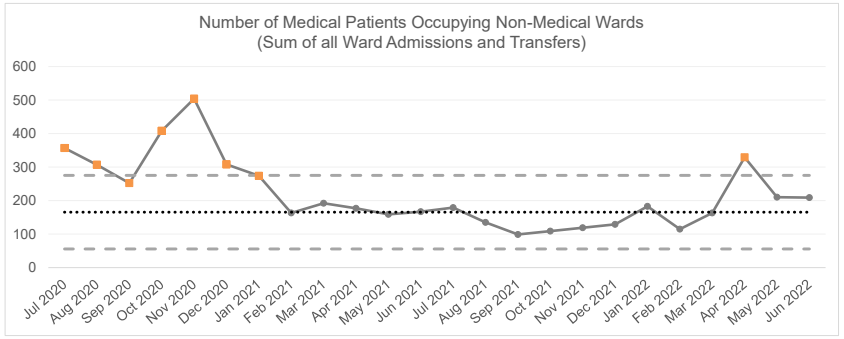
Data Analysis:
Discharged same day as admission: Note: Process limit re-calculation from May 21. Performance continues to show improvement with the most recent data points outside the expected range, showing the highest performance since May 2020. Note: The local target has been increased from 32% to 40% with
% Extended stay 21+ days: The performance of this indicator has been significantly deteriorating since rated since February 2022 and will not reliably achieve the target without process re-design.
Elective length of stay: The performance of this indicator continues to fall within the expected range. Note, the target can be expected to achieve and fail at random. Note: the target has been increased from 2.4 days to 2.5 days with effect from April 2022.
Non elective length of stay: This indicator has been showing an improvement for the past year coinciding with an increase in the percentage of patients discharged on the same day as admission. The indicator can be expected to achieve and fail the target at random. Note: The target has been decreased

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

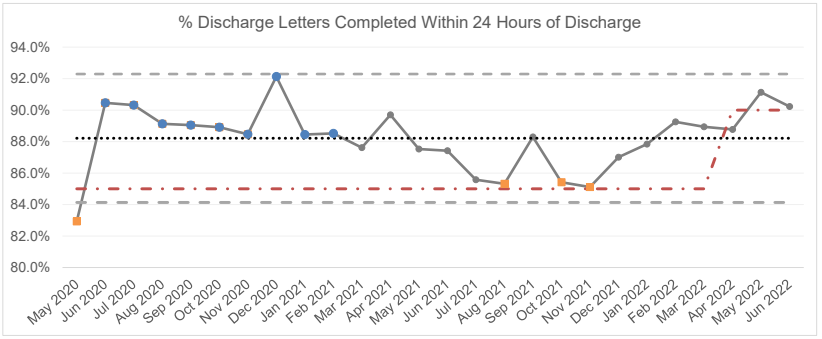
Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack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

Actions:
- Joint audit carried out between NLAG and EMAS to improve direct access to SDEC. Action plan developed; completion August 2022
- Work with Community Services/NEL & NL CCGs to improve patient pathways and alternative community pathways; ongoing
- Bid submitted for funding for Virtual Ward Development across Northern Lincolnshire which will provide an alternative to urgent care attendance and acute care if successful, outcome anticipated in July 2022.
- Discharge Programme in place including development of Home Care to reduce acute length of stay and improve flow, implementation by October 2022.
- Daily board rounds on wards - ongoing
- LLOS reviews in place for medicine twice per week led by the senior tri - ongoing

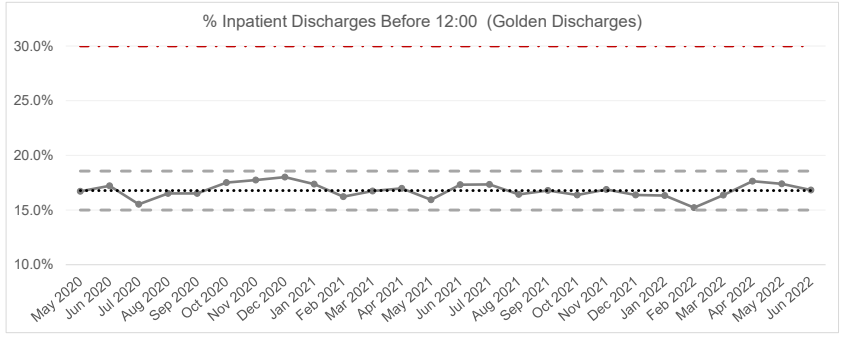
Mitigations:
- Daily board rounds on wards - work to further develop these to ensure they are effective and timley
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire.



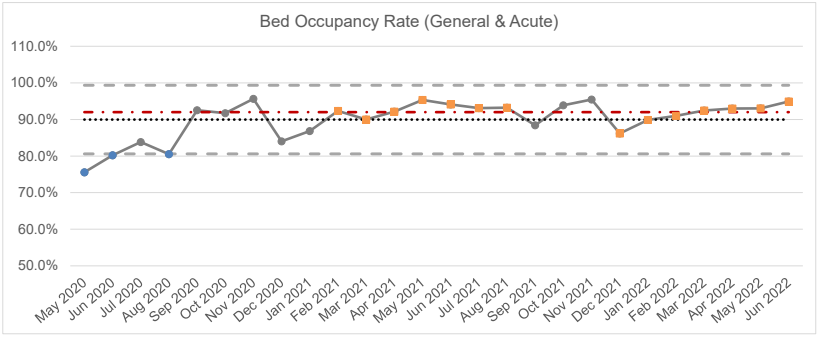
Jun 2022	209
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jun 2022	90.2%
Target	90.0%
Variance	Common cause - no significant change
Assurance	Inconsistently hitting passing and falling short of the target



Jun 2022	16.8%
Target	30.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Jun 2022	94.9%
Target	92.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and falling short of the target

Data Analysis:

Medical Outliers: For the past 18 months performance has predominantly been within the expected range, with the exception of a peak in April 22. The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed usage of wards out of usual scope.
Inpatient discharge letters: The data is predominantly falling within the expected range. The indicator can be expected to achieve and fail the target at random. Note: the local target of 85% has been increased to 90% with effect from April 2022.
Inpatient discharges before 12:00: Performance is currently stable and as expected. In terms of assurance, this indicator will not achieve the target without process re-design.
G&A Bed Occupancy: Performance has recorded an increasing trend for the past seven months, however it remains within the expected range for the data. The target can be expected to achieve and fail at random.

Challenges:

- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- NLAG staffing constraints (staffing, sickness, vacancy, use of agency/bank staff)
- Covid and IPC requirements for social distancing
- Environment and ability to create (and staff)escalation beds
- Time of discharges need to be earlier in day
- Although discharge to Assess as a process is fully embedded within the trust there is a need to concentrate improvement work on the whole discharge pathway, work is taking place to understand the current position and build a system wide improvement plan with our partners

Key Risks:

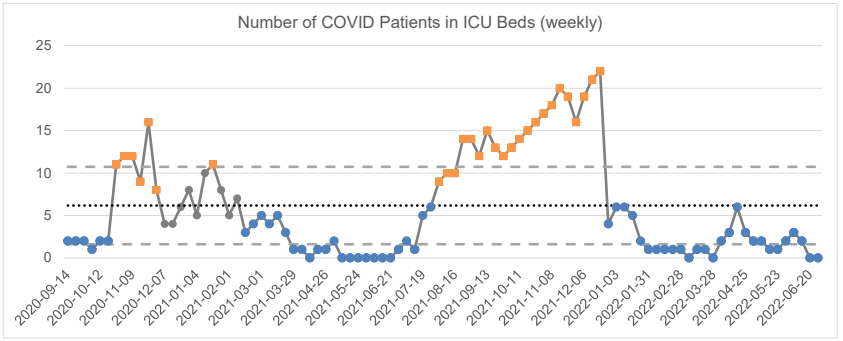
- Shortages in available workforce to meet service needs which results in inconsistancy and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission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

Actions:

- Daily board rounds on wards - ongoing
- LLOS reviews in place for medicine twice per week led by the senior tri - ongoing
- Regular meetings with system partners to understand current delays/issues - ongoing
- Discharge improvement plan currently being developed which pulls together all areasof discharge including checklist, discharge lounge, board rounds & transport - PFIG Action Plan in place detailing each action and timescales.
- Continuous engagement with ward staff around the discharge pathway. Completed and ongoing.

Mitigations:

- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from these escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire.



Jun 2022
0

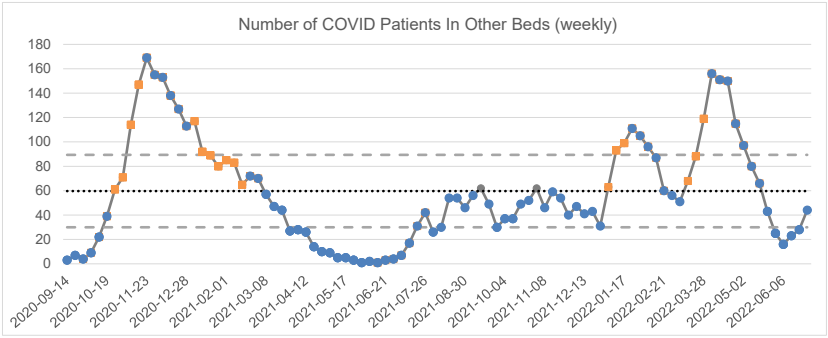
Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Jun 2022
44

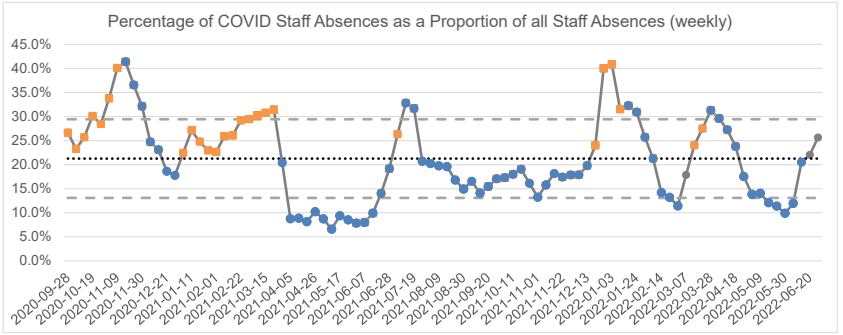
Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Jun 2022
25.6%

Target
No Target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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Data Analysis:

COVID Patients In ICU beds: The number of covid patients in ICU beds has decreased significantly in 2022 compared with the second half of 2021.

COVID Patients In Other Beds: Whilst the number of covid patients in other beds continues has fallen significantly from a peak in early April 22, they have started to very gradually increase over the last month but is not triggering a statistically significant concern at this point.

COVID Staff Absences: The rate has been volatile since mid December 21 with repeated changes between concerning and improving performance. The rate has started to very gradually increase over the last month but is not triggering a statistically significant concern at this point.

Challenges:

- Higher rate of sickness across the board impacting on all areas
- Limitation on cross cover for areas of higher specialised staff e.g critical care and theatres

Key Risks:

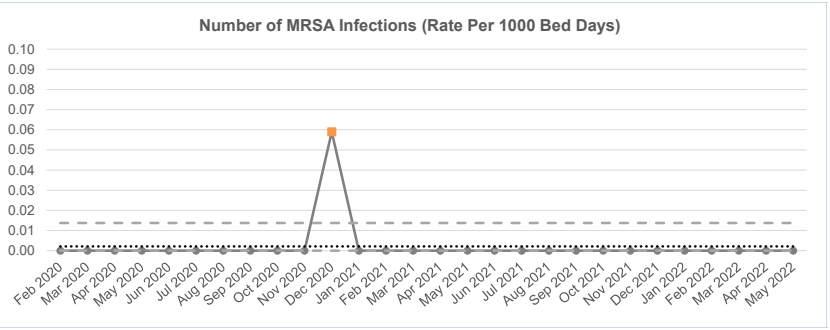
- Shortages in available workforce to meet service needs
- Covid-19 impacting physical capacity within the current footprint
- Quality of care when dependence of temporary staff to back fill sickness

Actions:

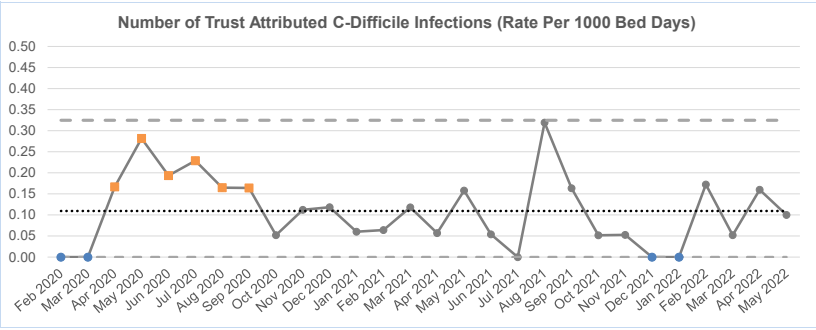
- Close monitoring of sickness and clear advise of guidance to all staff to ensure adherence to guidance is appropriate and minimal to meet safety and requirements of IPC
- Encouragement of staff to uptake the vaccine
- Requirement of patient facing staff to regualr lateral flow test, 2-3 times a week
- Adherence to continued IPC steps of PPE as per national guidelines

Mitigations:

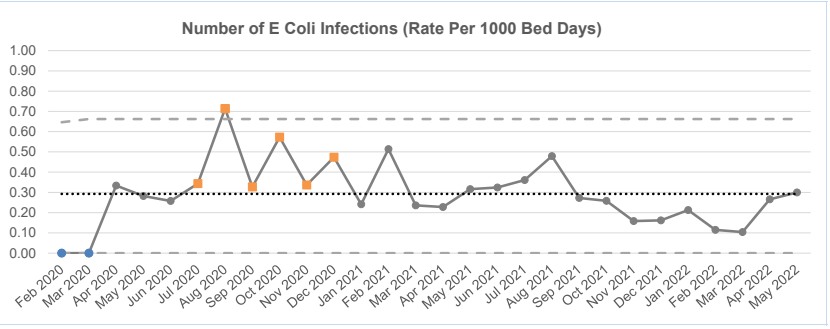
- Daily review of staffing by HON to support suitable deployment of staff across all areas
- Review in operations meeting of staffing resource in relation to activity and capacity
- Consolidation of COVID cases to dedicated areas with oversite of IPC
- Weekly review of staffing sickness levels by senior tri



May 2022
0.00
*Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



May 2022
0.10
*Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



May 2022
0.30
*Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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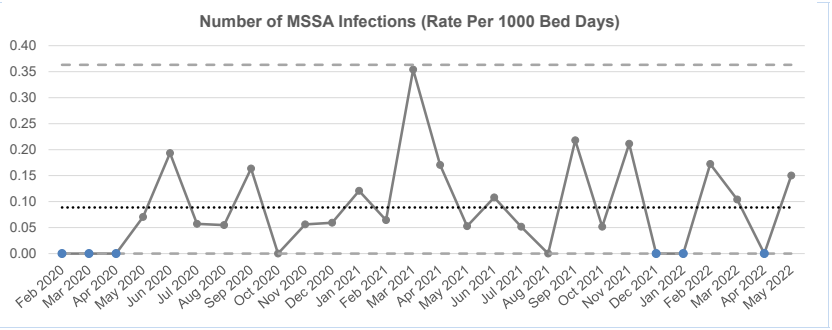
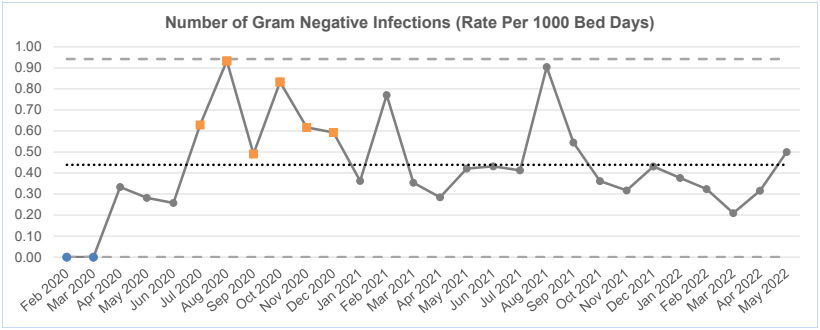
Data Analysis:
MRSA: The rate for May 2022 is 0.000. The number of infections YTD figure as of May 2022 is 0 with a target of 0.
C Diff: The rate for May 2022 is 0.100. The number of infections YTD figure as of May 2022 is 5 with a target of 33.
E Coli: The rate for May 2022 is 0.266. The number of infections YTD figure as of May 2022 is 11 with a target of 110.

Commentary:
The new trajectory of no more than 21 cases of hospital onset cases of C.fifficile is a significant challenge to achieve. The Trust reported cases that have so far gone through the PIR process show antimicrobials being the main predisposing factor which are broadly justified.



May 2022
0.15
*Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



May 2022
0.50
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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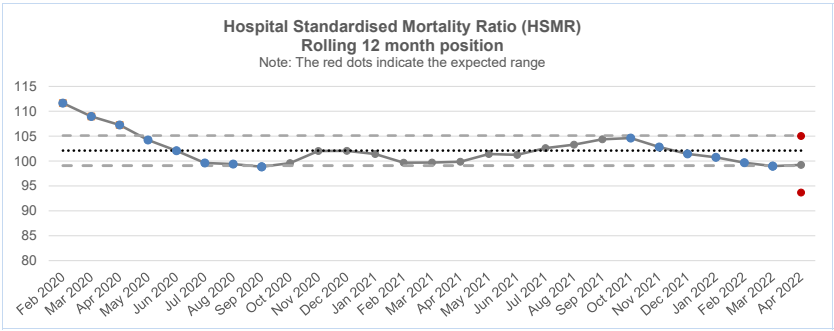
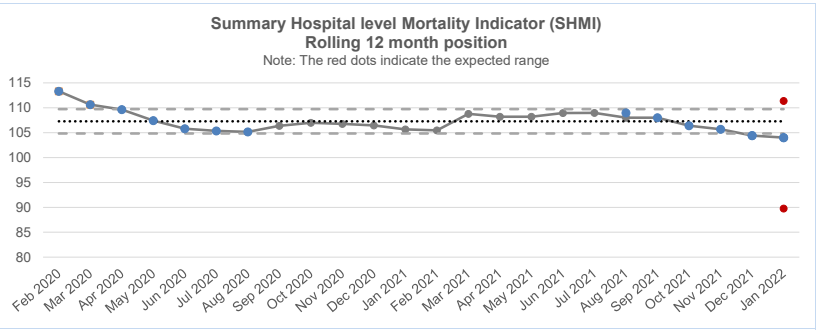
Data Analysis:
MSSA: The rate for May 2022 is 0.150. The number of infections YTD figure as of May 2022 is 3.
Gram Neg: The rate for May 2022 is 0.500. The number of infections YTD figure as of May 2022 is 16.

Commentary:
The MSSA and gram negative case number are as predicted



Apr 2022
99.2
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'Expected' range



Jan 2022
104.0
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'Expected' range

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This space is intentionally blank

Data Analysis:
HSMR: Two of the most recent three data points are close to the lower process limit triggering special cause improvement. The data represents a rolling 12 month position. Performance remains within the expected range.
SHMI: The data represents a rolling 12 month position. Performance remains within the expected range.

Commentary:
HSMR is a ratio between the number of actual deaths (in hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.

April's HSMR remains under 100 and continues to demonstrate a statistically significant improvement, within the expected range and in line with the national level.

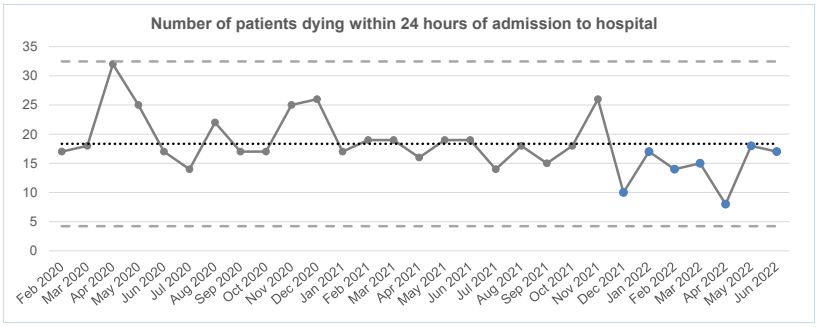
Mitigations: The HSMR along with other mortality indices are overseen by the Trust's Mortality Improvement Group (MIG).

SHMI
The official SHMI for the Trust remains within the 'as expected' range with a score of 104.01 for the period of February 2021 – January 2022 and is the lowest on record for the Trust (for the second month running). SGH SHMI remains stable at 100, DPOW continue to demonstrate improvement with a two point reduction to 107. Data continues to highlight a 'higher than expected' SHMI rate for Secondary Malignancies, congestive Congestive Heart Failure, and Organic Mental Disorders. Reviews of patient pathways are current underway or recenly completed.

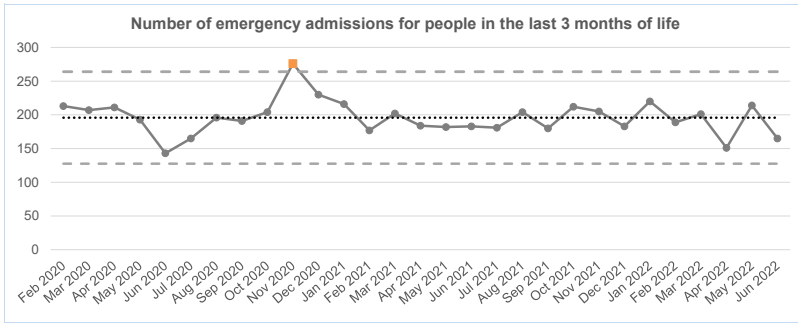
Issues/Risks:
There is a risk of breaching the Trusts 'expected range' if the out of hospital SHMI rises. There has also been a dip in the depth of coding noted since June 2021 which could negatively impact the SHMI.

Actions:
- The Trust is working with NHSE/I and local commissioners to undertake a review of recent deaths and EOL care, focusing on out of hospital care.
- Fortnightly meetings with the Trust's clinical leads for mortality continue to take place and oversee the data.
- Trust mortality clinical leads undertake screening on at least 85% of deaths per month to identify contributing factors, if any concerns are identified a full structured judgement review is undertaken to assess the care processes and to learn lessons.
- Review work is underway to investigate and identify any themes for SHMI alerts relating to heart failure, lung cancer and secondary malignancy.
- Dip in depth of coding currently being reviewed by Information Services Team to ascertain if this is in line with what other Trusts have observed.

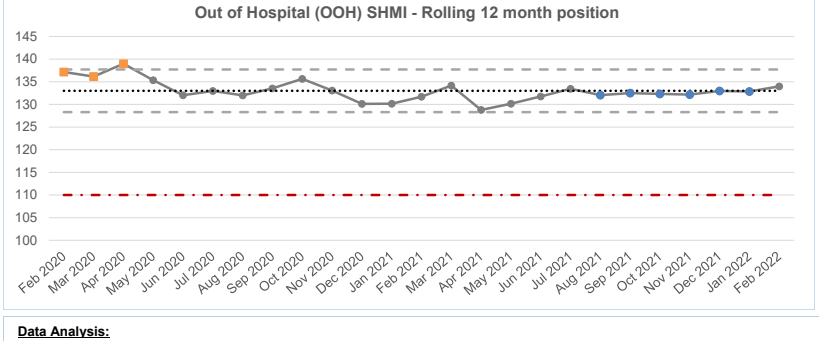
Mitigations:
- SHMI performance is overseen by the Trust's Mortality Improvement Group (MIG)
- Mortality and the reduction of SHMI remains a Trust Quality Priority for 2022/23.



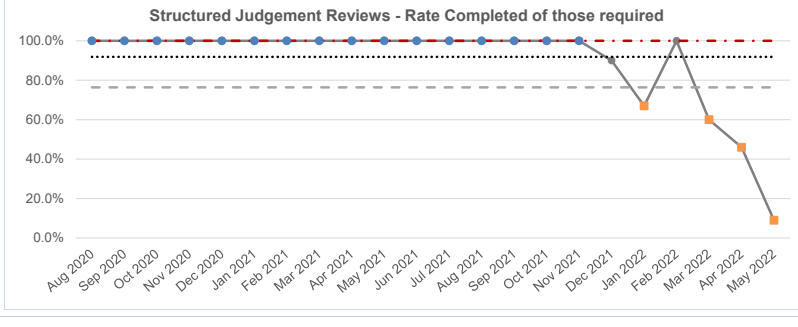
Jun 2022
17
Target
Reducing
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no numeric target therefore target assurance is not relevant



Jun 2022
165
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Feb 2022
134.0
Target
110.0
Variance
Common cause - no significant change
Assurance
Consistently failing the target



May 2022
9.0%
Target
100%
Variance
Special cause of concerning nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:

Deaths within 24 hours of admission: There were 17 patients recorded in June 2022 which is within the expected range of variation.

Emergency Admissions in the last 3 months of life: Performance has been within the expeted range for the past eighteen months.

Out of Hospital SHMI: The data represents a rolling 12 month position and the latest national data is presented (period ending February 2022). Performance remains within the expected range.

Structured Judgement Reviews: Performance has been declining for several months and has triggered concern on the chart. The target has not been achieved since November 2021.

Commentary:

Deaths within 24 hours of admission

Admission to hospital during the end of life phase may adversely affect the patient's experience and may represent a failure in advanced care plans resulting in an unplanned admission. The number of patients who died within 24 hours of admission continues within the expected range of variation and below the mean.

Actions:

- A sample of patients identified through the screening process, Structured Judgement Reviews and via the Medical Examiner (where admission was thought to be preventable) are reviewed by GP partners and where appropriate, discussed at collaborative meetings with community partners.
- CCG appointment of Palliative Care Nurse to focus on advanced care planning in the community. Further discussions ongoing regarding palliative care consultant provision.

Mitigations:

- EOL is one of the Trust's priorities and reports into the Mortality Improvement Group. The Trust works closely with community partners to review System themes for sharing and learning.
- Oversight by the Trust's Mortality Improvement Group (KPI reporting on a monthly basis).

Emergency admissions in last 3 months of life

Emergency admission to hospital during the end of life phase may represent a failure in advanced care plans and negatively impact the patient's experience. Data demonstrates that the Trust remains in line with the mean and within the control limits.

Actions:

- A sample of patients identified through the screening process, Structured Judgement Reviews and via the Medical Examiner (where admission was thought to be preventable) are reviewed by GP partners and where appropriate and discussed at collaborative meetings with community partners.
- Education to be provided to ambulance crews and care home staff regarding the RESPECT/DNACPR decisions and systems in place prior to transporting patients to hospital i.e. SPA advice. Cases with identified system failures are fed back to EMAS and care home staff via the EOL/Support to care home group.

Mitigations: Oversight by the Trust's Mortality Improvement Group as part of mortality KPIs.

Out of Hospital SHMI

Whilst the official SHMI demonstrates an improvement to beneath the Trust's mean average performance, data highlights further system collaboration is required to improve the out of hospital element. Recent reviews into Secondary Malignancies and Organic Mental Disorders have highlighted the necessity for further work and education to take place surrounding early initiation of EOL decisions/discussions, and advanced care planning in both primary and secondary care to prevent potential unnecessary admission to hospital.

Issues/Risks:

- The Trust's OOH SHMI remains higher than the target and could negatively impact the Trust's headline SHMI figure.
- The Trust is identified as having a higher OOH SHMI rate in comparison to regional peer group.

Actions:

- A new OOH mortality strategy is currently under development to target pathways where improvement has been identified i.e. frailty service.
- Appointment of palliative care provision in the community
- Audit undertaken by NHSEI (concentrating on GP/Community intervention) - awaiting findings to be provided
- CCG Focus on frailty management and risk stratification pathways
- Care home staff provied with equipment to undertake basic observations to better inform GPs of the patient's condition to reduce hospital admission. A pilot is in development to implement a NEWS2 type system in care homes, which will help the PCNS monitor patient deterioration.
- Early identification of palliative care, frailty index and standard palliative resources being rolled out across NEL care homes, with training to upskill staff on palliative management.

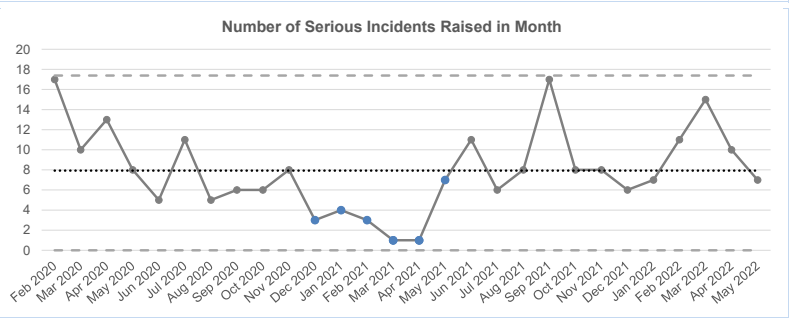
Structured Judgement Reviews (SJR)

The most recent months data should be interpreted with caution as reviewers are provided with 6-weeks to undertake a review once the case notes are released following coding procedures. Delay has been noted in completing the 1 outstanding NQB SJR for 2021. This case, along with the oustanding quarter 1 SJRs requring completion have been escalated to MIG and to the divisional management team.

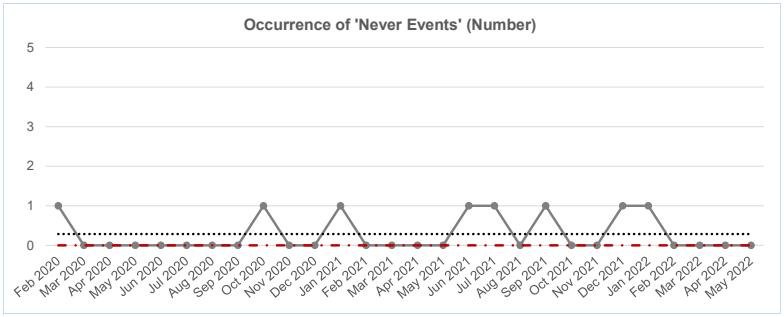
Actions: Escalation to Divisional Clinical Directors for Surgery & Critical Care and medicine divisions and Mortality Improvement Group.

Mitigations: Oversight by the Trust's Mortality Improvement Group.

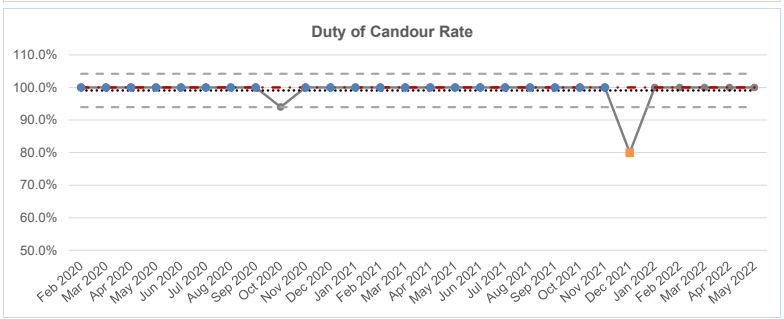
May 2022
100.0%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



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



May 2022
0
Target
0
Variance
Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore variance is not relevant.
Assurance
Due to the infrequency of Never Events a line chart is considered more appropriate than an SPC chart therefore target assurance is not relevant.



May 2022
100.0%
Target
100.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target

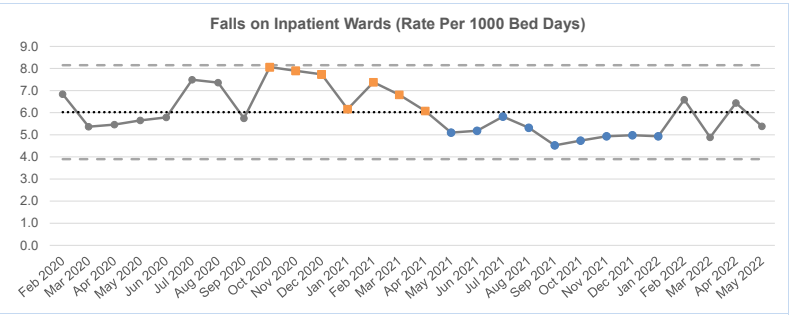
Data Analysis:
Patient Safety Alerts: Performance continues at 100%.
Never Events: Note the never events data is a subset of the serious incidents data. There were 0 never events recorded in May 2022 and this is the latest data provided.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents. The data is within the expected range of variation.
Duty of Candour: With the exception of October 2020 and December 2021 performance has achieved the target consistently for over two years.

Commentary:
Never Events:
There have been no Never Events declared since January 2022.

Duty of Candour: Duty of Candour for serious incidents is 100%. A very slight gap remains in relation to ensuring duty of candour is completed for all instances of moderate level harm within 10 working days. This presents the risk of non-compliance against regulations, which may result in a financial penalty. The position is much improved.

Risk: Position in relation to Duty of candour for incidents other than serious incidents are reported to divisions on a weekly basis showing the number of which are still outstanding and those that are overdue.

Actions: Work is ongoing with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed (monitored through SI panel with significant improvement noted). Duty of Candour Reports are availiable on Ulysses and are being monitored at divisional level as well as at SI Panel.



May 2022
5.4

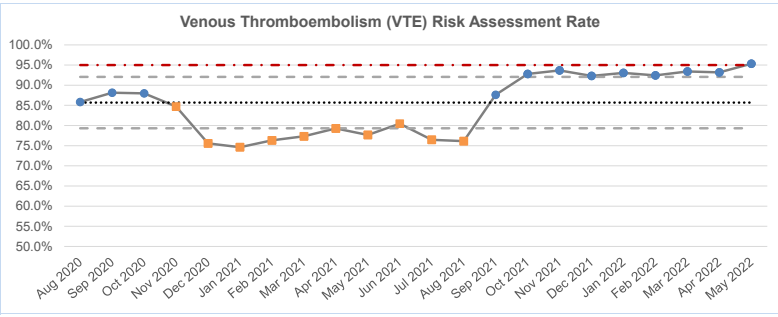
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



May 2022
95.3%

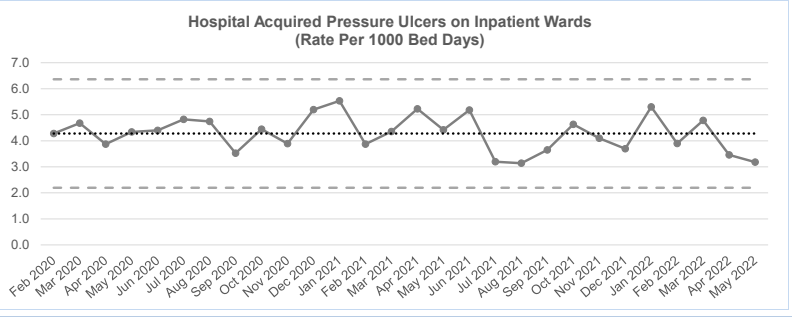
Target
95.0%

Variance

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

Assurance

Consistently failing the target



May 2022
3.2

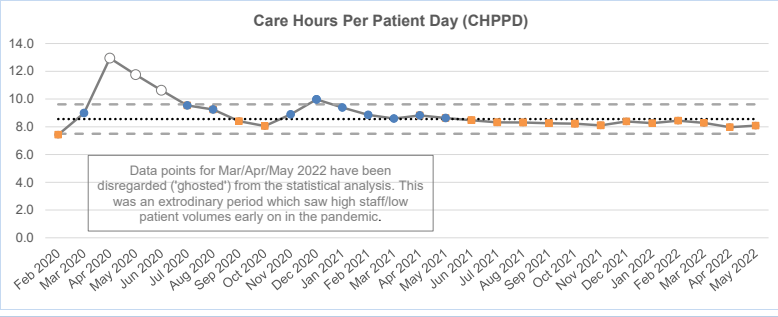
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



May 2022
8.1

Target
No target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant

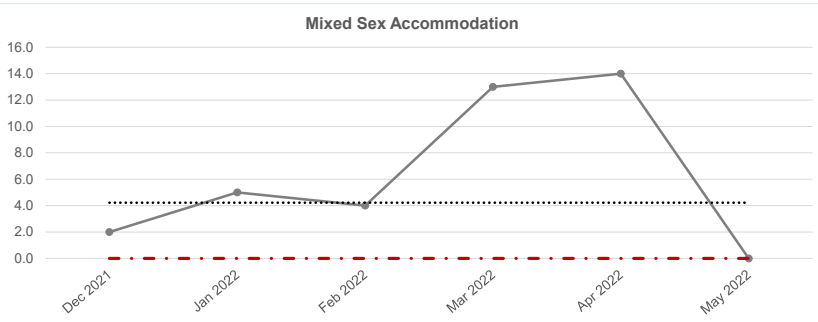
Data Analysis:
Falls on Inpatient Wards: Performance is consistently within the expected range.
VTE Risk Assessment: Performance has shown a significant improvement over the past 9 months. The figure for May has achieved the target, however, it is not possible, at this stage, to give assurance that it will consistently achieve the target in future months. More data is needed.
Hospital Acquired Pressure Ulcers: The data continues within the expected range.
Care Hours Per Patient Day: Performance has been consistently in poorer performance since June 2021 which is triggering concern on the chart.

Commentary:
Falls on Inpatient Wards : The number of reported falls has decreased in May 2022 and remains within the as expected range. Huddles for repeat falls are now expected to be led by Matrons with the Lead Nurse Patient Safety remaining responsible for leading huddles where harm has occured.
Hospital Acquired Pressure Ulcers : There has been a reduction in the number of reported pressure ulcers for two consecutive months.
CHPPD was 8.1 in May. The latest model hospital data for February 2022 indicates a national median of 8.1 and recommended peer median of 8.4, however it remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 20 months.

VTE Risk assessment figures now have the correct denominator, which shows improved performance over the past 6 months. Data for May 2022 demonstrates that the Trust has met the 95% target.

A new VTE Lead has been identified and work continues around education and updating the Trust's VTE policy to mirror national guidance. The policy has been drafted, however, a further meeting is due to take place to review and finalise the changes. Delay has occuresd due to the complexities involved and annual leave commitments of the authors. It is expected to be circulated in July/August 2022.

Mitigation: Monitored by the Quality Governance Group.



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

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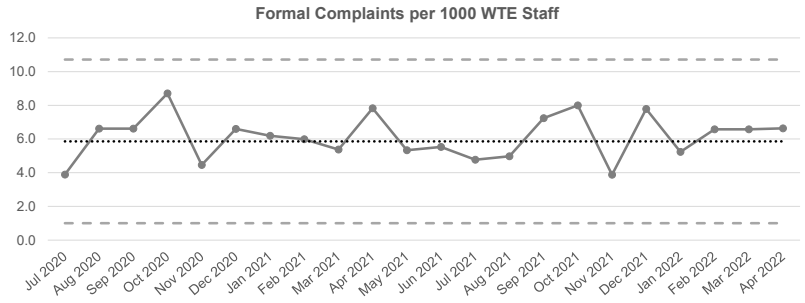
Data Analysis:
Mixed sex accommodation: There were no MSA breaches reported for May. There is insufficient data for SPC presentation.

Commentary:



Apr 2022
7

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target for this indicator, therefore target assurance is not relevant

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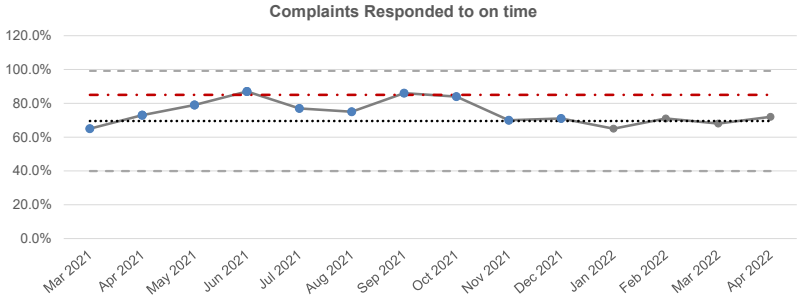

Apr 2022
72.0%

Target
85.0%

Variance

Common cause - no significant change

Assurance

Inconsistently hitting passing and failing the target

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Data Analysis:
Formal Complaints: The data continues within the expected range.
Complaints Responded to on time: The data continues within the expected range and is randomly hitting and missing the target.

Commentary:
Progress

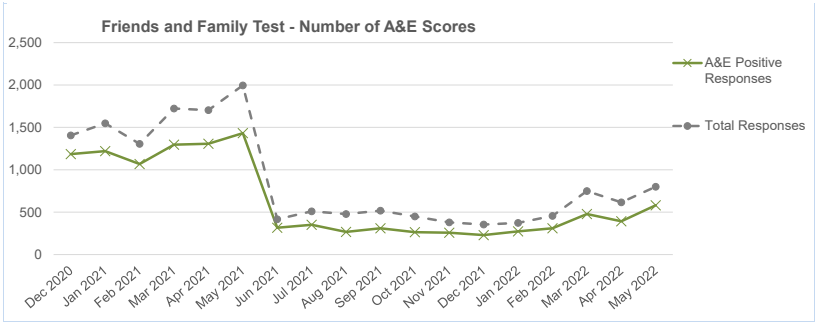
> Learning from RCA for delay >120 days shared with division
> Review of Temporary PALs & Complaints Manager post underway to support process
> Divisions reviewing Managaing Feedback through Complaints , Concerns and Compliments prior to sign off processes
> Focus on impartiality to ensure robust investigations

Risks

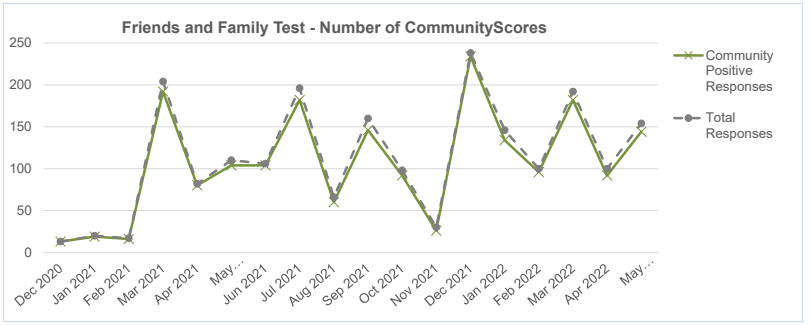
> Impact of increased complexity of complaints
> Workforce challenges of time required to undertake investigations by Lead Investigator
> Substantive PALs & Complaint manager on long term leave

Mitigations

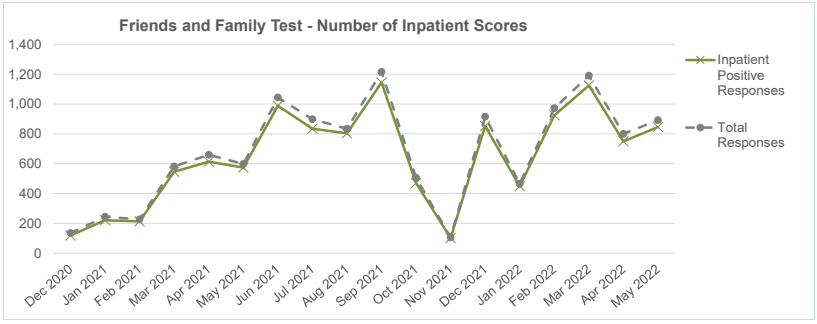
>Weekly Support and Challenge Meetinsg with central team for oversight
> Quarterly Divisional Patient Experience Review Meetings
> Review and updating of Lead Investigator training
> Monthly Divisional Complaint & PALS reporting shared



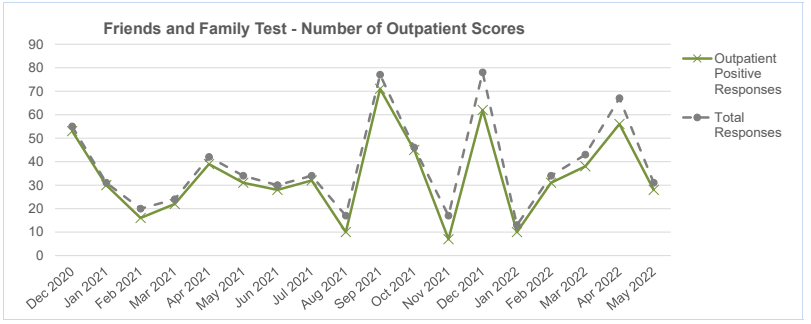
May 2022
582 out of 800
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



May 2022
144 out of 154
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



May 2022
846 out of 892
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



May 2022
28 out of 31
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

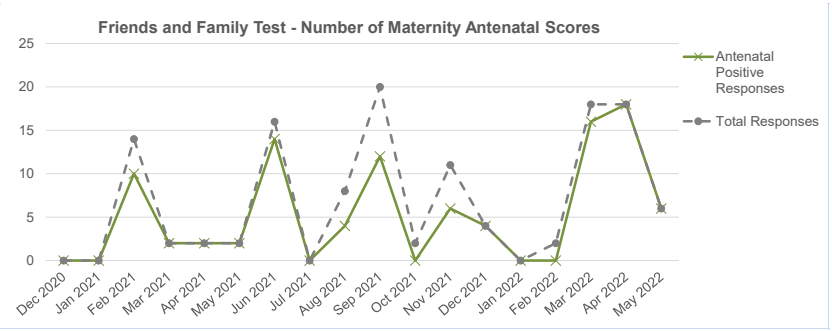
Data Analysis:
A&E FFT: There were 800 responses received in total for May 2022, and 582 were positive.
Community FFT: There were 154 responses received in total for May 2022, and 144 were positive.
Inpatient FFT: There were 892 responses received in total for May 2022, and 846 were positive.
Outpatient FFT: There were 31 responses received in total for May 2022, and 28 were positive.

Commentary:

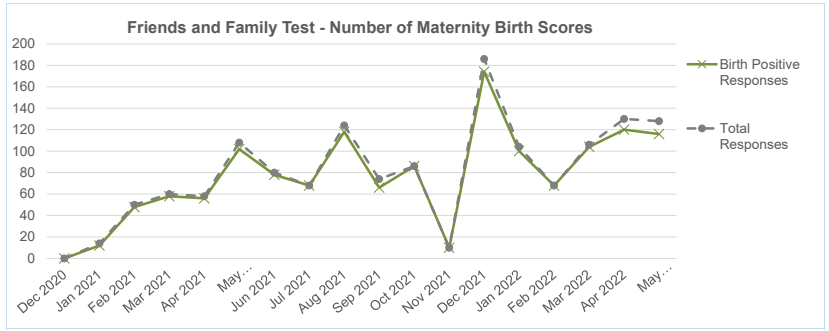
Progress
> Increase in ECC responses since survey changed
> Community reviewing access to smart phones and IWGC app
> QI team asked to support regarding ensuring telephone numbers are recorded accurately at source
> Temp PALs & Complaint manager post will enable band 7 Patient Experience Manager to focus on FFT
> Restablishing Patient Experience Officers role in FFT as Covid support requirement decreases

Risks
> Staff engagement remains poor
> Lack of reflective numbers of responses means data use is limited

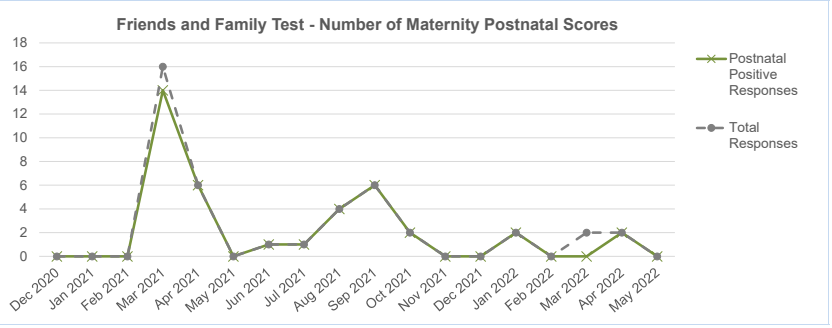
Mitigations
> Online access for support in place
> Quarterly Divisional Patient Experience Meetings ensure oversight and discussion of data
> Widely accessible across all sevices in various formats ensuring patients can provide feedback
> Promoted on social media
> Patient Feedback triangulated



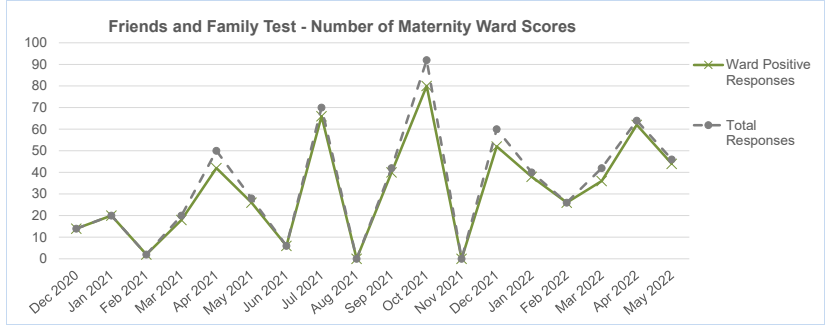
May 2022	
6	out of 6
Target	
No target	
Variance	
Inappropriate chart format for SPC	
Assurance	
Inappropriate chart format for SPC	



May 2022	
116	out of 128
Target	
No target	
Variance	
Inappropriate chart format for SPC	
Assurance	
Inappropriate chart format for SPC	



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



May 2022	
44	out of 46
Target	
No target	
Variance	
Inappropriate chart format for SPC	
Assurance	
Inappropriate chart format for SPC	

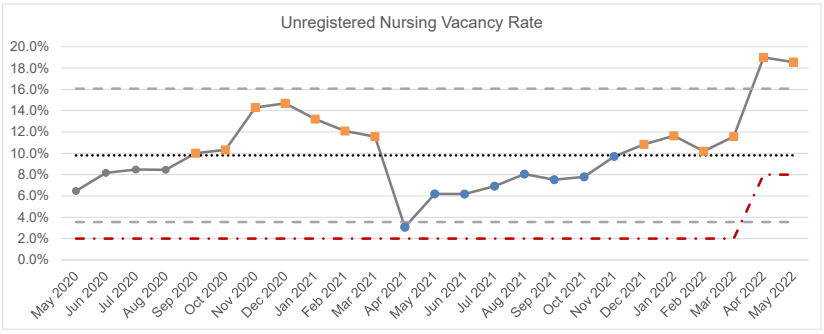
Data Analysis:
Maternity Antenatal FFT: There were 6 responses received in total for May 2022, all were positive.
Maternity Birth FFT: There were 128 responses received in total for May 2022, and 116 were positive.
Maternity Postnatal FFT: There were 0 responses received for May 2022.
Maternity Ward FFT: There were 46 responses received in total for May 2022, and 44 were positive.

Commentary:

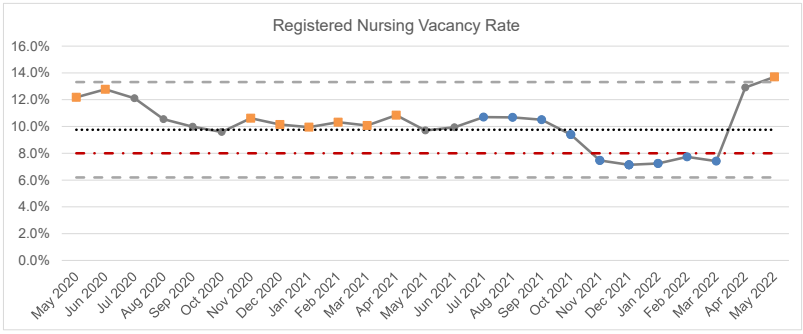
Progress
> Maternity Birth responses continues to provide insights across all maternity pathway
> IWGC asked to continue work on maternity response platform to improve user experience
> Temp PALs & Complaint manager post will enable band 7 Patient Experience Manager to focus on FFT
> re establishing Patient Experience Officers role in FFT as Covid support decreases

Risks
> Staff engagement remains poor
> Lack of reflective numbers of responses means data use is limited

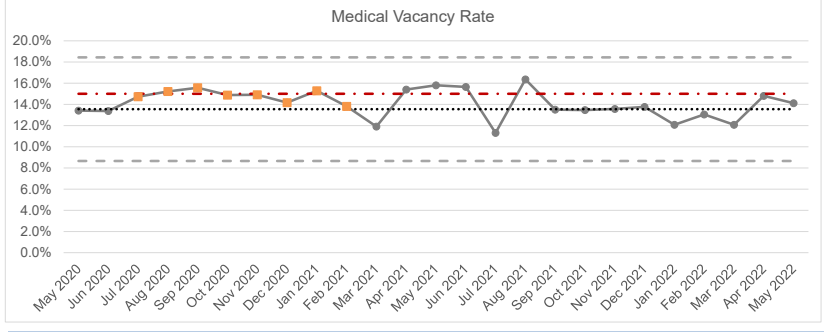
Mitigations
> Online access for support in place
> Quarterly Divisional Patient Experience Meetings ensure oversight and dsicussion of data
> Widely accessible across all sevices in various formats ensuring patients can provide feedback
> Promoted on social media
> Patient Feedback triangulated



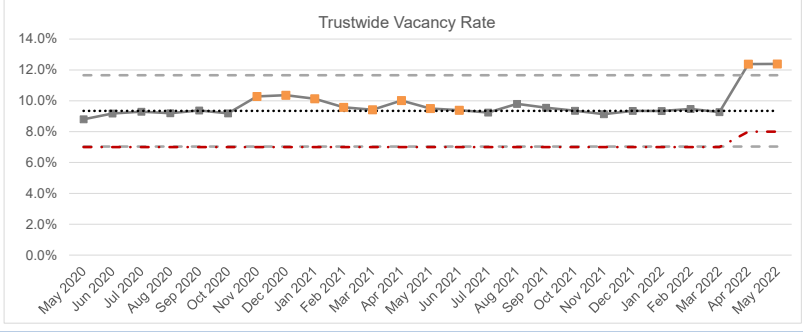
May 2022	18.6%
Target	8.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



May 2022	13.7%
Target	8.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



May 2022	14.1%
Target	15.0%
Variance	Common cause - no significant change
Assurance	Inconsistently hitting passing and failing the target



May 2022	12.4%
Target	8.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target

Data Analysis:
Unregistered Nursing Vacancies: After a significant reduction last spring, the rate has gradually been increasing and has now risen outside of the expected range. From April 2022 the target has been updated from 2% to 8%.
Registered Nursing Vacancies: After a period of improvement, performance has started to deteriorate in the last two months and is now recording concern.
Medical Vacancy Rate: Performance has been stable and as expected for over a year. The target can be expected to achieve and fail the target at random.
Trustwide Vacancy Rate: Performance has fallen outside the expected range over the past two months after consistenly falling within the expected range. It will continue to fail the target without process redesign. From April 2022 the target has been updated from 7% to 8%.

Commentary:
Unregistered Nursing Vacancies:

Issues/Risks: Retention of HCAs. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave, and lack of quality data around leavers reasons.

Mitigations: A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. A pool of appointed HCAs has been appointed with 14.55 WTE allocated to start between July and August, 27.88 WTE allocated with start date to be confirmed, and 21 awaiting allocation. Mass recruitment of HCAs is planned, with a view to appointing circa 120 HCAs to start between October 22 and March 23. Provisional selection dates are identified between 5th and 12th September. A Rapid Project Improvement Workshop is underway, supported by QI and NHSi/e to review the whole Unregistered Nursing process from sourcing to induction and retention. An event is taking place on 27th July with a wide variety of stakeholders to review the process and identify efficiencies and change processes. A nursing workforce plan is in development.

Actions: Undertake mass recruitment events. Undertake RPIW process and nursing workforce plan.

Registered Nursing Vacancies:

Issues/Risks: Availability of accomodation can delay recruitment processes. CPD Team capacity to support international nurses.

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

Mitigations: A project group led by the Chief Nurses office to oversee all activities. Newly qualified nurse (NQN) recruitment for 21/22 was successful, and attendence at university events to further strengthen NQN engagement. International nurses - ongoing recruitment of international nurses with cohorts planned for start.. A funding bid has been successful for further funding to support recruitment, with £360,000 awarded to support the arrival of 120 international nurses between January and December 2022. Awaiting outcome of business case to increase CPD team capacity to facilitate meeting target for international nurses. Nursing workforce plan aiming to facilitate start of 120 international nurses, 80 NQNs, 70 local, and to reduce turnover. Nursing career frameworks and introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term.

Commentary Vacancies Cont/d:

Medical Vacancies

Issues/Risks: Availability of accomodation can delay recruitment processes.

Actions: Ongoing recruitment activity across specialties.

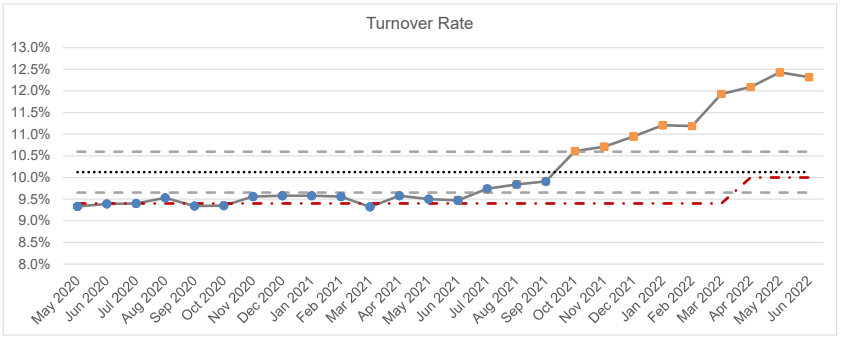
Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 63 medical staff has been established, with 10 scheduled to start in July and August and further starts in the longer term. A network of private landlords has been established to support accomodation needs where the Trust is unable to accomodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation. Accommodation team have given notice to long term tenants to free up on-site accommodation for new starters and a change of policy relating to length of stay. Recruitment team are meeting the accommodation team weekly to review priorities and identify accommodation needs. Junior Doctors intake between August and October has a current fill rate of circa 88%, with backfill plans and actions in place.

Trustwide Vacancy Rate

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

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

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



Jun 2022
12.3%
Target
10.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

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May 2022
5.4%
Target
4.1%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

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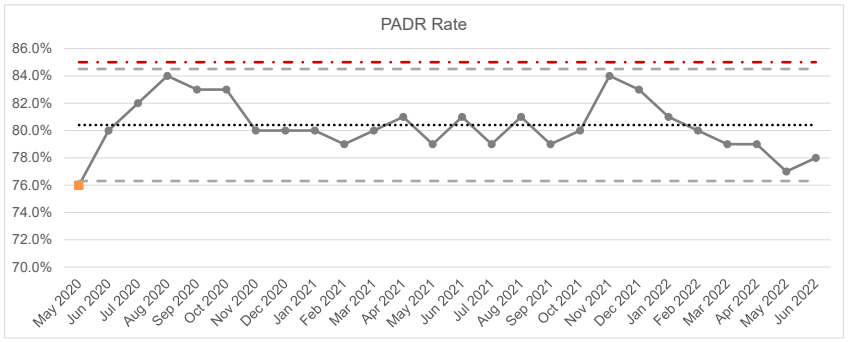
Data Analysis:
Turnover Rate: After having stayed fairly stable during the peak of pandemic, the turnover rate has been steadily increasing since the end of summer 2021 and has recorded concerning performance for the past nine months. The target has been updated from 9.2% to 10.0% from April 2022.
Sickness Rate: This indicator has recorded a general increase in sickness rates since last summer but usually falls within the expected range for the data. It is unlikely that the target will be achieved without process redesign.

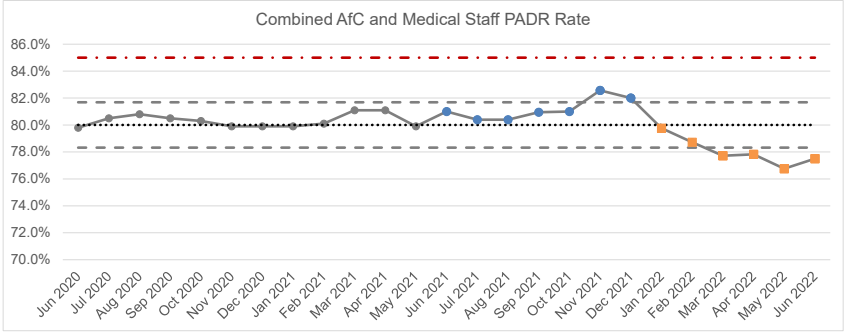
Commentary:
Analysis of the increased trajectory of turnover from Aug-21 - April 22, shows a steady increases in turnover with two marked sharp increases at August-21 and Feb 22. Our exit data at this time indicates these increases can be predominantly attributed to Nursing, Administration and Unregisterd Nursing staff groups. A deep dive to better understand reasons for leaving has been undertaken and discussed at the Workforce Committee. Whilst quality data (due to low uptake of exit questionnaires) is a problem, from the data we do have indicates that career development, culture, behaviour may be reasons.
Retention will be a key focus of our pending culture transformation programme.

The forthcoming Culture Transformation working group workstream focused on recruitment and retention will undertake this work.

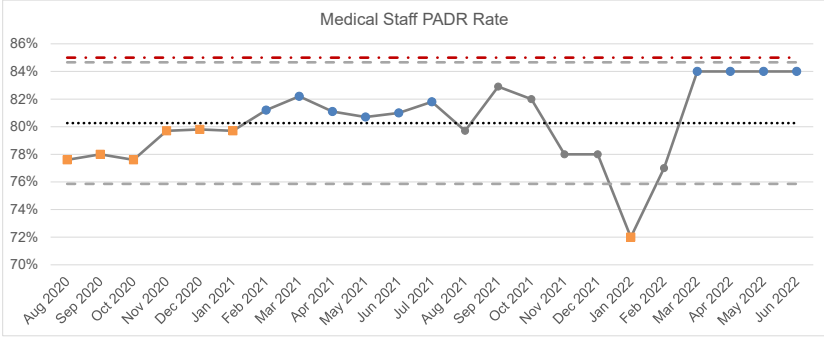
Sickness levels have fallen in May to be comparative of the same period in the previous year. The Trust have recently launched an updated sickness management policy and have commenced training to managers. Notably the national Covid terms and conditions have now reverted back to pre-Covid conditions, which means that Covid will be monitored and managed as part of the sickness management process and will become pay impacting. This brings Covid in-line with the management of all other reasons for illness within the Trust. The Covid specific data will continue to be measured to ensure understanding and prevalence amongst staff.



Jun 2022	78.0%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Consistently failing the target



Jun 2022	77.5%
Target	85.0%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Consistently failing the target



Jun 2022	84.0%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Consistently failing the target

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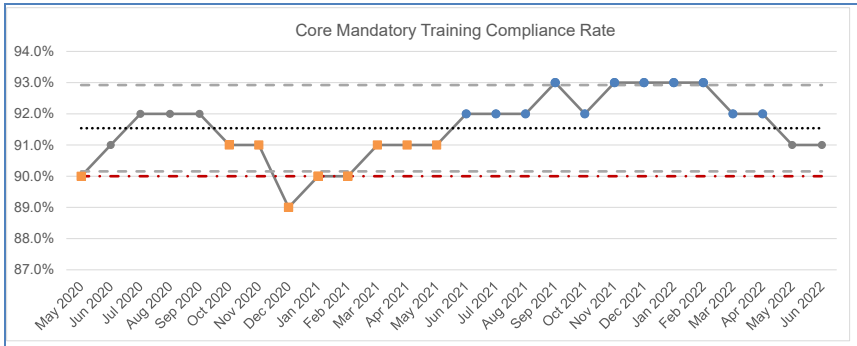
Data Analysis:
PADR Rate: Performance has been stable and is within the expected range since March 21, however the target cannot be met without process redesign.
Medical Staff PADR Rate: Performance has been predominantly within the expected range for the past two years with an improvement seen over recent months. Without process re-design the indicator will continue to fail the target.
Combined AfC and Medical Staff PADR Rate: Following eighteen months of stable or improving figures, performance has deteriorated in recent months and is now recording concern since January 22. Without process re-design this indicator will continue to fail the target.

Commentary:
The Education and Training Development (ETD) Team are preparing the refreshed Corporate Induction and new People Leader Induction, both of which include clear communications on the importance of completing and maintaining statutory and mandatory training. The forthcoming Leadership Individual Development Assessment (LIDA) online inventory includes assessing competency in the use of ESR for managing teams, including PADR and statutory and mandatory training compliance.Operational challenges continue to impact on staff capacity to be released to complete training/PADRs.

ETD are also working closely with the ESR Team to monitor compliance through Power BI for MT and PADR. This allows managers to look at real time data so it is imperative that our data is accurate. Power BI has now been signed off and ETD are reciving positive feedback from users.

Medical Staff appraisals: Over the last couple of years COVID has played a significant role within the medical appraisal process. National guidance and support was received for Doctors appraisals across the NHS from the GMC and NHSE/I that outlined how Trusts could support their doctors through their annual appraisals which resulted in doctors who had scheduled appraisals due between December and February having the ability to delay their appraisal to a later date. The Trust adopted this approach to maintain the much needed flexibility within the process ensuring the Trust was doing everything it could to balance the personal and professional wellbeing of its medical staff. NLAG adopted the NHSE/I national policy for medical appraisals which allows up to 18 months between appraisals. The Trust has also agreed and begun implementation from April 2023 that all doctors will have their scheduled appraisals between April and December, this should enable the Trust to have a balance of appraisal activity. Oversight of the appraisals is maintained and monitored through the Medical Director's office and any concerns are discussed with the Trust's appraisal lead and escalated through to the Medical Director.



Jun 2022
91.0%

Target
90.0%

Variance

Common cause - no significant change

Assurance

Consistently passing the target

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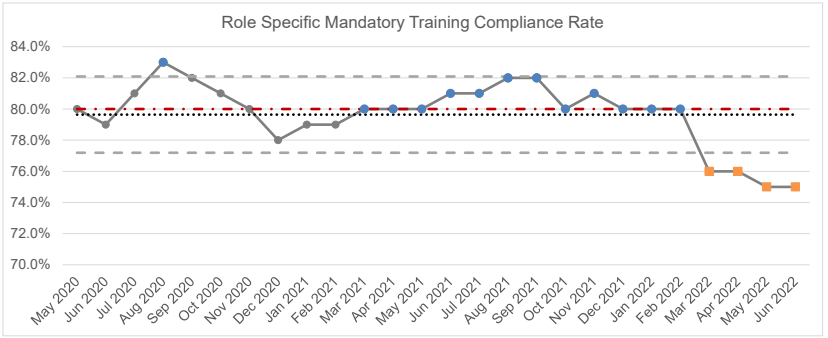

Jun 2022
75.0%

Target
80.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target

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Data Analysis:
Core Mandatory Training: Performance has recorded improvement for almost a year and the target has been consistently achieved during this time. The indicator can be reliablyexpected to achieve the target.
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past four months and is now outside of the expected range, recording a concern. The target is expected to be randomly achieved and not achieved.

Commentary:
The ETD Team are preparing the refreshed Corporate Induction and new People Leader Induction, both of which include clear communications on the importance of completing and maintaining statutory and mandatory training. The forthcoming Leadership Individual Development Assessment (LIDA) online inventory includes assessing competency in the use of ESR for managing teams, including PADR and statutory and mandatory training compliance.Operational challenges continue to impact on staff capacity to be released to complete training/PADRs.

ETD Team are completing a deep dive on Stat and Mand training and are currently working with the MT Leads to look at the mapping of competencies to make sure all new and existing positions are mapped correctly. The team are also working with the HRBP's to target areas with low compliance. A data cleanse within ESR is being completed for Resus Training to streamline the process of booking onto relevant courses and also setting up Learning Pathways for new starters to attend classroom delivery sessions firstly, and then alternate elearning and classroom sessions from then on.

The work the ETD Team are completing will help with compliance as the process for staff to find the relevant courses will be easier and streamlining the mapping of competencies.

ETD are also working closely with the ESR Team to monitor compliance through Power BI for MT and PADR. This will allow managers to look at real time data so it is imperative that our data is accurate. Power BI has now been signed off and ETD are reciving positive feedback from users.

IPR Appendix - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

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

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisation)s. If NLAG's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than NLAG. The colour shading is intended to be a visual representation of the ranking of NLAG (red indicates most organisations are performing better than NLAG, green indicates NLAG is performing better than many organisations. Amber shows NLAG is in the mid range).
Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 15/07/2022

* Indicates the benchmarked centiles are from varying time periods to the data presented in the IPR and should be taken as indicative for this reason

^ Indicates the benchmarked centiles use a variation on methodology to the IPR and should be taken as indicative for this reason

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Jun 2022	68.8%	92.0%	61	67/169	*May 2022
	Planned	Number of Incomplete RTT pathways 52 weeks	Jun 2022	336	0	63	63/168	*May 2022
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Jun 2022	24.5%	1.0%	51	78/157	* May 2022
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Jun 2022	52.5%	85.0%	19	109/134	*May 2022
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Jun 2022	63.3%	95.0%	22	102/130	*May 2022
	Urgent Care	Number Of Emergency Department Attendances	Jun 2022	12,899	No target	51	71/144	*May 2022
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Jun 2022	502	0	14	131/153	*May 2022
	Flow	Bed Occupancy Rate (General & Acute)	Jun 2022	94.9%	92.0%	43	91/158	^Q4 21/22
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Jun 2022	7.2%	No target	70	50/166	*May 2022
	COVID	Number of COVID patients in ICU beds (Weekly)	Jun 2022	0	No target	29	145/203	*May 2022
	COVID	Number of COVID patients in other beds (Weekly)	Jun 2022	44	No target			

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	May 2022	0.000	No target	100	1/137	*Apr 2022
	Infection Control	Number of E Coli Infections	May 2022	0.300	No target	88	17/137	*Apr 2022
	Infection Control	Number of Trust Attributed C-Difficile Infections	May 2022	0.100	No target	94	9/137	*Apr 2022
	Infection Control	Number of MSSA Infections	May 2022	0.150	No target	81	27/137	*Apr 2022
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Jan 2022	104.0	As expected	39	74/121	Jan 2022
	Safe Care	Number of Serious Incidents Raised in Month	May 2022	7	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	May 2022	8.1	No target	31	130/188	*Apr 2022
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	May 2022	95.3%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Apr 2022	6.6	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	May 2022	846 out of 892	No target	37	85/134	*Apr 2022

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	May 2022	5.4%	4.1%	42	125/214	*Nov 21

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

Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Jun 2022	68.8%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Jun 2022	336	0	Alert			Board
	Total Inpatient Waiting List Size	Jun 2022	11,083	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Jun 2022	24.5%	1.0%	Alert			Board
	Number of Incomplete RTT Pathways*	Jun 2022	34,527	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Jun 2022	17,175	No Target			n/a	FPC
	% of Inpatient Live Waiting List Risk Stratified	Jun 2022	100.0%	99.0%				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Jun 2022	52%	37%	Alert			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Jun 2022	29,478	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Jun 2022	7.2%	No Target			n/a	Board
	% Outpatient Non Face To Face Attendances	Jun 2022	28.2%	No Target	Alert		n/a	Board
	% Outpatient summary letters with GPs within 7 days	Jun 2022	23.5%	50.0%	Alert			FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Jun 2022	85.7%	99.0%		n/a	n/a	FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Jun 2022	28.3%	23.0%		n/a	n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Jun 2022	52.5%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Jun 2022	51	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Jun 2022	0.0%	75.0%	Alert			Board
	Cancer Request To Test In 14 Days*	Jun 2022	85.4%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Jun 2022	95.1%	93.0%	Alert			FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Jun 2022	92.0%	93.0%	Alert			FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Jun 2022	66.8%	75.0%				FPC
	Cancer Waiting Times - 31 Day First Treatment*	Jun 2022	95.0%	96.0%				FPC
	Cancer Waiting Times - 31 Day Surgery*	Jun 2022	77.8%	94.0%				FPC
	Cancer Waiting Times - 31 Day Drugs*	Jun 2022	91.9%	98.0%	Alert			FPC
	Cancer Waiting Times - 62 day Screening*	Jun 2022	20.0%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Jun 2022	63.3%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Jun 2022	12,899	No Target			n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Jun 2022	771	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Jun 2022	502	0	Alert			Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Jun 2022	40.9%	40.0%	Alert			Board
	% of Extended Stay Patients 21+ days	Jun 2022	9.2%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Jun 2022	2.1	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Jun 2022	3.8	3.9				Board
	Number of Medical Patients Occupying Non-Medical Wards	Jun 2022	209	No Target			n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Jun 2022	90.2%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Jun 2022	16.8%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Jun 2022	94.9%	92.0%	Alert			Board
	Percentage of patients re-admitted as an emergency within 30 days	Jun 2022	8.5%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Jun 2022	42.1%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Jun 2022	20.0%	No Target			n/a	FPC
COVID	Number of COVID patients in ICU beds (Weekly)	Jun 2022	0	No Target			n/a	Board
	Number of COVID patients in other beds (Weekly)	Jun 2022	44	No Target			n/a	Board
	% COVID staff absences (Weekly)	Jun 2022	25.6%	No Target			n/a	Board

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n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	May 2022	0.00	No target			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	May 2022	0.30	No target			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	May 2022	0.10	No target			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	May 2022	0.15	No target			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	May 2022	0.50	No target			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Apr 2022	99.2	As expected		L	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Jan 2022	104.0	As expected		L	As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Jun 2022	17	No target		L	n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Jun 2022	165	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Feb 2022	134.0	110.0	**Alert**		F	Q&S
	Structured Judgement Reviews - Rate Completed of those required	May 2022	9.0%	100.0%	**Alert**	L	?	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	May 2022	100.0%	No target			n/a	Board
	Number of Serious Incidents raised in month	May 2022	7	No target			n/a	Board
	Occurrence of 'Never Events' (Number)	May 2022	0	0		n/a	n/a	Board
	Duty of Candour Rate	May 2022	100.0%	100%			?	Board
	Falls on Inpatient Wards (Rate per 1000 bed days)	May 2022	5.4	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	May 2022	3.2	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	May 2022	95.3%	95.0%	**Alert**	H	F	Board
	Care Hours Per Patient Day (CHPPD)	May 2022	8.1	No target	**Alert**	L	n/a	Board
	Mixed Sex Accommodation Breaches	May 2022	0.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Apr 2022	6.6	No target			n/a	Board
	Complaints Responded to on time	Apr 2022	72.0%	85.0%			?	Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	May 2022	846 out of 892	No target		n/a	n/a	Board
	Number of Positive A&E Scores	May 2022	582 out of 800	No target		n/a	n/a	Board
	Number of Positive Community Scores	May 2022	144 out of 154	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	May 2022	28 out of 31	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	May 2022	6 out of 6	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	May 2022	116 out of 128	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	May 2022	0 out of 0	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	May 2022	44 out of 46	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Jun 2022	90.9%	90.0%			?	Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Jun 2022	95.0%	90.0%			?	Q&S
	Escalation of NEWS in line with Policy	May 2022	Blank	No target		n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	May 2022	40.0%	90.0%		n/a	n/a	Q&S
Sepsis	Rate of Adults Screened for Sepsis using the Adult Sepsis Screening and Action Tool (based on Manual Audit)	May 2022	40.0%	90.0%		n/a	n/a	Q&S
	Rate of those who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Adults (based on Manual Audit)	May 2022	0.0%	90.0%		n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool	May 2022	27.0%	90.0%		n/a	n/a	Q&S
	Rate of Children who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Children	May 2022	40.0%	90.0%		n/a	n/a	Q&S
Prescribing	Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA or WebV (based on Manual Audit)	May 2022	78.6%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV (based on Manual Audit)	May 2022	20.2%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	May 2022	80.0%	No target		n/a	n/a	Q&S
	Reduction in patients prescribed an antibiotic	Mar 2022	40.7%	50.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	May 2022	2.0%	No target		n/a	n/a	Q&S
	Antibiotic prescriptions have evidence of a review within 72 hours	Apr 2022	0.0%	70.0%		n/a	n/a	Q&S

Scorecard - Workforce

Northern Lincolnshire and Goole NHS Foundation Trust

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*Indicators marked with an asterix have unvalidated status at the time of producing the IPR.
^ Draft - The optimum method for analysing/presenting these figures is in development.
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate	May 2022	18.6%	8.0%	Alert	H	?	Board
	Registered Nurse Vacancy Rate	May 2022	13.7%	8.0%	Alert	H	?	Board
	Medical Vacancy Rate	May 2022	14.1%	15.0%			?	Board
	Trustwide Vacancy Rate	May 2022	12.4%	8.0%	Alert	H	?	Board
Staffing Levels	Turnover Rate	Jun 2022	12.3%	10.0%	Alert	H	?	Board
	Sickness Rate	May 2022	5.4%	4.1%	Alert		F	Board
Staff Development	PADR Rate	Jun 2022	78.0%	85.0%	Alert		F	Board
	Medical Staff PADR Rate	Jun 2022	84.0%	85.0%	Alert	H	F	Board
	Combined AfC and Medical Staff PADR Rate	Jun 2022	77.5%	85.0%	Alert	L	F	Board
	Core Mandatory Training Compliance Rate	Jun 2022	91.0%	90.0%			P	Board
	Role Specific Mandatory Training Compliance Rate	Jun 2022	75.0%	80.0%	Alert	L	?	Board
Disciplinary	Number of Disciplinary Cases Commenced	Jun 2022	0	No Target		L	n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Jun 2022	0	12		L	?	WFC
	Number of Suspensions Commenced	Jun 2022	0	No Target		L	n/a	WFC
	Average Length of Suspension (Weeks)	Jun 2022	0	No Target		L	n/a	WFC

NLG(22)120

Name of the Meeting	**Trust Board of Directors – Public Board**	
Date of the Meeting	2 August 2022	
Director Lead	Mike Proctor, NED & Chair of Quality & Safety Committee	
Contact Officer/Author	As above	
Title of the Report	**Quality & Safety Committee Highlight report (June and July meetings)**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide the Board with a summary of discussion/decisions of the Quality & Safety Committee	
Background Information and/or Supporting Document(s) (if applicable)	Quality & Safety Committee meetings	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Highlight Report to Trust Board

Report for Trust Board Meeting on:	2 August 2022
Report From:	Quality & Safety Committee 25 June 2022 and 25 July 2022

Highlight Report:

The Committee workplan was updated and is included as appendix A.

The Committee received a paper on the pathways for patients with Head and Neck Cancer. There was no identified harm arising from delays in diagnosis, and work was planned to streamline the diagnostic request process with one stop clinics.

Family services presented a combined divisional, Ockenden and CNST report. Midwifery staffing was identified as a concern, and it was noted that, in line with Ockenden recommendations, the Athena Continuity of Care team had been stood down to enable safe staffing at Scunthorpe on a temporary basis. The team had undergone an abduction simulation following the introduction of baby tagging, which had been a beneficial learning experience. The Committee noted the positive work of the Maternity Voices Partnership.

The Committee received a report on the visit by the Royal College of Paediatrics in relation to paediatric diabetes. The Committee noted the actions taken and will continue to monitor the delivery of the actions on a quarterly basis.

A report on patient experience was received, which highlighted themes of families feeling they were not being updated on their relative's condition, nighttime bed moves and unexpected treatment plans. The national inpatient survey was also received, and improvements in the Trust position noted.

The Nursing Assurance Report identified work to address delays in PEG tubes and nutrition, including a stop and check process on every ward at 1pm to review vulnerable patients and training on nutrition. Significant improvements in the PLACE score for food from 2018 were also noted. A deep dive into pressure ulcers had taken place to identify themes linked to longer waiting times in ED. The Committee noted that a 15 steps review had taken place at DPoWH ED and support commenced to address concerns.

On review of the IPR, the Committee acknowledged the continued improvement on the SHMI and the challenges in completing SJRs in a timely manner due to operational pressures, combined with the need for clinicians to familiarise themselves with the new electronic SJR process. The Committee also noted that VTE screening was now at target.

The Committee noted the completion of a Serious Incident investigation into the loss of one baby from a twin pregnancy. The report had identified that the Trust guideline had not been updated to take account of the most recent NICE guidance in relation to twin pregnancy risks. As a result staff were being reminded of the importance of checking fetal growth on the growth chart for both single and multiple pregnancies, staff were reminded of the importance of fetal heart rates being documented as a single number rather than a range, the division was to use the guidelines checklist when updating guidance, as a prompt to check for updated national best practice guidance, and the most recent best practice in twin pregnancies was to be shared with staff. The Committee also noted the completion of a

report into maternal death by HSIB. No concerns were identified from the investigation, and the good practice was being shared within the maternity teams.

The Committee noted the progress on the CQC improvement plan.

A report on End of Life gave good assurance of the work done particularly relating to the introduction of pain assessment tools, delivery of EPACS and the training on the new RESPECT process.

The Committee approved four further Patient Safety Specialists within the organization, acknowledging that patient safety was already a core part of their existing roles.

The Committee noted a report on issues with the radiology service at Hull Teaching Hospitals.

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Confirm or Challenge of the Board Assurance Framework:

The BAF was reviewed and scoring discussed. Members felt that it may be beneficial to include the non-Executive Committee chair in Executive reviews of the BAF and suggested text additions and deletions to ensure agreement on the assurance provided in the BAF at Committee.

Action Required by the Trust Board:

The Trust Board is asked to note the key points made.

Mike Proctor
Non-Executive Director

Appendix A

Quality & Safety Committee (QSC)
Committee Workplan Template

Northern Lincolnshire and Goole NHS Foundation Trust

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2022								2023							
								May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August
Medicine	√		√	√	Paper	6 monthly	Dr Anwer Qureshi		√						√						√		
Surgery	√		√	√	Paper	6 monthly	Mr Matthew Thomas					√						√					
Family Services	√		√	√	Paper	6 monthly	Ms Preeti Gandhi with Jane Warner and Debbie Bray		√							√						√	
Facing the Future	√				Paper	6 monthly	Debbie Bray, Ms Preeti Gandhi									√						√	
CNST	√		√	√	Paper		Jane Warner			√			√			√			√			√	
Ockenden	√				Verbal	Monthly	Jane Warner	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Pharmacy	√		√	√	Paper	6 monthly	Simon Priestly				√						√						√
Pathlinks	√		√	√	Paper	6 monthly	Mick Chomyn				√						√						√

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2022								2023							
								May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August
Community	√		√	√	Paper	6 monthly	Ant Rosevear	√						√							√		
End of Life	√		√	√	Paper	Quarterly	Donna Smith	√			√			√			√			√			√
IPR	√	√	√	√	Paper	Monthly	Kate Wood / Ellie Monkhouse	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Quality Priorities & Quality Account	√	√	√	√	Paper	Monthly	Hayli Garrod			√	√	√	√	√	√	√	√	√	√	√	√	√	√
Cancer & Learning	√	√	√	√	Paper	Quarterly – change to 6 monthly	Denise Gale			√						√						√	
Colorectal Cancer	√				Paper	6 monthly	Ramana Kallam and Sarah-Jayne Thompson	√						√						√			
Head and Neck Cancer	√				Paper	6 monthly	Joseph Muang and Kirsty Harris		√						√						√		
Lung Cancer	√				Paper	6 monthly	Jill Mill, Karen Smith			√						√						√	
Oncology Pathway	√				Paper	6 monthly	Jill Mill				√						√						√
Skin Cancer	√				Paper	6 monthly	Simone Woods					√						√					
Risk Stratification & Clinical Harm	√	√	√	√	Paper	Bi-monthly	Kishore Sasapu	√		√		√		√		√		√		√		√	

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2022								2023							
								May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August
PROMS	√	√	√		Paper	6 monthly	Hayli Garrod							√					√				
National Inpatient Survey	√	√	√		Paper	Quarterly	Mel Sharp		√			√			√			√				√		
Diabetes Management	√			√	Paper	Quarterly	Simon Buckley			√														
BAF	√	√	√		Paper	Quarterly	Helen Harris			√			√			√			√			√	
Annual Review of Committee Effectiveness	√		√		Paper	Annual	Mike Proctor											√	√				
Nursing Assurance Report	√	√	√	√	Paper	Monthly	Ellie Monkhouse	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Patient Experience Report	√	√	√	√	Paper	Quarterly	Jo Loughborough		√			√			√			√			√		
Annual Patient Experience Report	√	√	√	√	Paper	Annual	Ellie Monkhouse & Jo Loughborough		√												√		
IPC	√	√	√	√	Paper	Quarterly	Maurice Madeo			√			√			√			√			√	
Key SI Update incl Maternity	√	√	√		Paper	Monthly	Angie Legge	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
CLIP Report & Annual SI Report	√	√	√	√	Paper	Quarterly	Angie Legge	√			√			√			√			√			√
DoLS & Safeguarding	√		√		Paper	Quarterly	Vicky Thersby		√			√			√			√			√		
QIA	√		√		Paper	Quarterly	Hayli Garrod					√						√					

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	2022								2023							
								May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August
Potential Deviations from National Documentation	√		√		Verbal / Paper	Monthly	Angie Legge	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Register of External Agency Visits	√		√		Paper	6 monthly	Jennifer Moverley						√						√				
Annual Medication Report	√	√	√		Paper	Annual	Simon Priestly				√												√
Mental Health Act and Strategy	√		√		Paper	6 monthly	Kay Fillingham	√						√						√			
Annual Clinical Audit Programme	√	√	√		Paper	Annual	Hayli Garrod	√												√			
CQC Framework	√	√	√	√	Paper	Monthly	Jennifer Moverley	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Quality Governance Group	√	√	√	√	Paper	Monthly	Angie Legge	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Mortality Improvement Group	√	√	√	√	Paper	Monthly	Kishore Sasapu	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Patient Safety Champions	√		√		Paper	Monthly	Angie Legge	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Serious Incident Review Group	√		√		Paper	Quarterly	Angie Legge	√			√			√			√			√			√

Name of the Meeting	**Trust Board of Directors - Pubic**
Date of the Meeting	Tuesday 2 August 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse
Title of the Report	**Ockenden Update**
Purpose of the Report and Executive Summary (to include recommendations)	To note the current trust position for the Ockenden Report, 2020 and the baseline trust assessment of the Ockenden Report, 2022
Background Information and/or Supporting Document(s) (if applicable)	https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality Governance Group
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Ockenden Report(s)

Summary – Ockenden Report (2022)

The final report in the review of maternity services at the Shrewsbury and Telford Hospital NHS Trust independently assessed the quality of investigations relating to newborn, infant and maternal harm at the trust. It covers the findings, conclusions, and essential actions of this independent review of maternity services. The independent review was undertaken by Mrs Donna Ockenden who is a midwife.

This report follows the initial report on emerging themes and trends identified from the examination of 250 cases which was published in December 2020.

Themes from the final report include patterns of repeated poor care, increase in maternal deaths, stillbirths, hypoxic ischaemic encephalopathy, and neonatal death. The report highlighted that there was a systematic failure in governance and leadership. The report concluded that there were 15 Immediate & Essential Actions with a total of 92 actions, many of which were of a national and regional bearing.

A baseline assessment has been undertaken outlining the actions and the trust is compliant in 24 of the 92 actions with an additional 10 in progress. The report and actions do not relate to the maternity service in totality but require the joint work of other areas in the trust including Neonatology, Surgery & Critical Care (IEA 7 – MDT Training as well as IEA 11 – Obstetric Anaesthesia) and also that of the Medical Director, Chief Nurse, POE and finance division.

Recommendation

This report is far reaching for every hospital trust and maternity service. It is recommended that the report is noted and shared across all areas for joint working and ultimate compliance of the actions pertaining within it.

Background

The review of maternity services at5the Shrewsbury and Telford Hospital NHS Trust commenced 2017. It was commissioned by NHS Improvement, to examine 23 cases of concern collated by the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the trust in 2009 and 2016 respectively.

Since the review was commissioned, it ultimately examined the maternity care of 1,486 families, the majority of which were patients at the trust between the years 2000 and 2019 were reviewed. The outcome recommendations were extended to all maternity services nationally.

Ockenden Report, 2020

This centred around the initial 250 cases and outlined changes for the trust and all other maternity units nationally. There were 12 Immediate & Essential Actions for every maternity service.

7 Ockenden IEAs (including 12 Clinical Priorities): Trust _Northern Lincolnshire & Goole NHS Foundation Trust Exec Sign off Ellie Monkhouse – Chief Nurse	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	✓		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	✓		
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	✓		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	✓		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	✓		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	✓		
Confirmation that funding allocated for maternity staff training is ringfenced	✓		
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	✓		
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	✓		
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance		✓	
6) Monitoring Fetal Wellbeing			
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	✓		
7) Informed Consent			
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	✓		

This is the trust position as at February 2022, with the partially compliant priority – 'Risk Assessment throughout pregnancy' continuing to be resolved. The requirement is that a risk assessment is undertaken and recorded at every contact. The audit process to evidence this action is on-going.

The Trust action plan highlights 44 actions that are within the 12 Immediate & Essential Actions, 2 of which are still awaiting national action and further detail. Of the 42 actions, 25 are in green and the remaining 17 are being worked on.

Outstanding actions as shown below:-

Ockenden Action Plan – Outstanding Actions

22 July 2022

IEA 2 – Listening to Women and Families		
Action Plan	**Action**	**Evidence Outstanding**
Q11, 14, 15	Specific Non Exec Director supporting Maternity Service Embedding Safety Champion Service User Feedback	NED JD to specifically state Maternity NED. Evidence of embedded Safety Champion 'floor to board' process Evidence of monthly meeting and inclusion of co-production
IEA 4 – Managing Complex Pregnancy		
Q24, 25, 26, 28	Agreed criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. Complex women to have a lead consultant Complex women to have early specialist intervention	Audit each element SOP in place
IEA 5 – Risk Assessment Throughout Pregnancy		
Q 30, 31, 33	All women are formally risk assessed at each contact Birth Options clinic Personal Case and Support Plans (PCSP)	Audit 1% of notes – risk assessment, birth options clinic, PSCP, review place of birth at each visit SOP
IEA 7 – Informed Consent		
Q39, 41, 42, 44	Women have accurate information to enable their informed choice of place of birth and mode of birth, including maternal choice for caesarean delivery. Women to participate equally in all decision-making processes and make informed choices Women's choices must be respected	Website review Updated information for women 1% audit of medical records 5% audit of all relevant records

Workforce Planning		
Q45	Can you demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS / ICS level, given this is the direction of travel of the People Plan. Evidence of reviews, 6 monthly for all staff groups and evidence considered at board level.
Midwifery Leadership		
Q48	To meet the maternity leadership requirements set out by the RCM in Strengthening midwifery leadership: a manifesto for better maternity care: A Director of Midwifery in every trust and more Heads of Midwifery across the service. More Consultant midwives and Specialist midwives in every trust Strengthening / supporting sustainable midwifery leadership in education and research A commitment to fund ongoing midwifery leadership development	Action plan where manifesto is not met. Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care.
NICE Guidance		
Q49	To review approach to NICE guidelines in maternity and that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation ensuring that the decision is clinically justified.	Audit to demonstrate all guidelines are in date. Evidence of risk assessment where guidance is not implemented. SOP for all NICE guidelines with the demonstrable process for on-going review.

Ockenden – final report, March 2022

The review team, led by Midwife Donna Ockenden were made up of a professional team of midwives and doctors, including obstetricians, neonatologists, obstetric anaesthetists, physicians, cardiologists, neurologists and others, have examined the maternity care provided to these families and reported on several areas.

Patterns of repeated poor care

The review team found a regretful pattern of poor investigations into a significant number of incidents with a harmful clinical outcome. The review found evidence of poor investigations into three significant cases which took place within less than a year of one another. This resulted in missed opportunities for learning and a lost opportunity to prevent further baby deaths from occurring at the Trust. This pattern remained the same throughout the periods investigated.

Maternal death

In the 12 cases of maternal death, the review team considered that none of the mothers had received care in line with best practice, and in nine out of the twelve cases, significant or major concerns were identified. Internal investigations were poor, and only one external investigation was conducted. The internal investigations did not recognise system and service-wide failings to follow appropriate procedures. In some instances, women themselves were held responsible for the outcomes.

Stillbirth

In the 498 cases of stillbirth, one in four cases were found to have significant or major concerns that, if managed appropriately, might or would have resulted in different outcomes. Between 2011-19, 40% of the stillbirths reviewed did not have an investigation, again, missing opportunities for learning and preventing similar deaths that would occur in the future.

Hypoxic Ischaemic Encephalopathy

In cases of Hypoxic Ischaemic Encephalopathy (HIE) - new-born brain injury caused by oxygen deprivation to the brain - care provided to the mother in 65.9% of all HIE cases was a significant and major concern.

Neonatal death

In cases of neonatal death, 27.9% of incidents reviewed were identified to have significant or major concerns regarding the maternity care provided, that might or would have resulted in a different outcome. Between 2011-19, a significant 43% of neonatal deaths were not investigated.

Throughout this period, there were repeated failures to escalate concerns in both antenatal and postnatal environments, such as assessing the needs for emergency intervention during labour or providing proper and thorough investigations into the serious incidents.

Failure in governance and leadership

The review team identified failings to follow national clinical guidelines such as fetal heart rate monitoring or resuscitation. This, alongside delays in escalation and failure to work collaboratively across disciplines, resulted in many poor outcomes experienced by mothers or their babies, resulting in injury and death.

Some causes of delay were owed to the culture among the workforce, noting a lack of action from senior clinicians and a 'them and us' culture between midwifery and obstetric staff which meant midwives feared escalating concerns to consultants. Significantly, many members of staff at the Trust were too scared to speak out about their experiences in fear of the repercussions. Some mothers also described the additional stress these interactions had on their own experiences.

The review also mentions repeatedly the lack of compassion expressed by staff. Examples include clinicians being unprepared for meetings, justifying their actions, and again, explanations that laid blame on the family themselves.

Systemic issues such as insufficient staffing and training gaps were also noted to be a significant issue in the operational running of the Trust. Staff were overstretched and overworked throughout the period with inadequate support from some senior members of the Trust. There is no doubt that this presented difficulties in being able to provide safe clinical care to their patients.

Regrettably, the review found that investigatory processes were not followed and more concerningly, the maternity governance team inappropriately downgraded serious incidents to avoid external scrutiny, successfully covering up the true scale of serious incidents at the Trust.

If an open and honest candour was adopted and resulted in appropriate investigations, it is almost certain that much fewer incidents would have occurred and those babies and their mothers would not have suffered the significant harm that they did. Instead, the same mistakes were repeatedly made, and the safety of mothers and babies was unnecessarily compromised as a result.

As a result of the findings of the review, a significant number of 60 local actions for learning have been identified in a bid to improve the services provided at the Trust and bring an end to the significant and constant failings. Some 15 areas across all maternity services nationally were also identified as requiring immediate and essential actions, to be implemented nationally. These include:

- The need for significant investment in the maternity workforce and multi-professional training
- Suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to the present
- Strengthened accountability for improvements in cases among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families

Current position – Northern Lincolnshire & Goole

Midwifery Continuity of Carer (MCoC)

A review was undertaken as requested of the Midwifery Continuity of Carer (MCoC) model, specifically relating to the midwifery staffing. The 3 teams that were in operation across the trust – Daisy and Poppy at Grimsby and the Athena Team at Scunthorpe were reviewed including meeting with all staff within the teams and those working in the wider remit of the maternity service. The recommendation which was endorsed by the trust Executive Team for the Athena Team to be suspended with effect from 13 June 2022 for a period of 6 months or until such time as the midwifery staffing had significantly improved on the Scunthorpe site.

It was articulated by the national team that there would not be an expectation that compliance against the 15 Immediate & Essential Actions would be required until the East Kent Maternity report was published which was due in June 2022. It is anticipated that there are similar themes in both reports. The East Kent report though has been delayed and although it has still not been expected that compliance is evidenced, a baseline assessment of the 15 Immediate and Essential Actions and the 92 actions has been undertaken.

The 15 Immediate & Essential Actions –

1. Workforce Planning and Sustainability – financing a safe maternity workforce
2. Safe Staffing
3. Escalation and Accountability
4. Clinical Governance – leadership
5. Clinical Governance – Incident Investigation and Complaints
6. Learning from Maternal Deaths
7. Multidisciplinary Training
8. Complex Antenatal Care
9. Preterm Birth
10. Labour and Birth
11. Obstetric Anaesthesia
12. Postnatal Care
13. Bereavement Care
14. Neonatal Care
15. Supporting Families

Baseline Assessment

The 92 actions are all within the 15 Immediate & Essential Actions. The initial assessment of the report and actions clearly identify a number that require national intervention and resolution, and many others that will be regionally managed. The baseline assessment highlighted a number that are already met with others that are currently being worked on.

*Action relates to national or regional involvement / work not yet commenced

Immediate & Essential Action	Green	Amber	Red*	N/A
Workforce Planning and Sustainability	1		10	
Safe Staffing	1		9	
Escalation & Accountability	1	1	3	
Clinical Governance – leadership	1	2	4	
Clinical Governance – Incident Investigation and Complaints	2		5	
Learning from Maternal Deaths			3	
Multidisciplinary Training	4	3		
Complex Antenatal Care	2		3	
Preterm Birth	1	1	2	
Labour & Birth		2	2	2
Obstetric Anaesthesia	1		7	
Postnatal Care	4			
Bereavement Care	3	1		
Neonatal Care	3		5	
Supporting Families			3	

Baseline Assessment

Baseline assessment v2.docx

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 8 August 2022	
Director Lead	Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Jo Loughborough, Senior Nurse Patient Experience	
Title of the Report	**Annual Complaints Report**	
Purpose of the Report and Executive Summary (to include recommendations)	• Overview of complaint, concerns, and compliment activity throughout FY 21-22 • Progress made against KPIs. • Quality of complaints evidenced through timeliness and reopened activity • Themes	
Background Information and/or Supporting Document(s) (if applicable)	Reflects the first full year using new complaint process. Current supporting policy DCP071 now under review following learning throughout the year	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Patient Experience Group, Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

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Feedback from complaints, concerns, and compliments

ANNUAL REPORT

2021/2022

Performance for Period 2021-2022

Contents –

Background

It is a requirement of the Local Authority Social Services and National Health Service Complaints (Regulations) 2009 to produce an annual report. The purpose of this report is to inform the Trust Board and the public of the effectiveness of the complaints processes within the Trust, ensuring that we remain sighted on the timeliness, quality, and learning.

The complaints process is supported by the Complaints Team and PALs Team at Northern Lincolnshire and Goole NHS Foundation Trust (the Trust), in collaboration with Divisions across the Trust. The process is available for patients or their representatives who wish to make a formal complaint or raise concerns on a more informal basis. Anyone who expresses a view, verbally or in writing, which can reasonably be interpreted as a representation of their views and, with the appropriate consents, will have those views acknowledged via either of these processes.

Both PALS concerns and formal complaints will be dealt with in a way that is most suitable to the issues raised and will take into account the complainants views, the nature of the concern or complaint, the potential implications for the complainant and the potential implications for the Trust.

Both the PALS and Complaints processes put the patient or their representative at the centre of efforts to resolve the issues they have raised. The Trust recognises the importance of listening to the experience and views of our patients about our services, particularly if they are unhappy, and the Trust strives to make it as easy for them to do so.

Patients and their representatives also leave some wonderful feedback via various means. Sharing some of these ensure the balance of patient experience is viewed. Compliments are verbal or written expressions of praise, admiration or congratulations sent of a person's own volition and are recorded on a central database.

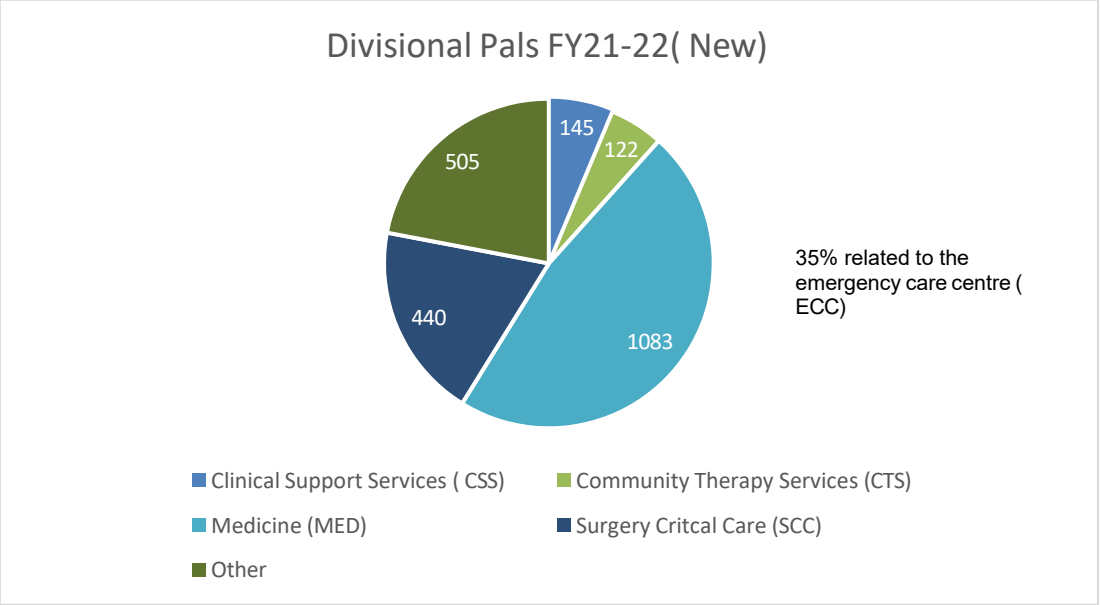
This report will provide information on the representations made via the PALS concerns and complaints processes in addition to the compliments received between 1 April 2021 and the 31 March 2022.

Patient Advice and Liaison Service (PALS)

A concern is an expression of dissatisfaction where the patient or their representative does not wish to make a formal complaint but wishes for their incident or experience in service to be logged and/ or investigated on an informal basis.

Between 1 April 2021 and 31 March 2022, the PALS Team received **2134** concerns. This is a significant increase of 62% from the previous year, as seen in the extract below. To give this some context the Trust has continued to work through visiting restrictions and delayed procedures due to the Covid 19 pandemic which has generated increased concerns.

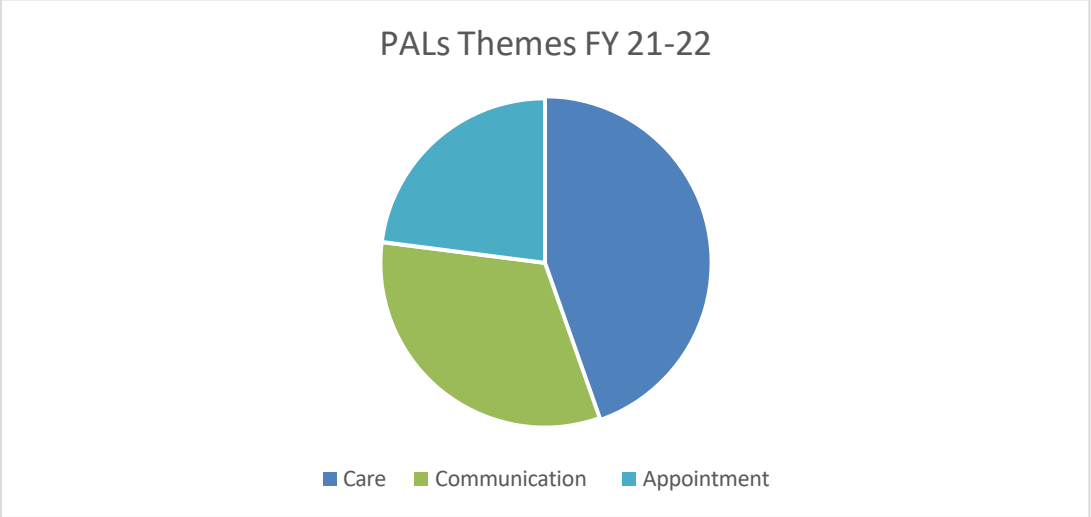
Year	2019/20	2020/21	**2021/22**
New PALs	1338	1327	**2134**



Response times indicated that 563, (27%) of the concerns were resolved within one working day and 80% improvement in day one resolution since last year, with 1125 (54%) closed within 5 working days. This is a similar achievement as the previous year (2020/21). The target has been adjusted to s a staged approach initially aiming for 60%. The central PALs team has experienced several staff changes which has caused disruption in the team however towards the latter end of the year this has stabilised. Cultural work has been undertaken with the team, and a fortnightly support and challenge meeting embedded to ensure oversight and escalation. The PALs team have worked collaboratively with ECC at Diana, Princess of Wales Hospital (DPOW) to manage their increased concerns and further work is planned to operationalise a team member daily across sites to work directly with wards and departments. This is hoped to improved understanding of the patient experience linked to the process.

PALs Themes and Learning Developments

The top themes from PALs concerns this year are shown below, with further detail around the sub themes which contribute to these.



Care → various aspects of general care and lack of involvement from family perspective

Communication → lack of communication between wards and families

Appointment → delays or no communication about changes/cancellations

The Trust addresses actions through local actions or wider learning. Direct care issues are addressed with wards or departments directly as part of the learning and monitored through further PALs and complaints. Themes arising are explored through Patient Experience Group but also through collaborative work with eh 15 Step assurance programs. Involvement is monitored monthly on adult inpatient areas through the Trust's INSIGHT survey.

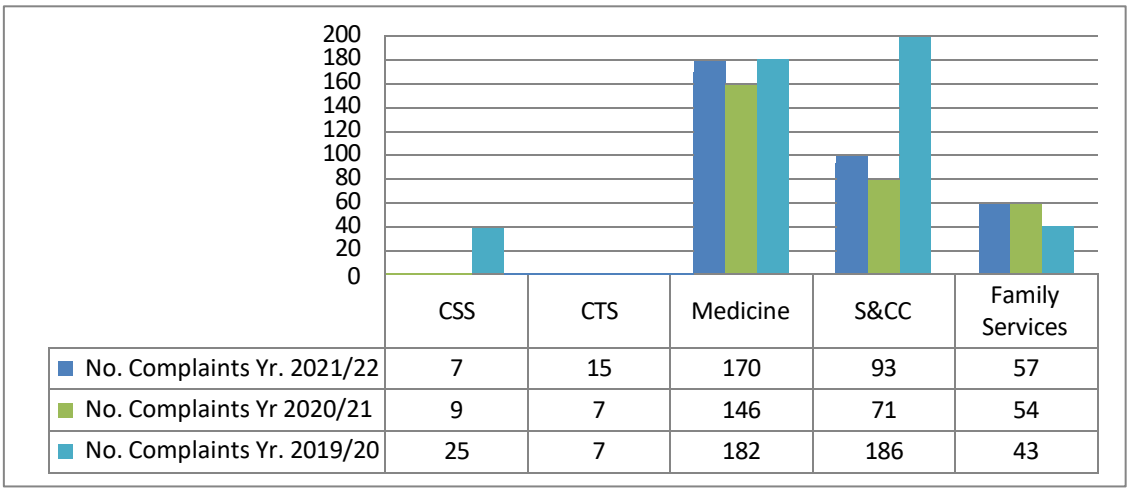
Communication remains a priority and the Trust has sought to be responsive to feedback with additional supportive initiatives through the last year. A Patient Contact Helpline has provided a touch point for families to reach out to if they cannot get a response from calling a ward, this is usually due to the clinical activity and related impact the clinical workforce prioritising care. Introduction of the Family Liaison Assistant role has supported some key ward areas with a staff resource to keep communication channels open and focus on patient well-being.

Through social media and the launch of a new digital outpatient appointment system it is hoped the communication will improve around managing appointments. The team also have a contact helpline for patients, which helps ensure wider accessibility not just digital, and are also "live "with the national "My Planned Care "portal, which details waiting times.

Formal Complaints

The Trust received 344 formal complaints throughout the year 2021/22, this is a19% increase from the previous year.

The chart below displays the number of complaints received by the division directly providing patient care:



	CSS	CTS	Medicine	S&CC	Family Services
No. Complaints Yr. 2021/22	7	15	170	93	57
No. Complaints Yr 2020/21	9	7	146	71	54
No. Complaints Yr. 2019/20	25	7	182	186	43

The central complaints team have worked with divisions during the last year to ensure that complaints timescales, quality of responses and learning were a priority. This has been monitored through the weekly support and challenge meetings, where visual tracking tools monitor week by week progress in line with a 12-week framework. This meeting has been key to ensuring escalation and development.

The number of complaints closed during 1 April 2021 to 31 March 2022 was 359, The Trust continues to work within its reviewed policy framework, which set out a 60 working day timescale. The number of complaints closed within timescale has remained within a 64-87% range as seen below, in chart A, with an overall average across the year of 74% managed in timescale. The average timescale to respond was 51 days. Clinical pressures from the Covid pandemic have caused some challenges in response times but through monitoring delays are fed back into divisional conversations for learning.

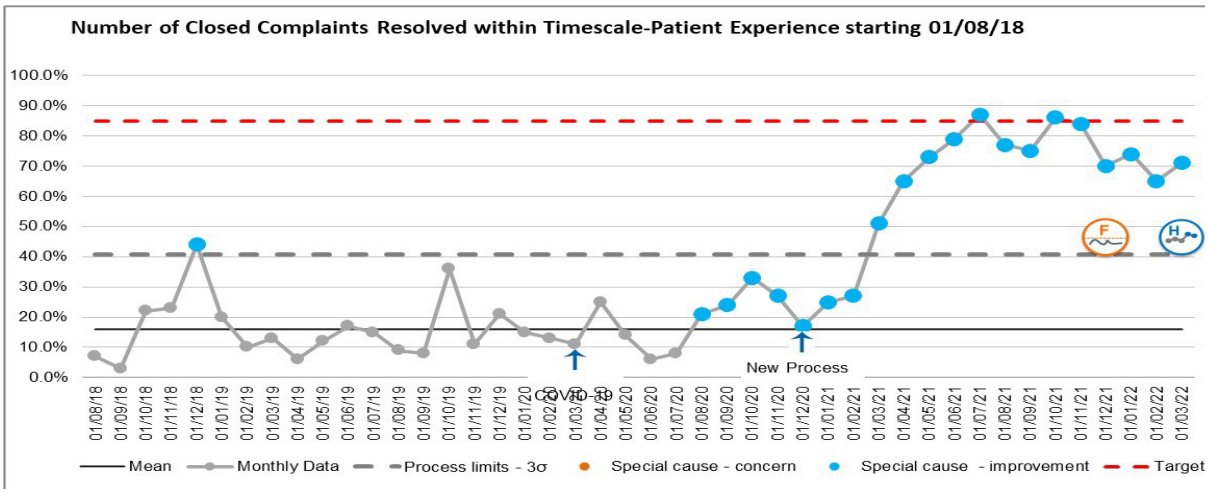
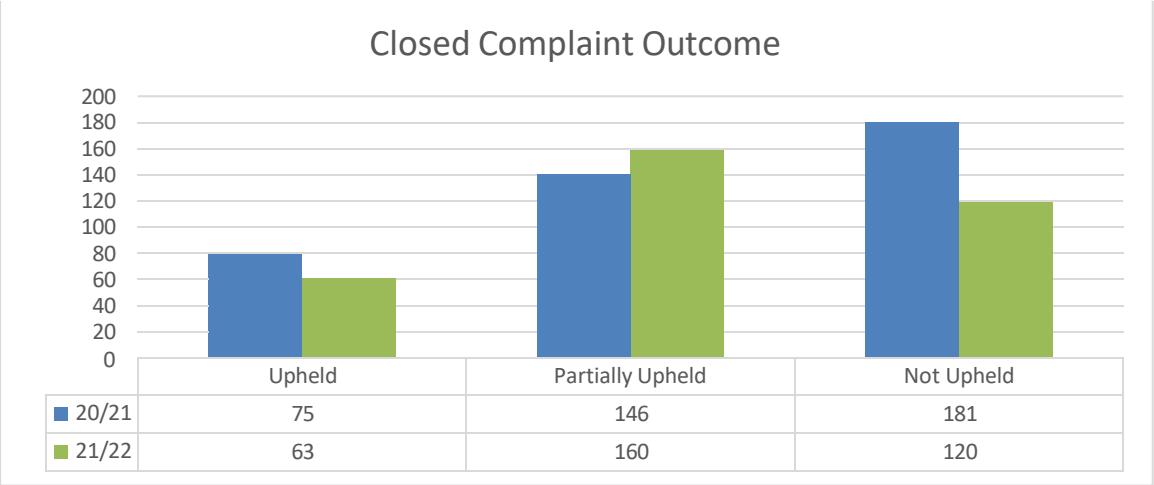


Chart A

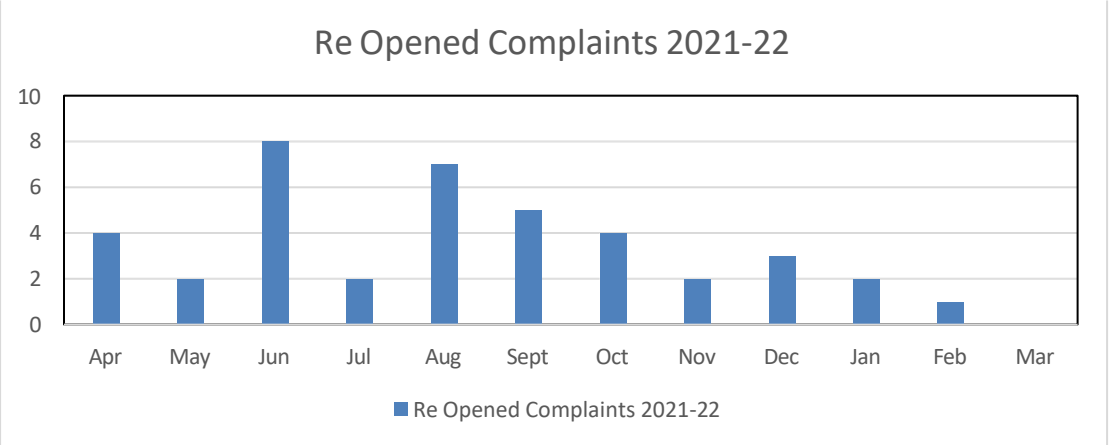
Of the formal complaints closed, the data below , graph B, demonstrates how many were upheld, partially upheld, and not upheld following investigation, 16 cases were classed as not applicable due to various reasons, such as progression to a serious incident.

Graph B



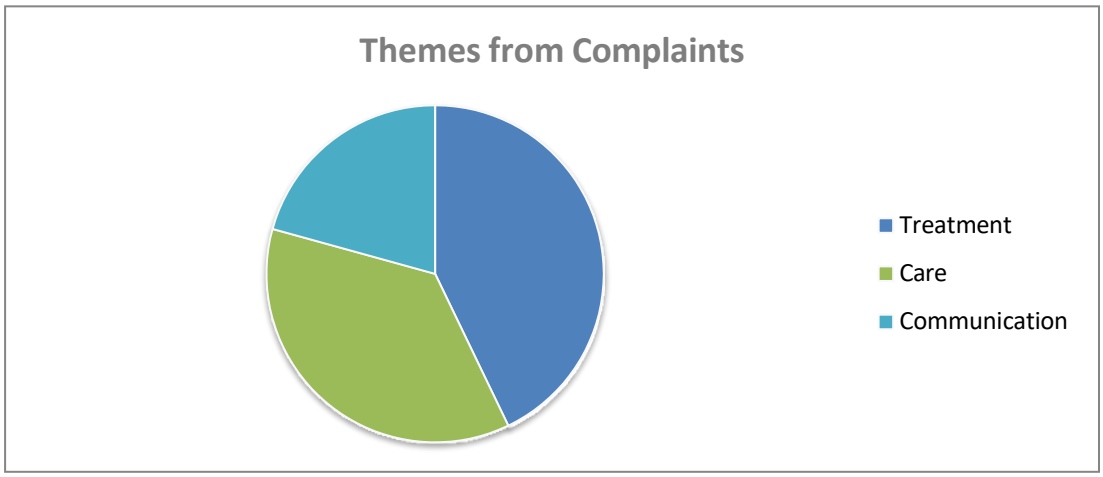
The Trust re-opened 40 complaints. It was expected at the beginning of April 2021 and in the following months to receive higher numbers of reopened requests due the closing of longstanding complaints towards the end of March 2021. This was when full transition to the new process was undertaken. Graph C, below, indicates that re opened rates have then normalised. Divisional teams are responsible for reviewing the re-opening requests and identifying if any further resolution can be reached through a further response or meeting.

Graph C



Complaint Themes and Learning Lessons

The visual data demonstrates, seen below in graph D, shows the headline themes for formal complaints during the period of 1 April 2021 to 31 March 2022:



Graph D

Further subheadings which contribute to these are:

Treatment → diagnosis or treatment pathway not followed as expected

Care identifiable → various aspects of care - no one specific theme

Communication about treatment → lack of communication, including updates

Themes are triangulated against other key metrics, serious incidents, claims, litigations, CCG incidents and inquests. Further work is planned in the coming weeks/months? to create a patient experience triangulation group due to amounts of patient feedback data that is collected within the Trust in varying formats.

Failure for treatment or a diagnosis due to clinical pathways not being followed as patients expected has been identified through the complaint learning and respective divisions discuss this through their speciality governance meetings. Any learning is incorporated into the complaint or should be identifiable through divisional governance documentation. This is an area which requires further development as clear evidence is not always available.

Care issues are addressed directly and monitored as details in the PALs section above. Complainants may also choose to share their learning through the patient story process to influence cultural change. The Trust continues to use stories for learning and Pat's Story, based on her complaint, formed part of this during February 2022 Trust Board.

Communication is a continual quality improvement aspect in response to the pandemic, as detailed in the PALs section. However, it is acknowledged that pre Covid communication was recurring theme. The Trust has implemented level 1 communication training to help develop improved staff skilled. SAGE and THYME is

a researched based nationally acclaimed tool centring around listening and empowering patients, and staff.

Learning Lessons

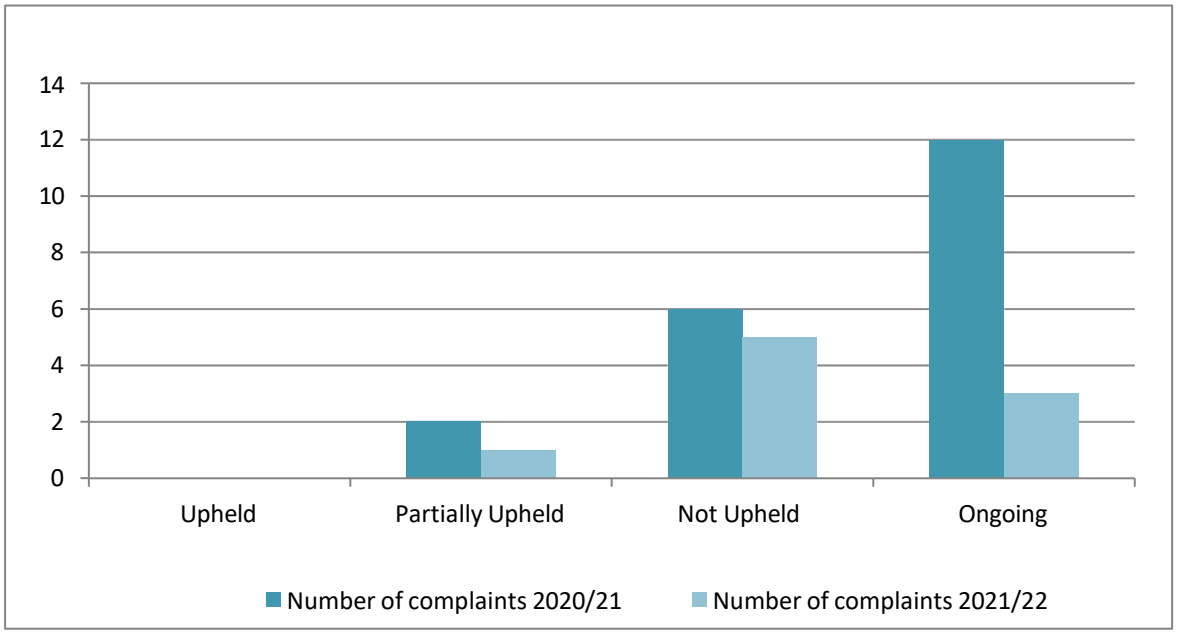
Learning lessons are now detailed in every upheld, or partially upheld, complaint. The Lead Investigator role, within the complaints process, is responsible for identifying learning as part of the emerging outcome. This is then translated into “what we have learnt from your complaint”.

Divisional team are accountable for actioning that learning nd being able to evidence outcomes. The central complaint team audit learning each quarter, although this has been problematic during Q2 due to staffing issues. Evidence of learning is shown to still require improvement.

Implementation of the new Trust reporting system, Ulysses, has meant that learning can be better reported at divisional level and actions assigned and monitored more robustly through this. However, the data sets are not consistently accurate and until this issue is fully resolved the next priority, of a learning log, cannot be progressed. In the interim the process is monitored through weekly support and challenge meetings when necessary, the quarterly complaint audit and through divisional governance process.

Parliamentary and Health Service Ombudsman (PHSO)

The PHSO have amended their investigative criteria and are currently pursuing cases which are not related to delays in the complaint process, issues which may resolve themselves with actions in place or non-critical delays because of Covid cases. The emphasis remains on exhaustive resolution at Trust level for these matters. The illustrated data seen below in graph E, details the Trusts performance regarding PHSO pursued complaints during the period 1 April 2021 – 31 March 2022, there are 3 cases not included in the figures below, as there has been no contact from PHSO in over a year.



Graph E

Feedback about the Complaint Process

To engage with our complainants and understand what we are doing well and what can be done better a survey is sent after each complaint is closed. From April 1st, 2021- March 31st, 2022 **29** people responded. 72% identified as female aged between 45-64.

There were some positive responses, especially around individual patient experience facilitators and their kindness towards complainants.

Where dissatisfaction was apparent this tended to center on the outcome of the complaint, not necessarily the process itself.

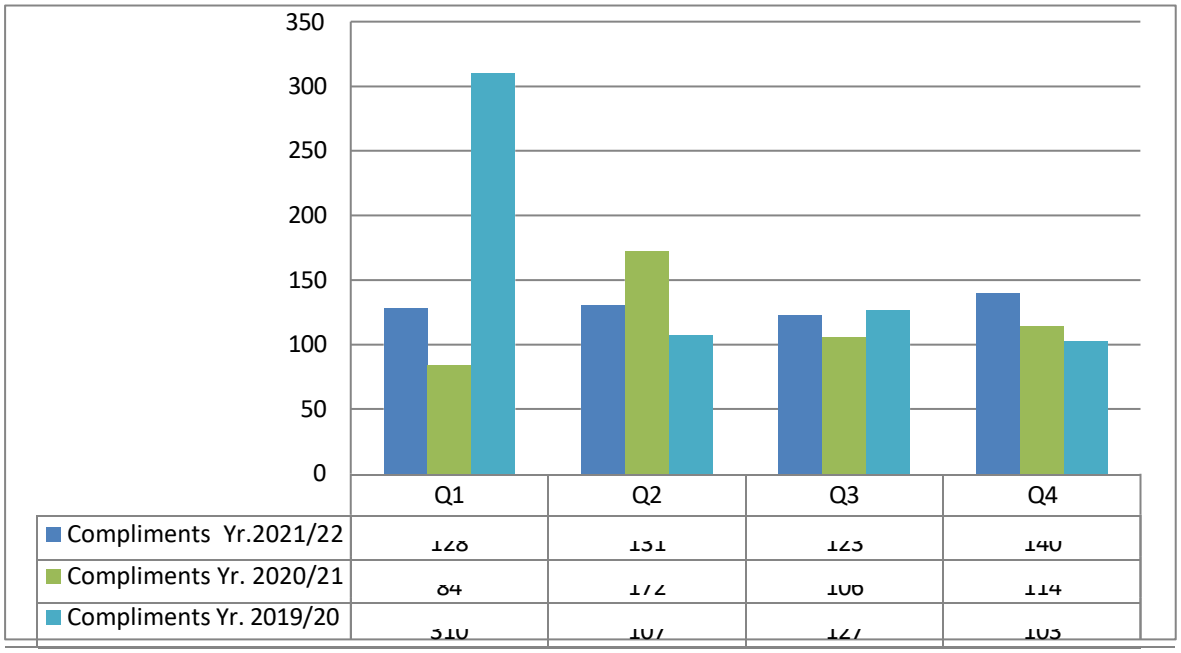
There is quality improvement to be done around ensuring updates are clear and timely, this will form part of 2022-2023 quality improvement plan.

Alternative methodology for gathering meaningful feedback is being explored.

Compliments

Compliments are central to the measurement of patient experience, as are complaints and concerns. It is recognised that logged compliments only form part of the recognition of positive feedback received across the Trust. Staff are encouraged to keep a folder with their area for their thank you cards and the compliments they receive directly. Compliments that are received through the PALS and Complaints Department are logged onto 'Survey Monkey'. Staff can also put their compliments onto the internal 'Hub'.

Below in graph F are the total number of compliments logged through Survey Monkey and the Patient Experience Hub shown across the year and historically.



Graph F

Developments

The quality improvement work within complaints and PALs continues. Through use of the PDSA (Plan, Do Study, Act) quality improvement cycle we are updating the policy, and staff engagement continues to form part of the evolving process.

The following have been part of years improvements.

- PALs team support and challenge meetings
- Weekly divisional PALs reporting
- ECC collaborative PALs work
- Review of divisional complaint report
- Complaint Delays monthly divisional feedback
- Transition to Ulysses system

The following aspects will be priorities for the forthcoming year, 2022- 2023:

- Creation of electronic Learning Log system
- Lead Investigator training review

Conclusion

This year has seen embedding of the new complaint process and the aim of sustaining this picture remains our priority. Northern Lincolnshire and Goole NHS Foundation Trust continued to feel the effects of the Covid 19 pandemic, including the availability of clinical staff to support the complaint process in the agreed timescale, however this was, and continues to be, mitigated by keeping complainants updated.

Divisional relationships have continued to strengthen, and this has helped considerably with addressing challenges and understanding their support requirements.

To ensure continued quality improvement the “Management of Feedback through Complaints, Concerns and Compliments” policy is in its final review stages. This will see learning, national guidance advice and staff feedback incorporated into the revised version. The Lead Investigator training is to be reviewed again following staff engagement. The PALs service will continue to build on the cultural and process work already commenced.

Learning from feedback will be the priority for the year 2022-23, with not only progressing practical developments to support the processes but to fortify impartial and robust divisional learning outcomes. These will be evidenced into actions which complainants can have assurance in.

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 2 August 2022	
Director Lead	Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Diane Hughes, Associate Director Special Projects	
Title of the Report	**Nursing, Midwifery & AHP Strategy Annual Report**	
Purpose of the Report and Executive Summary (to include recommendations)	This annual report showcases some of the work that has taken place over the last year by Nurses, Midwives and AHP to support the Nursing, Midwifery & AHP Strategy 2021- 2024. This has been even more of a success given the unprecedented pressure on our services and the continuation of the pandemic. This report highlights the great work that continues to go on across the organisation and how we continue to grow and develop our professional standards and practice.	
Background Information and/or Supporting Document(s) (if applicable)	The Nursing, Midwifery & AHP Strategy was launched in May 2021	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

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Nursing, Midwifery & AHP Strategy Annual Report 2022

Kindness · Courage · Respect

Introduction

Last year on International Nurses Day in May 2021, we launched our new and refreshed Nursing, Midwifery and Allied Health Care Professionals Strategy, 2021 to 2024, this annual report showcases some of the work that has taken place over the last year, and the incredible achievements that you have all contributed to. This has been even more of a success given the continuation of the pandemic and the unprecedented pressure on our services as part of the recovery process. The idea of this short annual report is for us to highlight the work that continues to go on across the organisation and how we continue to grow and develop our professional standards and practice. We still have a lot to do, but with your involvement and support we can continue to improve to enhance the quality of care that we provide across all of the organisation, across all of our professions.

This year we will be working more closely with our AHP Colleagues, with our new AHP forum and a sub strategy to support practice and closer team working with our nursing and midwifery colleagues. We have lots of Quality Improvement projects planned, some will be trust wide and we have included the key areas of focus for this year at the back of the report for you to all be aware of, and get involved with.

Don't forget to come and celebrate with us at the Conference on September 28th 'Our Success, Our Future, Our Time to Shine' where we will be showcasing all of your work and sharing best practice with you. You really do all have lots to celebrate!

Ellie Monkhouse
Chief Nurse

TABLE OF CONTENTS

What are our priorities and how will we achieve these?

Future 5 and Beyond Priorities...

1. Develop our leaders now and for the future
2. Improve recruitment and retention
3. Continue to build on our professional standards
4. Aim to provide harm free care
5. Focus on patient centred care

Future 5 and Beyond will...

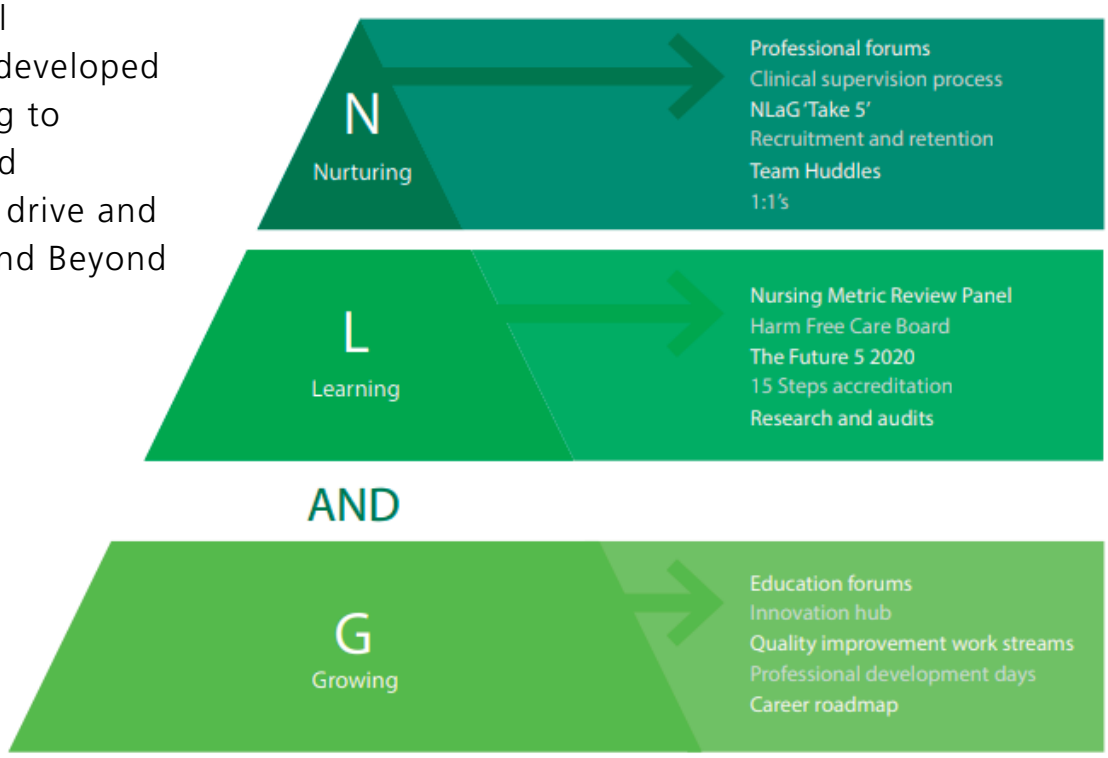
- Develop a practice of continuous learning and development
- Develop a valued and respected workforce
- Use our resources effectively to make sustainable changed
- Continue to embed and raise our professional standards
- Provide high quality, innovative safe care

The implementation of the Nursing midwifery & AHP strategy has made good progress during 2021/22. Due to winter pressure and the Trust on OPEL 4 on numerous occasion, some of the actions have not progressed as quickly as the team would have liked or have had a delayed start. The below table shows current progress (20th April 2022).

RAG		Number of actions
	Action complete and evidence available	1
	Action complete; evidence being compiled	11
	Action on track; will progress to timescale	34
	Suspended	1
	Not scheduled to have started yet.	12

The NLaG Professional Framework

The NLaG Professional Framework has been developed as a way of continuing to develop our teams and individuals to embed, drive and deliver the Future 5 and Beyond 2021 - 2024.



The Future 5, take 5, team time

The Future 5, Take 5, Team Time is to provide a structure to the introduction of weekly team huddles, led by local leaders.

This innovation will be embedded into the normal working routine as part of this strategy to help us take time to reflect on our work, our roles and our practices.

1. Develop our leaders now and for the future

Professional Development

The Trust has received monies to support continued professional development of our Nurses and AHP from Health Education England for the past two years. Partly due to the considerable operational pressures associated with the global Covid-19 pandemic, there have been significant challenges with respect to releasing staff utilising the full spend. However, in 2021/22, £386,693.72 was allocated on activity, which ranged from conventional HEI programmes, conferences, posts to deliver training, leadership and management programmes, clinical specialty courses, to assessment and support for learners in Professional Practice (Mentorship). Additionally we have successfully procured & rolled out clinicalskills.net We continue to develop our leaders and RCN leadership programmes have been delivered to Nurses and AHPS The 2021/22 spend represents an increase of £136k on the previous financial year.

Quality Improvement Education

- Since April 2021, 38 Nursing, Midwifery & AHP staff have been trained in QSIR Fundamentals/Virtual through our QI Academy. This has been done both face-to-face and virtually, covering staff from 7 directorates.
- In April 2022, the QI Team supported the Nursing Preceptorship work by facilitating QI sessions for our Nurse Preceptees. Tapping into their 'fresh eyes' as newly qualified staff, these sessions provided an introduction into QI and the methodology we use within the Trust (Model for Improvement) but also tools for generating ideas and next stage options.

Develop our leaders now and for the future within Midwifery

The Associate Chief Nurse Midwifery leads on Band 7 'maternity chat' events each month which are well attended and are used as a platform for discussion and support for those ward sisters, specialist midwives and labour co-ordinators. This gives the staff dedicated time to learn about current issues and planned changes. The main benefits to these sessions help with 'myth busting' staff morale and in turn retention of staff. It gives tome for appreciation and thanks to the staff

2. Improve Recruitment and Retention

Successful Recruitment of 163 International Nurses

As of April 2022, NLaG has welcomed its 13th cohort of international recruits, amounting to 163 recruits, 100% of whom have passed their NMC OSCE. Work will be prioritised to prepare for the new NMC OSCE in 2022/23, which has seen pass rates drop both in NLaG and nationally. However, we are proud to have seen our international nurses develop, for example, into Clinical Sisters and Staff Governors. A Buddy and Ambassadorial systems have been established along with CPD and career clinics, and we look forward, in the coming year, to supporting cultural work within the Trust.

Anthonia Nwafor, Staff Nurse

"I joined NLAG in February 2021 as a pre-registration Nurse. I took my OSCE in April and became a Registered Nurse and staff Nurse on Integrated Acute Assessment Unit B, now Acute Medical Unit Respiratory.

I was invited for the Governors meeting in August 2021 as a Trust Member, it was then I realised I could be part of the change NLaG needs. The role for the staff Governor came up and I applied.

In October, I became one of the Trust's staff Governors, a position I hold till date and so far I have been able to participate in 15 steps Challenge, advocate for staff and contribute to change in the Trust.

Recently, I was accepted on a Masters Degree in Nursing studies.

A lot has happened in a year and I'm beyond proud of myself of how far I have come and thankful to NLaG for all the support through kindness, courage and respect."

Professional Voice

The professional voice email was set up allow staff to raise any professional concerns or to share ideas. This was initially set up during the Coronavirus pandemic but has remained for staff.

The most popular enquiry received is about nursing apprenticeships and career development. Staff are actively encouraged to use the email address included below.

nlg-tr.twprofessionalvoice@nhs.net

2. Improve Recruitment and Retention

Health Care Assistants (HCA)

The Practice Development Team has conducted 28 week-long inductions for c. 225 HCAs staff new to the Trust in 2021 in response to the HCA zero vacancy campaign. The Team has also supported career conversation clinics for HCAs and is, at present, producing an innovative Preceptorship Policy and package for HCAs, which is formally offered in very few trusts in NHS England. Level 2 and 3 apprenticeships have been offered to our HCAs and SHCAs and thirtenn commenced on the programmes. Nursing apprenticeships are being developed and it is hoped that some of our HCAs will go on to consider career in nursing.

Practice Development Team Strategy

The Practice Development Team Strategy has been approved and will launch in June 2022. Structurally and in terms of content, the strategy dovetails with the Nursing, Midwifery and AHP strategy, and the Team have chosen to adopt the strapline of: 'Learning, Nurturing and Growing'.

Preceptorship

The team inducted over 70 newly qualified Nurses in the year 2021/22 and facilitated 5 week-long clinical inductions for this group. The Team also ran 8 further week-long clinical inductions for experienced staff new to the Trust. Work is ongoing to match the Trust's Preceptorship offer to the recent Health Education England Preceptorship standards consultation. The team is very confident that the NLaG package will meet these high standards. The Team is also working on a multi-professional Preceptorship Policy and package to encompass AHPs within the existing package and policy roe RNs and RMs.

Improve recruitment and retention within Midwifery

Within midwifery we have vacancies, similar to many other Hospitals. We have implemented several initiatives to retain our staff including the Associate Chief Nurse meeting with all those midwives looking to leave. To understand the reasons for leaving but also to offer alternative working patterns which may support them. We have actively recruited student midwives that are due to qualify in the autumn. We are at the early stage of international recruitment and the ward managers are involved in interviewing those interested in joining NLAG as midwives. We have been successful with applying for funding to support a Pastoral Support Midwife, a post that will work alongside newer midwives in gaining confidence with their work.

2. Improve Recruitment and Retention

Improve recruitment and retention within Medicine

- The medicine division have worked with Emergency Care Improvement Support Team to develop a career progression programme for Band 5 Registered Nurses
- They have invested in Clinical Educators for the Emergency Department's (ED) to support training & education
- They have developed our Emergency nurse practitioner teams within ED to successfully deliver the Urgent Care Service model

Advanced Clinical Practitioners (ACP)

We have 11 qualified and 19 trainee Advance Clinical Practitioners (ACPS) You'll find them in the Medicine and Surgery and Critical Care divisions. All of our ACPS have done their training with us and many were already part of the NLaG family before taking on this relatively new role.

The ACP are healthcare professional, educated to Masters level, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for.

A ACP framework has been developed and Annual Reviews of Compentecy Progression process in place.

Career Clinics

Career clinics have been been established for Registered Nurses and Healthcare Assistants wishing to develop their career. Staff are given support to consider where they are, where they want to be and why, and how they plan to get there. We can support staff to reflect on their training needs to support their career goals, and how they may consider using the Internal Transfer Policy to move to alternative roles.

2. Improve Recruitment and Retention

National AHP Workforce Supply Strategy Project

Project is looking at the AHP workforce and transforming it for the future, building links across the ICS /faculty. The aim is to have an organisational level strategic workforce plan for the AHP workforce.
The project covers several themes

- Finance – related to student tariff
- Workforce data and intelligence
- Retention and support for students and new graduates
- Return to practice
- International recruitment
- Apprenticeships
- AHP Support worker workforce

Achievements

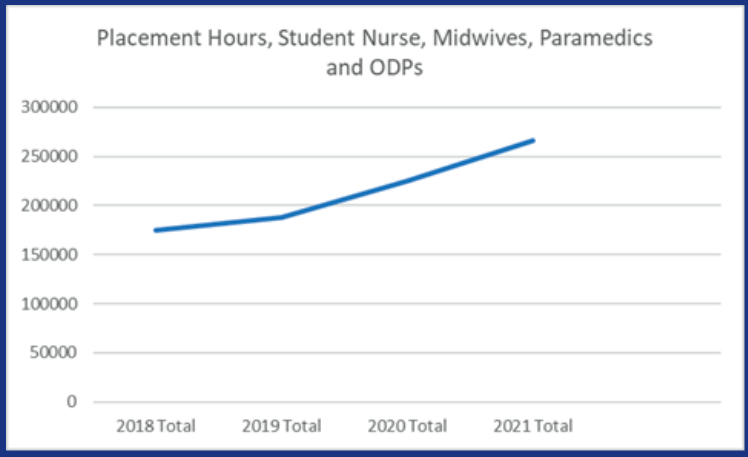
- Greater understanding of the depth and breadth of AHP workforce
- Understanding of what tariff is received from HEE for students
- Understanding of AHP support worker current qualifications and aspirations and that many are educated to degree level.
- Affirmation of several areas of good practice eg Support Worker Apprenticeships, preceptorship and international recruitment
- Working with the ICS AHP Faculty to develop the a wider ICS strategy for the AHP workforce

Next Steps

- 18 month Strategic workforce plan – looking at supply and demand issues and future developments for the AHP workforce to be submitted 30/06/22
- Student Tariff – Work to improve placement quality and experience to help support recruitment and retention.
- Business Case to be devloped for Pre-registration degree apprenticeships for AHPs in next year
- Development opportunities for support workers – implementation of the HEE AHP Support worker Career development framework and Support worker forum
- Development of a Multi-professional preceptorship programme in collaboration with nursing and midwifery.
- International Recruitment campaign – bid for money to support this
- Return to Practice Advertising Campaign – across all AHP professions offering placements to support re-registration

Supporting Students

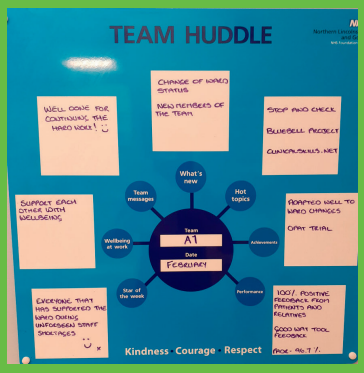
Achieved an 18.4% increase in nursing, midwifery, paramedic and ODP student placement hours in 2021 and have seen a 52.5% increase since 2018.It is hoped that these students will want to stay and work with us once qualified.



3. Continue to build professional standards

Team Huddle Boards

As part of 'the future 5, take 5, team time' within the Strategy , Huddle Boards where introduced to all our wards. The boards give opportunity for team discussion and ensure staff are kept up to date on key issues on patient safety and team wellbeing.



Stop and Check

Throughout the Trust we have rolled out and embedded a consistent safety huddle across the acute medical and surgical wards; the 'Stop & Check' safety huddle. The tool assists wards in focusing on the fundamentals of patient care, prioritising patient safety and reducing clinical incidents. It also provides the opportunity to focus on staff wellbeing and workload.

Led by the shift lead, the safety huddle refers to the trusts Intentional Rounding and links closely with the 'Stop & Check' section of the document. Encouraging staff to review their 'at risk' patients escalating where appropriate, update their documentation and reflect on their individual workload, it provides an opportunity to regroup as a team.

The 'Stop and Check' has been well received and adapted to meet the routines and needs of individual wards. It has been utilised as an opportunity to share ward specific themes for learning raised from incidents and within individual ward action plans to support ongoing improvements.

Continue to build on our professional standard within Midwifery

Work has been undertaken with the Royal College of Midwives to improve professional standards between colleagues and we worked together to formulate an improvement plan.

We also have a divisional 'employer of the month' which we can nominate and vote on. This could be for the staff member that has gone that extra mile and they are presented with flowers and a certificate.

3. Continue to build professional standards

15 Steps Challenge

The 15 steps programme has continued to develop over the last year, the toolkit has been reviewed to ensure it remains relevant and up to date with changes to practice. Supportive visits have been introduced to the process, which allows for improvement plans to be continuously reviewed and updated, gaining further assurance where needed and 'closing the loop' on learning. This has resulted in many areas going on to improve their ratings when re-visited. The acute 15 Steps programme has now been adapted and is successfully embedded within Community, Therapy and Outpatient areas within the Trust.

The last year has seen an increase in GOOD and OUTSTANDING 15 Steps achievements, this is a testament to the staffs ongoing hard work and commitment to improving standards. A total of 97 visits were undertaken; this includes areas who have received more than one visit due to achieving a rating of requires improvement or intensive support:

- 19 Received Outstanding
- 44 Received Good
- 31 Received Requires Improvement
- 2 Received Intensive Support

With the introduction of the 'Quality Times' last year we have been able to celebrate those successes and share learning. During the next year we look forward to celebrating the areas that achieve outstanding 3 times becoming EXCELLENCE AREAS within the trust. This will be a fantastic achievement and worth celebrating.


THE QUALITY TIMES

UNIFORM

THE QUALITY TIMES

OUR TIME TO SHINE

WORKING TOWARDS EXCELLENCE

GOOD & OUTSTANDING ACHIEVEMENTS

Research

Clinical research is vital to enhance health, reduce the burden of ill-health and develop life lengthening treatments. During the Covid-19 pandemic our team have supported studies to bring rapid changes and effective treatment to patients. Our research and clinical teams were central to recruitment and delivery of these studies. The research team doubled their recruitment target during 2021. Our Research Strategy is being finalised and aims to engage colleagues from all disciplines and directorates to play an active part in research and develop research as a core Trust activity.

3. Continue to build professional standards

Professional Nurse Advocate

The Professional Nurse Advocate (PNA) role was introduced nationally by Ruth May, the Chief Nursing Officer England in March 2021 to support the health and well-being of nurses.

Ruth May's, goal is 1 PNA: 20 Nurses by March 2024. Thus we will require 84 PNA's across all sites which means training 28 per year. As of April 2022, we have 31 PNA's/trainee PNA's in the team.

A Lead Nurse for the PNA programme has been appointed, and we have 4 ambassadors across sites and the national PNA implementation programme is being followed and the lead is coordinating a regional team to develop a PNA strategy. The NLaG PNA Council is meeting monthly to support the strategic direction of the role. PNA/Health and Well-being boards are in most areas and these have information about the role, course and who the local PNA is.

Patient Safety Days

A number of professional development days were planned in 2021/22 for matrons, ward sisters. registered nurse, midwives , AHP and healthcare assistant and support workers. Only one day was able to go ahead due pressures faced from the pandemic. These are refreshed for 2022 as patient safety and professional development days, with 21 dates between June 22 and March 23. This days will cover :

- Career pathways, apprenticeships and professional development
- Patient experience
- Patient safety initiatives
- Nursing, Midwifery & AHP strategy
- Culture transformation & Leadership

4. Aim to provide Harm Free Care

Chief Nurse Safe Staffing Establishment Reviews

All Ward Managers met with the Chief Nurse to discuss their Nursing establishments. During these meeting a number of metrics where discussed including, pressure ulcers, falls, fill rates, Care Hours per Patient Day (CHPPD). Data was also reviewed from the Safer Nursing Care Tool (SNCT) which wards collate every 6 month to monitor the acuity and dependency of patients.

Following these reviews an establishment paper was written and recommendation presented to the Trust Board for approval. This has resulted in an additional 58 WTE nurses and 45 WTE support workers being funded from April 2022.

The Chief Nurse also conducted desktop maternity staffing establishment reviews and the increases in establishments identified were included in the Trust's Ockenden Immediate and Essential Actions submission. The data for the establishment review using Birthrate Plus has been submitted and final report awaited.

Community Teams Keeping Patients Safe During the Pandemic

- Recognition for community services pandemic response, supporting primary care, care homes, hospice and community teams
- Introduction of the Community Response Team GP, co-locating a GP within the community Single Point of Access, supporting senior decision making in SPA
- Virtual End Of Life Care, and clinical observations and escalation training for care homes staff across North Lincolnshire

2021 HSJ Awards Community Provider of the Year Finalists

Aim to provide harm free care within Midwifery

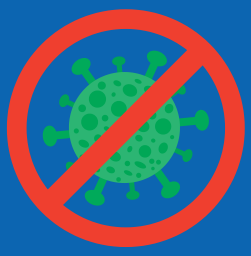
Within maternity services, harm free care is at the top of the agenda especially in light of recent reports such as Kirkup and the Ockenden Report. We have well embedded processes that audit frequently undertaken tasks, such as swab checks following delivery, 1:1 care in labour and the WHO checklist in the maternity theatre. These are undertaken by the labour co-ordinator every day and any omissions are responded to immediately.

With Ockenden monies that we have been fortunate to receive, we have also been able to increase MDT mandatory training provision, employed additional consultants and admin staff to support the training work as well as a midwifery educator.

4. Aim to provide Harm Free Care

Infection Prevention and Control Achievements

We currently have the lowest number of C.Diff cases for a hospital in the region and one of the lowest in the UK. The national objective is no more than 33 cases per year, and we reported a total of 20 cases. This is a 29% reduction compared to last year and a huge achievement that's been recognised regionally. As a result, our IPC team has been asked to share your good practice with other local hospitals.



It's been 18 months since our last hospital onset case of MRSA. The national target is zero cases per year, so we've been doing a brilliant job of meeting this for a long time now, despite the extra pressures we continue to face.

We've also been recognised for having one of the lowest E.coli rates in the region and there's even more room for improvement here in terms of oral care, preventing pneumonias, good hydration and urinary catheter management, particularly as we go into the summer months.

Another highlight from the IPC annual report shows our rates of nosocomial COVID-19 infections were on the lower end of the scale and we performed better than many of our neighbouring Trusts. This is despite the environmental challenges we faced and is a result of us introducing mitigating actions such as Redirooms, artificial walls, CubiScreens, HEPA filters, careful cohorting of patients and much more to protect our patients. This also led to us being shortlisted for a HSJ Patient Safety Award and presenting at the European Congress of Clinical Microbiology & Infectious Diseases conference in Lisbon.

Red Flags

General Nursing Red Flags

A nursing red flag is a warning sign that something may be wrong with nurse staffing.

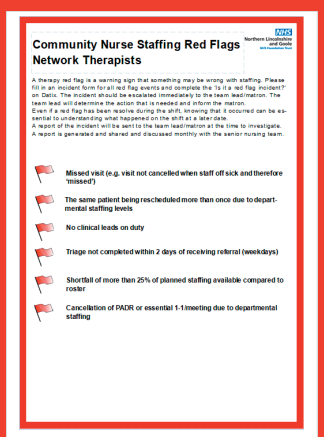
- Delay in Medicines rounds by 1 hour
- Delay in administration of IV medications by 1 hour to more than 3 patients
- Delay of more than 30 minutes to provide acute pain relief
- Less than 2 trained nurses on a clinical area
- Less than 50% substantive staff on a shift
- More than 50% of staff under 12 months qualified
- Trained nurse less than 12 months qualified, or still in preceptorship left in charge

Any staffing issues should be reported immediately to Shift Leaders and escalated to Matron (Site Lead at weekends and overnight)

Additionally, all nurse staffing red flag incidents should be recorded on SafeCare Live;

- Click on your ward or department
- Click on [redacted] (towards the top right had side of your screen)
- Select Flag Type from the drop down list
- Then choose whether the red flag is still open or has been resolved (even if a red flag has been resolve during the shift, knowing that it occurred can be essential to understanding what happened on the shift at a later date)
- Choose who, on the shift is the 'Owner' of the red flag (this may or may not be the person raising the red flag)
- Add any additional information under the Notes section
- The red flag incident information will be forwarded to your line manager and matron to investigate, and shared and discussed with the senior nursing team

NB If unable to access SafeCare Live, then please complete a Datix to report staffing red flag. Please complete the box 'Is it a red flag' incident on Datix.



Community Nurse Staffing Red Flags
Network Therapists

A therapy red flag is a warning sign that something may be wrong with staffing. Please fill in an incident form for all red flag events and complete the 'Is it a red flag incident?' on Datix. The incident should be escalated immediately to the team lead/matron. The team lead will determine the action that is needed and inform the matron. Even if a red flag has been resolve during the shift, knowing that it occurred can be essential to understanding what happened on the shift at a later date. A report of the incident will be sent to the team lead/matron at the time to investigate. A report is generated and shared and discussed monthly with the senior nursing team.

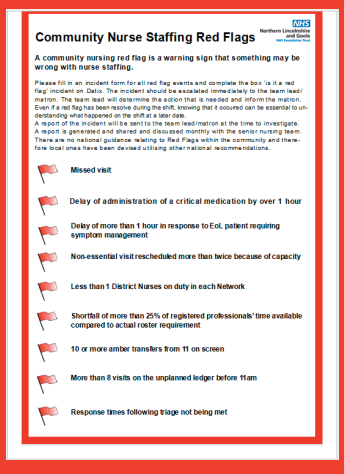
- Missed visit (e.g. visit not cancelled when staff off sick and therefore 'missed')
- The same patient being rescheduled more than once due to departmental staffing levels
- No clinical leads on duty
- Triage not completed within 2 days of receiving referral (weekdays)
- Shortfall of more than 25% of planned staffing available compared to roster
- Cancellation of PADR or essential 1-1 meeting due to departmental staffing

Midwifery Staffing Red Flags

A midwifery red flag is a warning sign that something may be wrong with midwifery staffing.

Please fill in an incident form for all red flag events and complete the box 'Is it a red flag' incident on Datix. Any issues should be reported immediately to the Shift Leader or Matron. Even if a red flag has been resolve during the shift, knowing that it occurred can be essential to understanding what happened on the shift at a later date. A report of the incident will be sent to the team lead/matron at the time to investigate. A report is generated monthly and shared and discussed with the senior nursing team.

- Delayed or cancelled time critical activity
- Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital (e.g. diabetes medication)
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation onto the ward and being seen
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process
- Delayed recognition of and action abnormal vital signs (e.g. Sepsis or Urine Output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour
- Below safe staffing levels following escalation
- Co-ordinators non-supernumerary >2 hours providing Intrapartum



Community Nurse Staffing Red Flags

A community nursing red flag is a warning sign that something may be wrong with nurse staffing.

Please fill in an incident form for all red flag events and complete the box 'Is it a red flag' incident on Datix. The incident should be escalated immediately to the team lead/matron. The team lead will determine the action that is needed and inform the matron. Even if a red flag has been resolve during the shift, knowing that it occurred can be essential to understanding what happened on the shift at a later date. A report of the incident will be sent to the team lead/matron at the time to investigate. A report is generated and shared and discussed monthly with the senior nursing team. There are no national guidance relating to Red Flags within the community and therefore local ones have been devised utilising other national recommendations.

- Missed visit
- Delay of administration of a critical medication by over 1 hour
- Delay of more than 1 hour in response to EoL patient requiring symptom management
- Non-essential visit rescheduled more than twice because of capacity
- Less than 1 District Nurses on duty in each Network
- Shortfall of more than 25% of registered professionals' time available compared to actual roster requirement
- 10 or more amber transfers from 11 on screen
- More than 8 visits on the unplanned ledger before 11am
- Response times following triage not being met

- We have reviewed & refreshed our safe satffing red flags
- We have embedded the use of safe staffing red flags across the organisation to ensure staff feel empowered to easily raise concerns

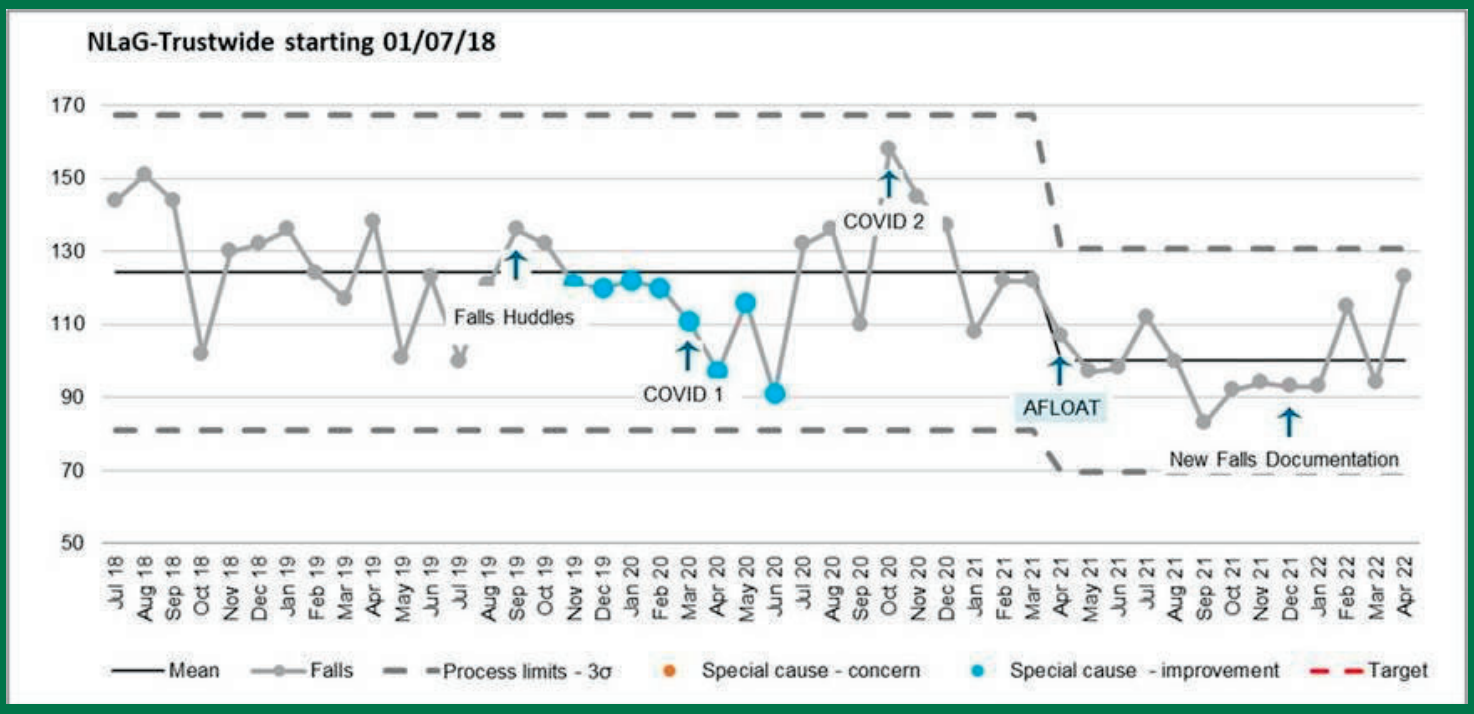
4. Aim to provide Harm Free Care

Harm Free Care - Falls

2021/22 has seen a continued reduction in the number of reported in patient falls despite the ongoing challenges faced by the COVID-19 pandemic. Multi-disciplinary team huddles have been completed for all incidents where moderate, or greater, harm has been sustained. Huddles for patients who have fallen more than once are more challenging to complete for every patient. There are plans to review these huddles during 2022/23 to increase the number of patients who are reviewed.

New falls risk assessments and care plans have been rolled out to further improve the care of patients who are identified as at risk of falls on admission to the Trust. The care plans were developed to address key themes and learning from the falls huddles and support individualised care. The roll out of the new documentation also included the roll out of the AFLOAT assessment and supportive care.

The below table shows a reduction of falls.



5. Focus on Patient Centred Care

Patient Experience

During 2021/22 the Patient Experience Teams at Northern Lincolnshire and Goole NHS Foundation Trust worked tirelessly to maintain and enhance the experience of care during a challenging time. Below are some of the highlights of the last year, which evidence what we did to #makeadifference.

The first year of our Patient Experience priority outlines were successfully delivered through collaboration and co-design, which will continue to shape 2022/23.

Collected 13,900 pieces of Patient Feedback

Answered over 8500 calls via the Patient Contact Helpline

Welcomed 65 new, & 19 existing Volunteers into our NLaG family

Supported over 300 hours of communication through Family Liaison Assistant role

Utilised and shared meaningful activities to enhance patient wellbeing

Assisted over 200 JITSI calls to connect loved ones , sometimes across the world

Recruited 13 temporary Family Liaison Assistants during Covid to support improving communication for families

SAGE & THYME®
Notice distress, listen carefully, respond helpfully

Facilitated level 1 communication skills through SAGE & THYME programme

Welcome!

Ensured a responsive approach to visiting across the whole Trust throughout each month

5. Focus on Patient Centred Care

Discharge Improvement Work

Two pieces of work were commenced to improve the quality and timely discharge of patients.

Criteria Led Discharge (CLD) is being piloted in elective orthopaedics DPOW. Criteria Led Discharge allows member of the MDT team competent in CLD to discharge patients that have met the defined criteria set by the Consultant. This benefits the patient by reducing the length of stay and improving communication about the discharge.

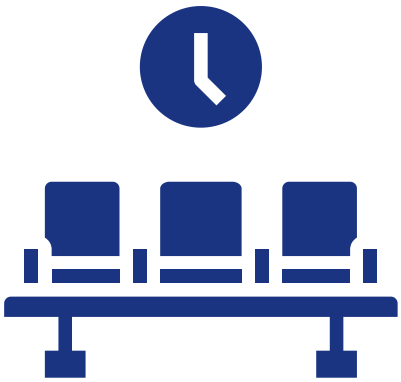
The second piece of work is to increase the use of the discharge lounges by 30%. This work looks at the current data and works with both the discharge lounges and the wards to improve communication and make change. This project is being run as a quality improvement collaborative working with the Quality Improvement team

Both of these projects will help to improve the patient flow throughout the hospital and the quality of the discharge for the patient.

New patient pathways

- Implemented new models of care – Urgent Care Service
- Strengthened patient pathways for SDEC to enable patients to be diagnosed, treated and discharged in the same day and extended service hours

Focus on patient centred care within gynaecology and breast services



Within the division including gynaecology and breast services, we ensure that we capture patient experience and any lessons learnt are shared amongst the service. We have many examples of our services having a clear focus on the patient and their needs. Following a recent PALS concern, we have made changes to our waiting areas at Grimsby so that those that have had baby loss are not invited to sit with pregnant women. Review appointments are now held in the outpatients department within the the main hospital rather than in maternity, which causes anxiety and upset and hopefully this small change will be found to be of help to women and their partners.

5. Focus on Patient Centred Care

Community Unplanned Nursing Services

Developed pathways working alongside partners in EMAS and Medicine Divisions, culminating in:

- Delivery of COVID Virtual Ward and OPAT Pathways in 2021/22 and also laying foundation for development for further Virtual Ward Pathways. This allows the patients to receive treatment form the comfort of their own home.
- Transfer of Category 5 calls directly from EMAS stack to reduce ambulance attendance and conveyance rates and provide community based care to patients for whom this is clinically appropriate, reducing the number of patients needing to come into hospital.
- Achieved compliance with Urgent Community Response requirements ahead of the deadline of 31 March 2022
- Implemented and secured recurrent funding for Community Response Team GP, strengthening skill mix and pathways within unplanned services

Community Planned Nursing Services

- Delivery of Community Nursing Allocation System, Malinko, improving visibility of demand and capacity across these services
- Quality Improvement ethos embedding in the services to review patient pathways and continue to find effective and efficient ways of working
- Securing of £1.1m investment in community services to build community and out of hospital capacity
- Ongoing developments and quality improvements alongside investment into continence services has seen a dramatic reduction in the number of patients awaiting to be seen.

5. Focus on Patient Centred Care

Quality Improvement (QI)

What is Quality Improvement?

Staff… continuously trying to improve how they work and the quality of care and outcomes for patients. This requires a systematic approach based on iterative change, continuous testing and measurement, and the empowerment of frontline teams.

Fundamental to the principle of QI is an understanding that those closest to complex quality problems (frontline teams, patients and carers) are often best placed to find the solutions to them.

A few of the QI projects…

- NBBS (Neonatal blood spots) - To reduce the number of repeat neonatal blood spot test at NLAG from the current level of 10.2% down to the national target of <2% by August 2021

29 hours of staff time saved over 3 months

The rate has improved from 10.2% to 2.6%

Positive outcome for babies, parents and staff

The first QI collaborative at NLaG

60% fewer babies need the test repeated

- Safe and Secure Medication - To improve the compliance with safe and storage process which will then improve the percentage rate as reflected in the Safe and secure audit. The accepted minimum target is 90% to be achieved by 30 November 2021

30 minutes of staff time saved

No medication related incidents since the project began on some wards

Cost saving across all wards - 6k of stock that has been returned to pharmacy

Ward	March 2021	March 2022	Feb 2022
19	Closed	92%	89%
22	64%	96%	100%
24	62%	92%	81%
Disney	62%	96%	81%
Stroke	50%	76%	96%
16	62%	96%	
17	62%	79%	
23	62%	96%	
IAAU B	75%	100%	
C1	48%	72%	
C2	70%	77%	
B2	70%	81%	
B3	62%	88%	

5. Focus on Patient Centred Care

End of Life Care (EOLC)

Introduced Blue Bell Model across number of our wards, strengthened EOLC governance framework, and contributed to the Northern Lincolnshire End of Life Pathway which sets out the quality improvement plans for the next five years. Working with all divisions to enable and improve the care we provide to patients at the end of life.

Improving End of Life Care - The Bluebell Principles and Family's Voice Project
The Aim of the Project

- To recognise the possibility of imminent death
- To communicate with the dying person
- To communicate with families and others

* To have an individual plan of care

What did the team do?

1. They worked closely with the system to agree an End of Life Strategy which focused on delivering the National Ambitions for Palliative and End of Life Care.
2. They developed a set of principles which we are educating our nursing teams to work to. These are the Bluebell Principles. They are designed to underpin the Trusts core values.
3. They introduced the Family's Voices Diary to enable our patients loved ones to actively participate in discussions regarding their relative's care

What have they achieved?

1. They have developed a package of improvement measures that will give a positive impact on End of Life Care. We are rolling out across each ward and involving all staff to create greater awareness,
2. They have introduced sundries such as tote bags, comfort packs, to show that we not only care about our patients – we care about their friends and relatives too.
3. They have introduced a logo that can be recognised as meaning 'end of life .....and they are not finished yet !

The feedback the team have received since launching Bluebell has been extremely positive from both patients, relatives and staff.

BLUEBELL

Our plans for the future

Nursing, Midwifery & AHP priorities 2022/23

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

1. Develop our leaders for now and for the future

- Quality Improvement Councils
- Rollout Innovation Stations
- Criteria led discharge
- Increase number of attendees at senior leadership meeting

2. Improve recruitment and retention

- Recruitment and retention with 5 year work plan & apprenticeships
- Develop an AHP forum
- AHP workforce and establishment review process

3. Continue to build on our professional standards

- Essential training and patient safety days for clinical teams
- Train 84 Professional Nurse Advocates and Restorative Clinical Supervision
- Safeguarding supervision for midwives and safeguarding team
- Roll out and embed stop and check
- Development of Excellence Wards & Departments for 15 Steps

4. Aim to provide harm free care

- Embed the use of Intentional Rounding
- Embed the use of Fall Huddles
- Fluid Charts used appropriately
- Increase Ward Assurance Tool (WAT) compliance

5. Focus on patient centred care

- Increase number of patient feedback forms responses (FFT)
- Improve timeliness of PALS responses
- Dementia friendly hospital
- Improve quality of discharge
- Pain Management
- Development of strategies
- Increase use of discharge lounge by 30%

CONTACT US:

nlg-tr.twprofessionalvoice@nhs.net

Kindness · Courage · Respect

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	2 August 2022	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Performance and Estates & Facilities areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives. Also attached are the results and action plan from the recent Committee self-assessment exercise.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	✓ Pandemic Response ☐ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	2nd August 2022
Report From:	Finance & Performance Committee – 22-06-22 and 20-7-22

Highlight Report:

ED performance remains low which is down to increase in numbers and the flow in the hospital. There is a small reduction in the 12hr trolley waits. Recent ED audit suggests that there are ambulance handovers challenges with clocks running after the handover. UCS continues to be a success but the risk is GP coverage of service. Bed Occupancy remains high. The Committee asked about escalation beds open, it was explained that the hope is to reduce the escalation beds. The opening of SDEC 24/7 was queried and confirmation was given that the funding isn't available yet.

Risk stratification is an automated process which has made good progress with the outstanding patients. The Committee received assurance on Ophthalmology automated processes and the use of safety officers to monitor the waiting lists within the specialty. The Committee asked about the number of overdue patients and received assurance over these.

Outpatient Transformation Programmes such as Connected Health Network, PIFU, Patient Knows Best and Digital Communications were discussed in detail

RTT small deterioration in position but mutual Aid having an effect, 7 pathways at 104week+, 3 are mutual aid. The committee queried the increase in RTT waiters and it was explained that bottle necks are being investigated and actions being taken to increase productivity.

Diagnostic deterioration in June but data quality issue identified with St Hughs, position better than England average since Jan 2022, the use of the independent sector in the short term is being looked into to improve the position. Cancer is underachieving in 8 out of 9 indicators, roadmap in place to address improvement. The 62 day backlog for NLaG is 11.4%, this is worse than national but better than local trusts. The Committee asked about Cancer waiting list, the joint diagnostic work with HUTH and the levelling up of long waiters with HUTH, was assured of the progress.

The committee questioned the ERF and it was said that improvement is required and that the trust is looking at productivity. The Committee was not assured that the 104% activity levels will be reached.

The final phase of oxygen upgrade at DPoW is due to take place and this will complete the ring-main system. There is a big challenge at SGH where there is no funding for ward upgrades but this has been raised as a risk. The Board questioned the timescales of the rolling programme of ward upgrades, the response was that ward upgrades will happen as soon as capital is made available.

The Fire Safety report was presented although more changes are likely to be required as the Grenfell enquiry is still ongoing and Hospitals are most likely to be classified as a high risk building. The Committee heard that the DPoW fire alarm system had been replaced and discussed replacements of the SGH and Goole systems. The SGH system will cost circa £4m, the Committee heard evidence the system was resulting in increasing false alarms. NLaG had avoided fines due to the open and honest relationship with Humberside fire.

The Committee heard of plans to implement an external fire authorizing engineer is one of the next steps in order to implement annual audits.

Fire warden training has been revised and training is being restarted as wardens have been moved due to office changes. There is ongoing work to fix the fire door issue at SGH.

The committee received assurance over the BAF risk rating, but in time the likelihood will increase, and it is being monitored. It was questioned whether the patients and staff were safe and if NLaG were breaking any legislations it was confirmed that risks are mitigated as far as possible and NLaG are not breaking legislation.

Confirm or Challenge of the Board Assurance Framework:

SO1-1.4 was worked through and assurance was given on the risk, gaps and plans. Specific time was given to discuss the costs of the backlog of maintenance.

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

NLG(22)125

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	02 August 2022
Director Lead	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee
Contact Officer/Author	Fiona Osborne, Associate Non-Executive Director and Chair of Workforce Committee
Title of the Report	**Workforce Committee Highlight Report and Board Challenge**
Purpose of the Report and Executive Summary (to include recommendations)	The Committee recommended highlighting the following matters to the Board, namely: • The Committee received an update on the Leadership Strategy and the programme of activity has proceeded at pace. • Workforce Race Equality Standards and Workforce Disability Equality Standards Annual Reports were received by the Committee. Improvement actions already in train were discussed however, the Committee noted there was more to do. • Nursing Recruitment was flagged as an issue although the rise in vacancies is due to the 2022/23 establishment changes and not as a result of a spike in staff leaving. • The Committee were presented with the Medical Revalidation Report. The Committee recommended the report to the Board No changes to the BAF risk ratings were raised by the Committee.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable

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

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
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4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
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BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	02 August 2022
Report From:	Michael Whitworth, NED & Chair of Workforce Committee

Highlight Report: Workforce Committee – 19 July 2022

Introduction

- The aim of this report is to provide an update and prompt discussion and scrutiny of the work of the Committee and Board Assurance.

Items Highlighted by the Committee for the Attention of the Board

- The Committee received an update on the Leadership Strategy and the programme of activity has proceeded at pace. There are 3 strands of work
    - Foundations in Leadership will launch an induction plan for new leaders and a Leadership Individual Development Analysis in September.
    - Professional Leadership Development is mapping leadership career pathways and will launch a Course Approvals Panel in October as well as forming a PADR Working Group
    - Values Based Leadership has agreed £150k funding through a business case and is currently deigning the Be the change- Leading with Kindness, Courage and Respect programme. This is planned for launch in October/November

- The Committee Reviewed a new Recruitment dashboard which provides information on performance on a Trust level and how the Divisions and Recruitment Team perform in driving recruitment activity. The report is being shared with the Divisions monthly and key learnings are being applied to processes as a result of the KPIs.

- Nursing Recruitment was flagged as an issue with both Qualified and Non-Qualified vacancy rates increasing. The rise in vacancies is due to the 2022/23 establishment changes and not as a result of a spike in staff leaving. The Committee heard that plans to reduce the vacancy levels are advanced however the impact will not be immediate due to the timescales from advert to start date.

- The Committee were presented with the Medical Revalidation Report which summarises the appraisal position for doctors connected to NLAG as their Designated Body. The Committee recommended the report to the Board.

Items for Committee Ratification and Assurance

- The Committee approved the Freedom to Speak Up Quarterly Report

- Workforce Race Equality Standards and Workforce Disability Standards Annual Reports were received and approved by the Committee. The statistics showed a mixed picture of some improvement and some deterioration from the position in 2020. The Committee discussed the work programme and will keep a watching brief on progress. The Committee were presented with current activity to encourage BAME and disabled people to come and work for the Trust as well help improve their experience in line with their colleagues once working here. The Committee discussed further ways that we could support BAME and Disabled staff members.

Confirm or Challenge of the Board Assurance Framework:

No changes to the BAF risk ratings were raised by the Committee.

Action Required by the Trust Board:

The Board is asked to receive and note the content of this highlight report.

NLG(22)127

<table>
<tr><td>Name of the Meeting</td><td>Trust Board of Directors</td></tr>
<tr><td>Date of the Meeting</td><td>02 August 2022</td></tr>
<tr><td>Director Lead</td><td>Christine Brereton, Director of People</td></tr>
<tr><td>Contact Officer/Author</td><td>Karl Portz, Equality, Diversity & Inclusion Lead
Nico Batinica, Associate Director Workforce and Recruitment</td></tr>
<tr><td>Title of the Report</td><td>Workforce Race Equality Standards (WRES) Annual Report</td></tr>
<tr><td>Purpose of the Report and Executive Summary (to include recommendations)</td><td>
The purpose of this paper is to report to the Trust Board the Workforce Race Equality Standard (WRES) annual report/data for 21/22. Data is required to be published by no later than 30th August 2022. This report has been submitted to the TMB and the Workforce Committee.

WRES data is reported by 9 key indicators, which is taken from ESR (indicators: 1,2,3, 4 and 9) and automatically from the annual staff survey (indicators 5-8).

The statistics showed a mixed picture of some improvement and some deterioration from our position in 2021 WRES 1 - 4 and WRES 9, and 2020 WRES 5 - 8:

<table>
<tr><td>Indicator</td><td>Compared to 2021 WRES 1-4 and WRES 9, and 2020 WRES 5 – 8</td></tr>
<tr><td>WRES 1 – Workforce overall</td><td>Improved</td></tr>
<tr><td>WRES 2 – Recruitment</td><td>Improved</td></tr>
<tr><td>WRES 3 – Disciplinary</td><td>Improved</td></tr>
<tr><td>WRES 4 – Access Training</td><td>Same</td></tr>
<tr><td>WRES 5 – Bullying from patients</td><td>Deteriorated</td></tr>
<tr><td>WRES 6 - Bullying from staff</td><td>Same</td></tr>
<tr><td>WRES 7 - Career opportunities</td><td>Deteriorated</td></tr>
<tr><td>WRES 8 - Discrimination from manager/other staff</td><td>Deteriorated</td></tr>
<tr><td>WRES 9 – Board representation</td><td>Improved</td></tr>
</table>

In 2021 we have relaunched our staff network group for our BAME staff and members will form part of the Culture Transformation Working Group which was launched in June. A key focus of our culture transformation work will be to focus on values, behaviours and leadership aimed at improving all staff experience especially those where evidence suggest (such as WRES) that experience is worse.
</td></tr>
<tr><td>Background Information and/or Supporting Document(s) (if applicable)</td><td>The Workforce Race Equality Standard (WRES) was introduced from the NHS Equality and Diversity Council (EDC) and forms part of the standard NHS contract. From April 2016 is has also formed part of the inspection framework under the “Well Led” domain.</td></tr>
<tr><td>Prior Approval Process</td><td>✓ TMB
☐ PRIMs
☐ Divisional SMT
✓ Other: Workforce Committee</td></tr>
</table>

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

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Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Race Equality Standard Report for Workforce Committee / Trust Board

1.0	**PURPOSE OF THE REPORT**
1.1	To update the Workforce Committee on progress against the Workforce Race Equality Standard (WRES) Indicators.
1.2	To update the Workforce Committee on our submission, the revised data, and information as per our contractual requirements.
1.3	To highlight key priorities and actions required during 2022/23, to make improvements against the WRES.
2.0	**BACKGROUND/CONTEXT**
2.1	The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 by the NHS Equality and Diversity Council (EDC).
2.2	The link provided signposts to a short four minute video clip describing the Workforce Race Equality Standard. https://www.youtube.com/watch?v=G44C9yn-oo0
2.3	Research and evidence suggest less favourable treatment of Black and Minority Ethnic (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.
2.4	The WRES seeks to prompt enquiry to better understand why BME may staff receive poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.
2.5	In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BME staff in the NHS. The principal outcome of measuring performance against the standard is that it helps organisations to measure where they are against key best practice indicators, where they need to be, and how to plan for improvements to achieve and maintain optimum performance for each indicator.
2.6	The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board BME representation.
3.0	**IMPLICATIONS FOR THE ORGANISATION**
3.1	As of the 1st April 2015, the WRES forms part of the standard NHS contract. From April 2016 it has also formed part of the CQC inspections framework under the 'Well Led' domain.
3.2	A fundamental component to enable making progress against this standard is staff engagement and involvement.

4.0 DATA ANALYSIS – METRICS FOR THE 9 WRES INDICATORS

4.1 WRES 1

	Indicator	31st March 2021		31st March 2022	
		Descriptor	**Indicator**	**Descriptor**	**Indicator**
WRES 1	Percentage of BME staff in Bands 8-9, Very Senior Managers, compared with the percentage of BME staff in the overall workforce *Note: VSM includes Executive Board Members and Senior Medical Staff but excludes Medical and Dental Grades e.g. Medical Consultants. There are a small number of staff with Ethnicity unknown/null and these have also been excluded	Number of BME Staff in Bands 8-9 and VSM	16	Number of BME Staff in Bands 8-9 and VSM	19
		Total Number of Staff in Bands 8-9 and VSM	250	Total Number of Staff in Bands 8-9 and VSM	268
		Percentage of BME Staff in Bands 8-9	**6.40%**	**Percentage of BME Staff in Bands 8-9**	**7.09%**
		Number of BME Staff in overall workforce	788	Number of BME Staff in overall workforce	959
		Number of Staff in overall workforce (including all staff groups and not disclosed staff)	6982	Number of Staff in overall workforce (including all staff groups and not disclosed staff)	6973
		Percentage of BME Staff in overall workforce	**11.28%**	**Percentage of BME Staff in overall workforce**	**13.75%**

The table above shows that in 2022 BME staff represents 13.75% of all staff in AfC bands 1-9, Medical workforce and Very Senior Managers (VSM's). This is an increase on last year of 2.47%. The increase in BME representation is largely due to an increase in BME staff within the medical and dental workforce. The percentage of BME staff in a Band 8 position or above (including VSM) has increased, from 6.4% in 2021 to 7.09% in 2022. It also shows that there is a lower percentage of BME staff in Bands 8-9 and VSM compared to BME representation within the overall workforce (13.75%).

As recommended by NHS England, Medical and Dental Grades (which includes Trainee Grades) are excluded in the Bands 8-9 and VSM figures as these groups generally have a much higher proportion of BME staff. This staff group in 2021 consisted of 424 BME staff and 135 white staff, and in 2022, 503 BME staff and 138 white staff. The total increase in BME representation within the medical workforce has increased by 7.38%.

The BME workforce should reflect the local population, which across England is very diverse from region to region. The table below gives rounded figures from 2011 Census data to show white and BME populations within the different regions. The 2021 Census data will not be available until late June 2022.

<u>2011 Census data (rounded figures):</u>

Area	White Population	BME Population
England	87%	13%
Yorkshire and Humber	87%	13%
Inner London	55%	45%
North East Lincolnshire	94%	6%
Northern Lincolnshire	93%	7%
East Riding	93%	7%

4.2 **WRES 2**

	Indicator	31st March 2021			31st March 2022		
		Descriptor	**White**	**BME**	**Descriptor**	**White**	**BME**
WRES 2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	Number of shortlisted applicants	10469	4339	Number of shortlisted applicants	3928*	717*
		Number appointed from shortlisting	1119	77	Number appointed from shortlisting	1003	125
		Ratio shortlisted / appointed	1119/10469	77/4339	Ratio shortlisted / appointed	1003/3928	125/717
		Likelihood candidates are appointed from shortlisting	**0.107**	**0.018**	Likelihood candidates are appointed from shortlisting	**0.255**	**0.174**
		The relative likelihood of White staff being appointed compared to BME staff is 0.107/0.018= **6.02 greater**			The relative likelihood of White staff being appointed compared to BME staff is **1.46 greater**		

** The significant reduction in number of applicants shortlisted is due to a process change to how job adverts are managed through the NHS TRAC system.

The above table shows the relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts. The data periods used are between 1st April 2020 and 31st March 2021 and, 1st of April 2021 and 31st March 2022. The 2020/21 data shows white staff have a likelihood that is 6.02 times greater than BME staff to be appointed from shortlisting. In 2021/22 this likelihood decreased, to a ratio of white staff having a 1.46 times greater chance of being appointed from shortlisting compared to BME applicants, which shows a significant improvement.

As a comparator from the 2021 WRES data the National Picture shows that white staff are 1.61 times more likely to be appointed from shortlisting than BME staff.

4.3 **WRES 3**

	Indicator	31st March 2021				31st March 2022			
		Descriptor	**White**	**BME**	**Unknown**	**Descriptor**	**White**	**BME**	**Unknown**
WRES 3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	Number of staff in workforce	5934	788	260	Number of staff in workforce	5813	959	201
		Number of staff entering formal disciplinary process	138	35**	12	Number of staff entering formal disciplinary process	78	18	6
		Likelihood of entering a formal disciplinary process	138/5934= 0.023	35/788= 0.044		Likelihood of entering a formal disciplinary process	78/5813= 0.013	18/959= 0.019	
		The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is therefore 0.044/0.023= 1.91 **(more likely to enter a formal disciplinary)**				The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is therefore 0.019/0.013= 1.4 (**more likely to enter a formal disciplinary)**			

*Note: this indicator is based on data from a two-year rolling average of the current year and the previous year.

The table above shows the relative likelihood of BME staff entering a formal disciplinary process compared to white staff. In 2021** the relative likelihood of BME staff entering a formal disciplinary process compared to white staff was 1.91, showing that BME staff were nearly twice as likely to enter the disciplinary process compared to white staff. In 2022, the relative likelihood of BME staff entering a formal disciplinary process compared to white staff decreased to 1.4.

**The high number of disciplinary sanctions for BAME staff in 2021 was due to concerns that were raised to the Head of Nursing in April 2020, in relation to unauthorised access to a patient's information which led to a full HR investigation. As a result of that investigation a number of staff where issued with a sanction. In total, 102 White staff / 32 BAME / 10 Ethnicity not stated or declared.

4.4 **WRES 4**

	Indicator	31st March 2021				31st March 2022			
		Descriptor	**White**	**BME**	**Unknown**	**Descriptor**	**White**	**BME**	**Unknown**
WRES 4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	Number of staff in workforce	5934	788	260	Number of staff in workforce	5813	959	201
		Number of staff accessing mandatory training	5306	735	246	Number of staff accessing mandatory training	4985	884	182
		Likelihood of accessing non-mandatory training	5306/5934 = 0.89	735/788= 0.93		Likelihood of accessing non-mandatory training	4985/5813= 0.86	884/959= 0.92	
		The relative likelihood of BME staff accessing non-mandatory training compared to White staff is therefore **0.93/0.89= 0.96 more likely**				The relative likelihood of BME staff accessing non-mandatory training compared to White staff is therefore 0.92/0.86= **1.07 more likely**			

The relative likelihood of BME staff accessing non-mandatory training in 2021 0.96 times more likely than white staff. In 2022, the relative likelihood of BME staff accessing non-mandatory training was 1.07 times more likely than White staff. Therefore, BME staff are more likely to access non-mandatory training and Continuous Professional Development (CPD) than white staff. There has been a decrease in the percentage of BAME staff accessing non mandatory training this due to the higher number of BAME staff employed in the organisation. An additional 149 BAME staff accessed non mandatory training in 2022.

4.5 **NHS Staff Survey 2021**

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

	Indicator	2020 Staff Survey Result		2021 Staff Survey Result	
WRES 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Ethnicity	%	Ethnicity	%
		White	21.80%	White	22.0%
		BME	24.60%	BME	31.9%
		Average Acute Trust score White 25.4 % BME 28.0%		Average Acute Trust score White 26.5% BME 28.8%	

4.6 **WRES 5**

BME staff report a 9.9% higher negative experience than their white colleagues. There has been an increase of 7% from the 20/21 for BME staff. This is above the average acute Trust score for both White and BME staff.

WRES 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Ethnicity	%	Ethnicity	%
		White	30.3%	White	28.80%
		BME	38.3%	BME	38.10%
		Average Acute Trust score White 24.4% BME 29.1%		Average Acute Trust score White 23.6% BME 28.5%	

4.7 **WRES 6**

There has been a slight decrease in staff experiencing harassment, bullying or abuse from colleagues for white staff. Although it remains the same for BME staff in 21 and 22, this is significantly worse for our BME staff with a gap of 9.3% between white and BME staff. This is 10% higher that the national acute trust average.

WRES 7	Percentage believing that trust provides equal opportunities for career progression or promotion	Ethnicity	%	Ethnicity	%
		White	52.00%	White	53.50%
		BME	48.40%	BME	40.10%
		Average Acute Trust score White 59.4% BME 45.2%		Average Acute Trust score White 58.6% BME 44.6%	

WRES 7

In 2020, 48.4% of BME staff felt that the trust provides equal opportunities for career progression or promotion. However, this percentage has decreased to 40.1% in 2021. It remains below the national average.

4.8

WRES 8	In the last 12 months have you personally experienced discrimination at work from the Manager/team leader or other colleagues		

Ethnicity	%
White	6.8%
BME	18.9%

Average Acute Trust score
White 6.1%
BME 16.8%

Ethnicity	%
White	8.50%
BME	21.40%

Average Acute Trust score
White 6.7%
BME 17.3%

WRES 8

In 2020, BME staff felt 12.1% more likely to have personally experienced discrimination at work from their manager/team leader or other colleagues compared to white staff. This gap increased slightly during 2021 to 12.9%. This is remains higher than the reported National average for BME staff.

4.9

WRES 9	Boards are expected to be broadly representative of the population they serve (data 31/03/22)

Ethnicity	%
White	92.9%
BME	7.1%

Ethnicity	%
White	87.5%
BME	12.1%

WRES 9

The Trust Board BME representation within the last year has risen from 7.1% in 2021 to 12.1% in 2022. The Trust Board BME representation is now closely aligned with the rest of the workforce which stands at 13.75%.

5.0 PROGRESS AND ACTIONS

5.1 **Reporting and Assurance**

- **Progress 2021/2022**
  The Trust Equality and Diversity Strategy and Equality Objective (2018 – 2022) are in place. In addition, an Equality, Diversity and Inclusion (EDI) two year action plan is now under development which will set out our commitment to actions required to redress disparity, progress, timescales and supporting evidence.
- We are continuing to work closely with and support the Trust's Freedom to Speak Up Guardian.
- All staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias.
- All new staff receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias. Additionally, we are launching a new People Leader Induction which will include unconscious bias and cultural awareness training.

- **Further Actions 2022/2023**
  - To ensure that all WRES actions are monitored through the Equality and Diversity action plan and included in the wider engagement and culture transformation programme of work.
  - Ensure the EDI action plan is regularly up dated and new actions are developed as required.
  - To provide reports on progress against the EDI action plan.
  - As part of strengthening culture awareness ensure that our staff equality networks (BAME Network) are represented and actively involved in the EDI Working Group and the Culture Transformation Working Group.
  - To look are breaking down data (where this is possible) to identify hotspot areas and take more bespoke action.

5.2 **Workforce and Recruitment**

- **Progress 2021/2022**
  All recruitment panels now include an equality representative. The Trust's Head of Recruitment has worked with the Trust EDI Lead through the Recruitment Review to ensure that all stages of the recruitment processes are fair and free from discrimination.

- **Further Actions 2022/2023**
  - To monitor recruitment and retention of staff and particularly, explore reasons staff leave the Trust by protected characteristic, and to identify any outliers.
  - To develop a Trust training package to strengthen cultural awareness and to recognise, understand and effectively manage unconscious bias within the recruitment process.

5.3 **Disciplinary and Staff Experience**

- **Progress 2021/2022**
  A key focus has been to engage with our staff and increase the visibility of EDI support in the workplace. Therefore, to give all staff an opportunity to openly discuss their concerns and experience we have held at least two face to face EDI engagement events each month so far in 2021/22. We have had over 800 conversations with a diverse range of staff this year to date. As part of these conversations we have also

	included Health and Wellbeing support as we recognise that staff from minority groups often have additional challenges in accessing this type of support. We have appointed a Chair for our BAME staff equality network and have grown our membership of our BAME Facebook group to over 70 members. In addition, to expand a reach out to our minority staff further we have launched an equality Twitter account @nlag4inclusion and the followers of the account are quickly growing, strengthening our social media promotion of the work we are doing. To support our new overseas nursing recruits we have introduced a face to face Equality, Diversity and Inclusion awareness session as part of their induction programme. • **Further Actions 2022/2023** We are continuing to grow our BAME staff equality network. To ensure the network is able to influence decision making which shapes and influences their employee experience we will shortly form an EDI working group. This working group will inform the Trust's new Culture Transformation Programme and Leadership Strategy.
5.4	**Trust Board and Senior Leadership** • **Progress 2021/2022** We recognise that Trust Board and the senior leadership community has some elements of diversity. However, due to the small numbers these percentages are very fragile. We continue to review our data intermittently. • **Further Actions 22022/2023** To interrogate in more detail the diversity within the senior leadership community to understand areas of under-representation and consider what positive actions are required to address the gaps.
6.0	**The report to be received.**
6.1	To note the contents of this report against the NHS Workforce Race Equality Standard.
6.2	Approve the data content which we are required to share with NHS England and our commissioners.
6.3	To note the actions proposed for 22/23 and to monitor progress of those actions and wider culture transformation programme through the Workforce Committee.

NLG(22)128

<table>
<tr><td>Name of the Meeting</td><td>Trust Board of Directors</td></tr>
<tr><td>Date of the Meeting</td><td>02 August 2022</td></tr>
<tr><td>Director Lead</td><td>Christine Brereton, Director of People</td></tr>
<tr><td>Contact Officer/Author</td><td>Karl Portz, Equality, Diversity & Inclusion Lead
Nico Batinica, Associate Director Workforce and Recruitment</td></tr>
<tr><td>Title of the Report</td><td>Workforce Disability Equality Standards (WDES) Annual Report</td></tr>
<tr><td>Purpose of the Report and Executive Summary (to include recommendations)</td><td>
The purpose of this paper is to report to the Trust Board the Workforce Disability Equality Standard (WDES) annual report/data for 21/22. Data is required to be published by no later than 31st August 2022. This report has been submitted to the TMB and the Workforce Committee.
WDES data is reported by 10 key indicators, which is taken from ESR (indicator metrics: 1, 2 and 10) and automatically from the annual staff survey (indicator metrics 4-9). Metric 3 is a two year average score.
The statistics showed a mixed picture of some improvement and some deterioration from our position in 2021 Metrics 1-3 and Metric 10, and 2020 for Metrics 4 – 9 a&b:
<table>
<tr><td>Indicator</td><td>Compared to 2021 Metrics 1, 2 and 10, and 2020 for Metrics 4 – 9 a & b</td></tr>
<tr><td>Metric 1 – Workforce overall</td><td>Improved</td></tr>
<tr><td>Metric 2 – Recruitment</td><td>Same</td></tr>
<tr><td>Metric 3 – Disciplinary</td><td>Two year average</td></tr>
<tr><td>Metric 4 – Bullying and Harassment from:
Service users/relatives /public
Managers
Colleagues
Reporting incidents of bullying and harassment</td><td>
Improved
Improved
Improved
Deteriorated</td></tr>
<tr><td>Metric 5 – Career Opportunities</td><td>Improved</td></tr>
<tr><td>Metric 6 – Pressure to attend work if unwell</td><td>Improved</td></tr>
<tr><td>Metric 7 – Organisation values their work</td><td>Deteriorated</td></tr>
<tr><td>Metric 8 – Adequate reasonable adjustments made</td><td>Deteriorated</td></tr>
<tr><td>Metric 9 – Staff engagement</td><td>Deteriorated</td></tr>
<tr><td>Metric 10 – Trust Board Representation</td><td>Deteriorated</td></tr>
</table>
In 2021 we have relaunched our staff network group for our Disabled staff network and members will form part of the Culture Transformation Working Group which was launched in June. A key focus of our culture transformation work will be to focus on values, behaviours and leadership aimed at improving all staff experience especially those where evidence suggest (such as WDES) that experience is worse.
</td></tr>
</table>

Background Information and/or Supporting Document(s) (if applicable)	The Workforce Disability Equality Standard (WDES) was introduced from the NHS Equality and Diversity Council (EDC) and forms part of the standard NHS contract. From April 2019 is has also formed part of the inspection framework under the "Well Led" domain.	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	As outlined in the report	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Disability Equality Standard Report for Workforce Committee Board

1.0	**PURPOSE OF THE REPORT**
1.1	To update the Workforce Committee on progress against the Workforce Disability Equality Standard Indicators. https://www.england.nhs.uk/wp-content/uploads/2019/01/wdes-2021-metrics.pdf
1.2	To update the Workforce Committee on our submission and the data, as per our contractual requirements.
1.3	To highlight key priorities and actions required to make improvements against the Workforce Disability Equality Standard.
2.0	**BACKGROUND/CONTEXT**
2.1	As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and will be at the heart of our People Strategy. The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect. NHS England, with its partners, is committed to tackling discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients and the delivery of high-quality healthcare.
2.2	The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS. The WDES follows the NHS Workforce Disability Equality Standard (WDES) as a tool and an enabler of change.
2.3	The Workforce Disability Equality Standard is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local actions to enable them to demonstrate progress against the indicators of disability equality.
2.4	The WDES is mandated through the NHS Standard Contract and as of the 1st April 2019, it forms part of the standard NHS contract and it is highly likely to form part of future Care Quality Commission inspections under the 'Well Led' domain.
2.5	It was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
2.6	The implementation of the WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees and enable a more inclusive environment for our disabled staff.

	The report must be published by 31 August 2022 and based on the data from the 2021-22 financial year. A key component to making progress against this standard is staff engagement and involvement.

3.0 DATA ANALYSIS – METRICS

3.1 Metric 1

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

This data was collected from ESR as at 31 March 2021 and 31 March 2022.

Metric 1a Non-Clinical Workforce							Mar-21	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	52	3.00%	1519	86.70%	181	10.30%	1752	81.20%
Cluster 2: AfC Band 5 – 7	8	2.70%	264	89.20%	24	8.10%	296	13.70%
Cluster 3: AfC Band 8a – 8b	4	6.50%	56	90.30%	2	3.20%	62	2.90%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	1	2.10%	45	95.70%	1	2.10%	47	2.20%
Total	**65**	**3.01%**	**1884**	**87.34%**	**208**	**9.64%**	**2157**	

Metric 1a Non-Clinical Workforce							Mar-22	
	Disabled		Non-Disabled		Unknown or Null		Total Number of Staff	
	Number of Staff	%	Number of Staff	%	Number of Staff	%	Number of Staff	%
Cluster 1: AfC Bands 1 – 4	55	3.17%	1519	87.50%	162	9.33%	1736	80.48%
Cluster 2: AfC Band 5 – 7	10	3.28%	272	89.18%	23	7.54%	305	14.14%
Cluster 3: AfC Band 8a – 8b	5	7.14%	62	88.57%	3	4.29%	70	3.25%
Cluster 4: AfC Band 8c, 8d, 9	1	2.17%	45	97.83%	0	0.00%	46	2.13%

& VSM (inc Exec Board)								
Total	**71**	**3.29%**	**1898**	**87.99%**	**188**	**8.72%**	**2157**	

Metric 1b Clinical Workforce							**Mar-21**	
	Disabled		**Non-Disabled**		**Unknown or Null**		**Total Number of Staff**	
	Number of Staff	**%**	**Number of Staff**	**%**	**Number of Staff**	**%**	**Number of Staff**	**%**
Cluster 1: AfC Bands 1 – 4	39	2.50%	1351	86.50%	172	11.00%	1562	32.40%
Cluster 2 : AfC Band 5 – 7	75	3.00%	2108	85.60%	281	11.40%	2464	51.10%
Cluster 3 : AfC Band 8a – 8b	1	0.90%	101	90.20%	10	8.90%	112	2.30%
Cluster 4: AfC Band 8c, 8d, 9 & VSM (inc Exec Board)	0	0.00%	31	96.90%	1	3.10%	32	0.70%
Cluster 5: Medical and Dental staff, Consultants	2	0.90%	180	83.30%	34	15.70%	216	4.50%
Cluster 6: Medical and Dental staff, Non-consultant career grade	1	0.60%	126	81.80%	27	17.50%	154	3.20%
Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	3	1.10%	225	78.90%	57	20.00%	285	5.91%
Total	**121**	**2.51%**	**4122**	**85.43%**	**582**	**12.06%**	**4825**	

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

Non-consultant career grade								
Cluster 7: Medical and Dental staff, Medical and Dental trainee grades	2	0.67%	246	82.00%	52	17.33%	300	6.23%
Total	**146**	**3.03%**	**4192**	**87.04%**	**478**	**9.93%**	**4816**	

In the tables, metric 1a and metric 1b clearly show that the percentage of disabled staff in both the non-clinical and clinical workforce is very low standing at 3.11% of the total (combined non clinical and clinical workforce workforce) .This percentage has increased slightly by 0.45% from 2021. This is comparable to what is reported nationally across NHS trusts (3.7% disabled staff worked within NHS in 2021). The tables above highlight that there is a high proportion of the workforce which record their disability status as either unknown or a null response, although there are fewer unknown recordings when compared to last year (a reduction of 1.8%). Medical and dental staff have a higher number of unknown and null responses as well as lower disability declaration rates when compared to the non-clinical and clinical workforce.

3.2

Metric 2

The table below shows the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts for 2020-21 and 2021-22.

	Indicator	2020-21			2021-22		
Metric 2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**	**Descriptor**	**Disabled Staff**	**Non-Disabled Staff**
		Number of shortlisted applicants	698	14081	Number of shortlisted applicants	287	4337
		Number appointed from shortlisting	33	1147	Number appointed from shortlisting	42	1080
		Ratio shortlisted/ appointed Likelihood candidates are appointed from shortlisting	33/698= 0.05	1147/14081= 0.08	Ratio shortlisted / appointed Likelihood candidates are appointed from shortlisting	42/287= 0.15	1080/4337= 0.25
		The Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff is 1.6			The Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff is 1.67		

Note: This refers to both external and internal posts.

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

The data shows that the likelihood of disabled staff and non-disabled staff being appointed from shortlisting in 2020-21 was that non-disabled staff were 1.6 times more likely to be appointed from shortlisting compared to disabled staff, in 2021-22 the ratio remained largely unchanged to show that non-disabled staff were 1.67 times more likely to be appointed from shortlisting.

*It should also be noted that NLaG as part of the Department of Work and Pensions scheme are a Disability Confident Employer, and therefore operate a guaranteed interview scheme for disabled applicants who meet the minimum person specification.

3.3 **Metric 3**

Metric 3 explores the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. Data is based on the number of staff entering the formal capability procedure from a two-year rolling average of the current year and the previous year and includes capability cases with and without underlying health reasons (UHR).

	Indicator	No UHR				UHR			
Metric 3	The relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. This has been split by UHR and No UHR.	Average number of **Disabled staff** entering the formal capability process 2020 - 2022	Average number of **Non-Disabled staff** entering the formal capability process 2020 - 2022	Average number of **Unknown/Null** staff entering the formal capability process 2020 - 2022	Average number of staff entering the formal capability process 2020 - 2022	Average number of **Disabled staff** entering the formal capability process 2020 - 2022	Average number of **Non-Disabled staff** entering the formal capability process 2020 - 2022	Average number of **Unknown/Null** staff entering the formal capability process 2020 - 2022	Average number of staff entering the formal capability process 2020 - 2022
		1	4	1	5*	1	22	5	27*

	No UHR	UHR
Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	7.02	1.28

Note: A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

*Please note these totals are a two year average of all staff entering a formal capability process.

Due to small number of disabled staff in the Trust (217) compared to non-disabled staff (6090), with 666 unknowns. Disabled staff with an Underlying Health Reason (UHR) are 1.28 times more likely to enter the formal capability process than non-disabled staff. Disabled staff without a UHR are 7.02 times more likely to enter a capability process than non-disabled staff. The figure for No UHR is significantly higher than the figure for UHR due to the low number of disabled staff in the organisation compared to non-disabled staff.

3.4 **2021 NHS Staff Survey Results Analysis Metrics 4, 5, 6, 7, 8 and 9a**

The metrics 4, 5, 6, 7, 8 and 9a overleaf represent unweighted question level responses to key findings in the NHS for NLaG staff. The staff survey results surrounding the disabled workforce between 2020 and 2021 are similar, with slight improvements to some of the metrics.

	Metric	2020 Staff Survey Result		2021 Staff Survey Result	
Metric 4.1	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months	Disabled	29.60%	Disabled	28.00%
		Non-disabled	19.90%	Non-disabled	21.00%
		NHS Average Score		NHS Average Score	
		Disabled	30.90%	Disabled	32.40%
		Non-disabled	24.50%	Non-disabled	25.20%
Metric 4.2	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	Disabled	26.50%	Disabled	22.50%
		Non-disabled	13.10%	Non-disabled	11.90%
		NHS Average Score		NHS Average Score	
		Disabled	19.30%	Disabled	18.00%
		Non-disabled	10.80%	Non-disabled	9.80%
Metric 4.3	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Disabled	34.50%	Disabled	30.70%
		Non-disabled	19.90%	Non-disabled	20.30%
		NHS Average Score		NHS Average Score	
		Disabled	26.90%	Disabled	26.60%
		Non-disabled	17.80%	Non-disabled	17.10%
Metric 4.4	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	Disabled	50.20%	Disabled	42.90%
		Non-disabled	43.20%	Non-disabled	44.00%
		NHS Average Score		NHS Average Score	

		Disabled	47.00%	Disabled	47.00%
		Non-disabled	45.80%	Non-disabled	46.20%

Metric 4

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

- Patient's, relatives or the public is 7% higher for disabled staff than non-disabled staff. However, this is remains below the national NHS average
- Managers is 10.6% higher for disabled staff than non-disabled staff. There is a reduction from 21 to 22 of 4%. This remains above the national average score
- Other colleagues are 10.4% higher for disabled staff than non-disabled staff. Similar to 21 and still above the national average
- Disabled staff are less likely to report harassment, bullying or abuse at work than non-disabled staff.

Metric 5	Percentage believing that the Trust provides equal opportunities for career progression or promotion	Disabled	45.70%	Disabled	47.20%
		Non-disabled	53.30%	Non-disabled	53.90%
		NHS Average Score		NHS Average Score	
		Disabled	51.60%	Disabled	51.40%
		Non-disabled	57.40%	Non-disabled	56.80%

Metric 5

Disabled staff are 6.7% less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff. This has slightly increased from 21.

Metric 6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled	36.90%	Disabled	35.80%
		Non-disabled	23.40%	Non-disabled	26.40%
		NHS Average Score		NHS Average Score	
		Disabled	33.00%	Disabled	32.20%
		Non-disabled	23.40%	Non-disabled	23.70%

Metric 6

Disabled staff felt 9.4% more pressured to attend work, despite not feeling well enough to perform their duties compared to non-disabled staff.

Metric 7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	28.00%	Disabled	26.70%
		Non-disabled	42.30%	Non-disabled	36.80%
		NHS Average Score		NHS Average Score	
		Disabled	37.40%	Disabled	32.60%
		Non-disabled	49.30%	Non-disabled	43.30%

Metric 7

Disabled staff felt 10.1% less satisfied that the organisation valued their work compared to non-disabled staff.					
Metric 8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled	72.00%	Disabled	70.50%
		NHS Average Score		NHS Average Score	
		Disabled	75.50%	Disabled	70.90%
Metric 8 70.5% of disabled staff from the staff survey feel we have made adequate adjustments to enable them to carry out their work. A 1.5% reduction compared to the previous year, but in line with the national average.					
Metric 9 Part a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Disabled	6.1	Disabled	6.0
		Non-disabled	6.7	Non-disabled	6.6
		Organisation Score	6.6	Organisation Score	6.4
		NHS Average Score		NHS Average Score	
		Disabled	6.7	Disabled	6.4
		Non-disabled	7.1	Non-disabled	7.0
Metric 9a The engagement score for disabled staff is 0.6 less than that of non-disabled staff therefore disabled staff feel less engaged with compared to non-disabled staff.					
Metric 9 Part b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) If no what actions are planed?	Yes As part of the Trust's Equality Objectives plans the Trust has developed a Disability Network to give disabled staff a voice.		Yes As part of the Trust's Equality Objectives plans the Trust has developed a Disability Network to give disabled staff a voice.	

Metric 10

Metric 10	The percentage of NLaG Board and Executive Team who classify themselves as having a disability or long-term condition at 31 March 22.	**31-Mar-21**			
		Trust Board and Executive Team	**Disabled**	**Non-Disabled**	**Not Declared**
			7.14%	85.71%	7.14%
		31-Mar-22			
		Trust Board and Executive Team	**Disabled**	**Non-Disabled**	**Not Declared**
			12.1%	93.75%	0.00%

The percentage of NLaG Board and Executive Team members who classify themselves as having a disability has improved from last year, 7.14% in 2021 and 12.1% in 2022.

4.0 PROGRESS AND ACTIONS

4.1 **Reporting and Assurance**

- **Progress 2021/2022**
  The Trust Equality and Diversity Strategy and Equality Objective (2018 – 2022) are in place. An Equality, Diversity and Inclusion (EDI) two-year action plan is now under development which will set out our commitments to actions required, progress, timescales and supporting evidence including actions for WDES.
- We are continuing to work closely with and support the Trust's Freedom to Speak Up Guardian.
- All existing staff and managers, as part of their mandatory training, receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias.
- All new staff receive equality, diversity and inclusion training which has a focus on inclusive behaviours and exploring unconscious bias.
- The Trust's CEO has been appointed as the joint chair of the NHS CEO National Disability Forum and actively supports this agenda.

- **Further Actions 2022/2023**
  - To ensure that all WDES actions are monitored through the EDI action plan and included in the wider engagement and culture transformation work and plans.
  - Ensure the EDI action plan is regularly up dated and new actions are developed as required.
  - To provide reports on progress against the EDI action plan.
  - As part of strengthening culture awareness ensure that our staff equality networks (Disability Network) are represented and actively involved in the EDI Working Group, and the Culture Transformation Working Group.
  - To look are breaking down data (where this is possible) to identify hotspot areas and take more bespoke action.

Workforce and Recruitment

4.2

- **Progress 2021/2022**
  All recruitment panels now include an equality representative. The Trust's Head of Recruitment has worked with the Trust EDI Lead to ensure that all stages of the recruitment processes are fair and free from discrimination. We continue to promote the values of disability and be a disability confident employer.

- **Further Actions 2022/2023**
  - To monitor recruitment and retention of staff and particularly, explore reasons staff leave the Trust by protected characteristic, and to identify any outliers.
  - To develop a Trust training package to strengthen cultural awareness and to recognise, understand and effectively manage unconscious bias within the recruitment process.
  - We have recently been approved and are entering into DFN Project SEARCH helping young people with learning disabilities to transition from education into employment.

4.3 **Capability and Staff Experience**

- **Progress 2021/2022**
  A key focus has been to engage with our staff and increase the visibility of EDI support in the workplace. Therefore, to give all staff an opportunity to openly discuss their concerns and experience we have held at least two face to face EDI engagement

	events each month. We have had over 800 conversations with a diverse range of staff this year. As part of these conversations we had also included Health and Wellbeing support as we recognise that staff from minority groups often have additional challenges in accessing this type of support. We have appointed a disability staff equality network and have grown our membership of our Disability Facebook Group to over 35 members. In addition, to expand a reach out to our minority staff further we have launched an equality Twitter account @nlag4inclusion and the followers of the account are quickly growing. To support our new overseas nursing recruits we have introduced a face to face Equality, Diversity and Inclusion awareness session as part of their induction programme. • **Further Actions 2022/2023** We are continuing to grow our Disability staff equality network and to ensure the network is able to influence decision making which shapes and influences their employee experience. We will shortly form an EDI working group which will inform the Trust's new Culture Transformation and Leadership Strategy.
4.4	**Trust Board and Senior Leadership** • **Progress 2021/2022** We recognise that Trust Board and the senior leadership community has some elements of diversity. However, due to the small numbers these percentages are very fragile therefore, we are conducting a deep dive into our data. • **Further Actions 22022/2023** To interrogate in more detail the diversity within the senior leadership community to understand areas of under-represented and consider what positive actions are required to address the gaps.
5.0	**Recommendations.**
5.1	To note the contents of this report against the NHS Workforce Disability Equality Standard.
5.2	Approve the data content which we are required to share with NHS England and our commissioners.
5.3	To note the actions proposed for 22/23 and to monitor progress of those actions and wider culture transformation programme through the Workforce Committee.

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	2 August 2022	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance Matt Clements, Assistant Director of Finance, Financial Management	
Title of the Report	**Finance Report M01**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of M03 of the 2022/23 reporting period.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: F&P Committee – 20 07 22
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Finance Report Month 3

June – 2022/23

Executive Summary Month 2 2021/22

NHS Northern Lincolnshire and Goole NHS Foundation Trust

The Trust had a £0.60m deficit in May, £0.99m worse than plan. The Trust now has a £1.26m year-to-date deficit, £2.34m worse than plan.

Income was £0.02m below plan in month.

• The ERF income plan was again recognised as fully achieved, per system requirements. However the Trust did not achieve the 104% activity target for May despite spending the Capacity Reserve set aside in the plan, meaning an estimated £1.35m Elective Recovery Funding received year-to-date is at risk of being removed if lost activity is not recovered. Electives, day cases and outpatient procedures were all low.

• Other income was £0.02m below plan because of Covid-19 Outside Envelope income, which was £0.09m below plan offset by lower testing costs. The adverse income variance was also offset by minor favourable variances across several areas, but mostly due to increased injury recovery income.

Pay was £0.49m overspent in month.

• Medical staff was £0.75m overspent. Over establishment bookings across Medicine Acute Care and ED caused £0.15m overspends, non delivery of recruitment CIP £0.09m, and premium pay covering sickness and vacancies caused overspends in Geriatrics (£0.07m), ENT (£0.06m) and Ophthalmology (£0.05m). £0.17m overspends across the trust were due to waiting list payments, but these are mostly not resulting in achieved ERF due to low productivity vs 19-20. £0.12m Anaesthetics overspends were due to consultant intensivists awaiting job plans and premium pay covering vacancies. Staff covering UCS GP contracts caused a £0.08m overspend but is offset by non-pay underspends. A cost pressure in T&O (hot clinics, £0.04m) is awaiting business cases to be approved or services to be stood down.

• Nursing was £0.16m underspent in month. However, £0.17m vacancy underspends across Maternity, Community District Nursing and NICU, £0.03m trainee ACP underspends obscure cost pressures that would otherwise amount to £0.65m from circa 60 additional escalation beds. Additional duties in ED and SDEC agency premiums (£0.14m) are the other key overspends.

• Other Pay was £0.6m underspent. Over-delivery of non-recurrent CIP within Corporate functions masks overspends across E&F admin (£0.05m) and support staff (£0.03m) due to 6-week HSA training and sickness, and in the Workforce Resource centre due to overspends on Care Navigators and Site Management.

Non Pay was £0.51m overspent in month

• This was mainly because of clinical supplies (£0.66m overspent). This was partly offset by outsourcing being £0.2m lower than plan. The £0.46m balance was mainly due to £0.05m Path chemistry activity/supplies (partly offset by pay underspends), and Surgery clinical supply overspends in Urology (£0.1m due to day cases being 12% higher than 19-20) and General Theatres £0.24m. Although General Theatres ERF activity is below plan, Surgical non-elective patients have increased by 29% vs 19-20, including trauma 7%, General Surgery 54% and colorectal 85%. The General Theatres spend has also been affected by a change in use of energy sealing devices to aid recovery, which requires a business case for a detailed financial impact analysis. Cardiology (Pacemakers) £0.04m was also overspent but was not offset by ERF, so needs further investigation.

Post EBITDA items were £0.07m underspent in month

• This was mainly due to a high cash balance in the month, resulting in interest received and a reduced PDC charge.

COVID-19 expenditure was £1.75m year-to-date

• This was £0.28m below plan. Inside envelope costs need reducing urgently as the income is non-recurrent.

Income & Expenditure to 30th June 2022

Income & Expenditure	Annual Plan to 31st March 2023 £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Income	374,338	31,194	31,082	(112)	93,579	93,598	19
ERF Income	0	0	0	0	0	0	0
TIF	0	0	0	0	0	0	0
Block Top Up	58,394	4,866	4,932	65	14,599	14,599	(0)
Covid Inside Envelope Block	11,387	949	949	(0)	2,847	2,847	(0)
Covid Outside the Envelope	1,700	142	51	(91)	425	220	(205)
Other Income	39,338	3,220	3,338	117	9,637	10,275	638
Donated Income	0	0	0	0	0	113	113
Total Operating Income	**485,157**	**40,372**	**40,351**	**(20)**	**121,086**	**121,651**	**565**
Clinical Pay	(256,495)	(20,888)	(22,003)	(1,115)	(64,416)	(66,915)	(2,499)
Other Pay	(65,707)	(6,073)	(5,446)	627	(16,494)	(16,494)	(0)
Total Pay	**(322,203)**	**(26,960)**	**(27,449)**	**(488)**	**(80,909)**	**(83,409)**	**(2,500)**
Clinical Non Pay	(70,187)	(5,572)	(6,340)	(768)	(16,717)	(17,796)	(1,079)
Other Non Pay	(71,403)	(5,800)	(5,544)	257	(17,489)	(16,768)	722
Total Non Pay	**(141,590)**	**(11,372)**	**(11,884)**	**(512)**	**(34,206)**	**(34,563)**	**(357)**
Operating Expenditure	**(463,793)**	**(38,333)**	**(39,333)**	**(1,000)**	**(115,116)**	**(117,973)**	**(2,857)**
EBITDA	**21,364**	**2,039**	**1,018**	**(1,021)**	**5,971**	**3,679**	**(2,292)**
Depreciation	(16,169)	(1,252)	(1,267)	(15)	(3,689)	(3,799)	(110)
Interest Expenses & Other Costs	(233)	(19)	30	49	(58)	63	121
Dividend	(6,251)	(488)	(448)	40	(1,463)	(1,292)	171
Total Post EBITDA Items	**(22,653)**	**(1,759)**	**(1,685)**	**74**	**(5,210)**	**(5,028)**	**182**
Remove Capital Donated I&E Impact	1,289	107	68	(39)	322	92	(230)
Remove Impairments (allowable)	0	0	0	0	0	0	0
Remove variance on gains on disposals	0	0	0	0	0	0	0
Remove net impact of consumables donated from other DHSC b	0	0	0	0	0	0	0
Remove net loss on disposal of DHSC donated equipment	0	0	0	0	0	0	0
I&E Surplus / (Deficit)	**0**	**387**	**(599)**	**(986)**	**1,083**	**(1,257)**	**(2,340)**

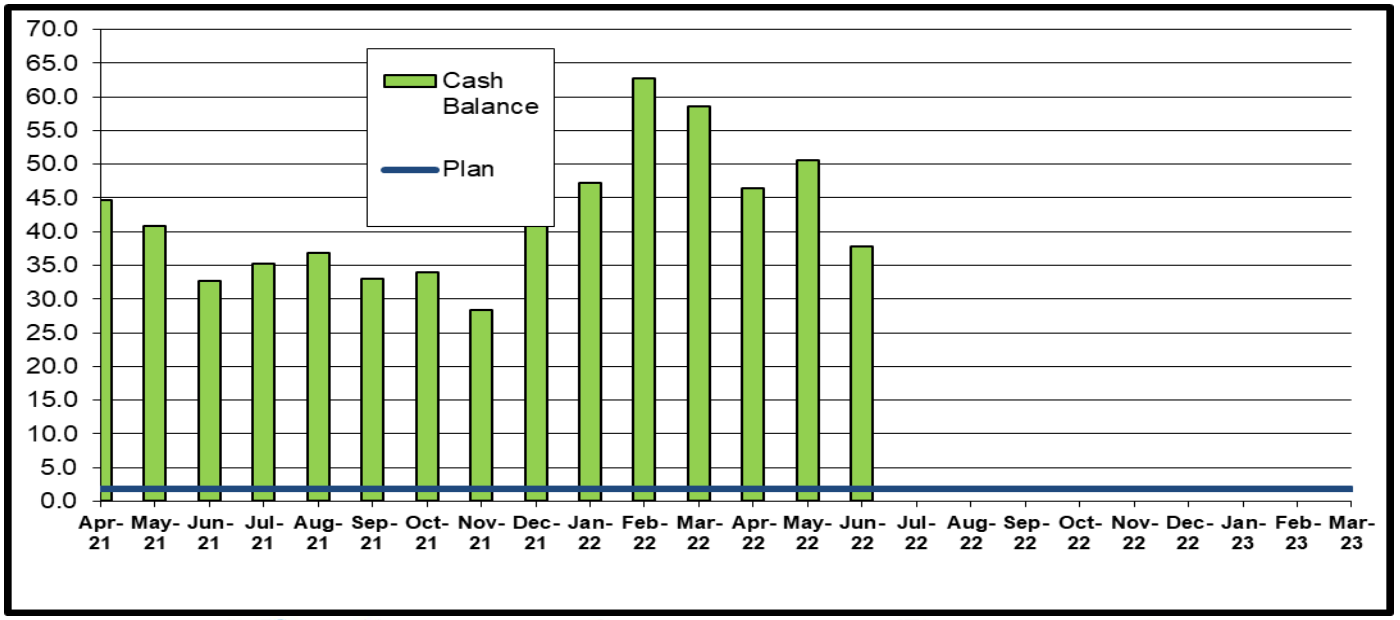
COVID-19 Expenditure

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	1,099	0	1,099
Backfill for higher sickness absence	305	0	305
Decontamination	0	91	91
After care and support costs (community, mental health, primary care)	0	15	15
COVID Medicine Delivery Unit (CMDU) service	23	0	23
COVID-19 virus testing - rt-PCR virus testing	36	6	42
COVID-19 virus testing - Rapid / point of care testing - locally procured reagents costs	87	89	175
Total COVID-19 Expenditure	1,548	201	1,749
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	83,409	34,563	117,972
COVID-19 % of Total Trust Operating Expenditure	1.9%	0.6%	1.5%

Cash

The cash balance at 30th June was £37.86m, an in-month reduction of £12.7m.

	£m	£m
Cash Balance as at 30th June		**37.86**
Commitments:		
Income received in advance	1.64	
Capital creditors	5.67	
Capital plan underspend	3.69	
Capital loan repayments	0.17	
June PAYE/NI/Pension	11.57	
Public Dividend Capital payment	1.29	
To support other creditors due	11.94	
		(35.96)
NHSi minimum balance		**1.90**



Balance Sheet as at 30th June 2022

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	259.73	262.64
Stocks & WIP	3.65	3.48
Debtors	10.87	12.95
Prepayments	4.53	5.92
Cash	50.58	37.86
Total Current Assets	69.63	60.20
Creditors : Revenue	44.04	40.94
Creditors : Capital	8.67	5.67
Accruals	20.36	21.55
Deferred Income	2.86	1.64
Finance Lease Obligations	2.00	1.82
Loans < 1 year	0.67	0.69
Provisions	1.55	2.01
Total Current Liabilities	80.16	74.31
Net Current Assets/(Liabilities)	(10.53)	(14.11)
Debtors Due > 1 Year	1.25	1.25
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	8.21	8.21
Finance Lease Obligations > 1 Year	14.48	14.48
Provisions - Non Current	5.50	5.50
TOTAL ASSETS/(LIABILITIES)	222.27	221.60
TOTAL CAPITAL & RESERVES	222.27	221.60

- Stock has reduced in month following a stocktake in all areas.
- Debtors have increased in month. United Lincs Hospital have outstanding invoices for May and June, these have been settled during the first week of July.
- The Trust cash balance has reduced to £37.86m, the Trust has paid a number of capital invoices and the payments for trade invoices has been higher than in previous months.
- Deferred income reduced again in month following the release of June income from Health Education.
- Revenue creditors and accruals have reduced in month, following an increase in authorisation of invoices/goods receipting of orders. Capital creditors have reduced. The BPPC figures for the Trust continue to be above 90%. The value paid for Non NHS invoices is 92.2% and NHS 95.4%, this is an improvement from previous months. We are continuing to monitor the BPPC and are communicating to staff the importance of authorising invoices.

NLG(22)130

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	2 August 2022	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Finance areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	✓ Pandemic Response ☐ Quality and Safety ✓ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	2nd August 2022
Report From:	Finance & Performance Committee – 22-06-22 and 20-07-22

Highlight Report:

The Trust has a breakeven financial plan for 2022/23 but the Trust now has a £1.26m year-to-date deficit, £2.34m worse than plan. ERF was not achieved as activity had not made plan for May or June. Therefore, £1.35m of Elective Recovery Funding is at risk of potential clawback if activity levels are not recovered in line with plan.

The main pressures were in medical staffing with a number of material overspends across the board. In the Medicine Division ED and acute care amounting to £1.4m overspend. Nursing was in line with the plan but with continued pressures due to escalation beds (£1.6m) which were circa 60 above the funded position offset by underspends in Midwifery.

The Committee queried if the surgery division were being given focus as there seems to be underlying issues within the divisions medical staffing pay, it was confirmed that there are monthly meetings being held with the surgery division to understand their spend.

CIP is slightly behind plan YTD with the main area being predominantly Medical Staffing, however there are plans being put in place to try and recover this position. Non-Recurrent CIP is forecast to be higher than plan and will therefore have knock on effects to future years.

Committee asked for assurance on activity to recover the Q1 deficit to plan of £2.3m which was given.

COVID-19 expenditure is £1.75m year-to-date and despite lower than planned activity levels the Trust is witnessing increased pressure on its Drugs and Clinical Supplies expenditure

The Capital programme is behind plan on ward 25 and ED schemes, there is also a knock-on effect from the ED slippage onto the IAAU plan, which could jeopardise completion within this year.

The underlying financial position to the Trust's planning assumptions removing non-recurrent impacts resulted in a revised underlying deficit of £26.18m in May and £26.90 in June.

The committee questioned whether the ERF programme would be met, assurance was given that the trust will be attempting to meet the necessary activity levels to receive ERF.

The Recovery Support Programme letter was discussed in June.

The national cost collection submission update was discussed and the clinical care levels were highlighted as something that has been brought to attention. The committee questioned the acceptance level of the internal audit report and assurance was given.

The Business Case planning process was discussed with the Executive involvement highlighted as a positive as well as the new scorecard which led to evidence-based decisions. The business cases were shortlisted to 3 per division and anything that affected patient safety was automatically included. The first draft of business cases amounted to £32m but this was then cut to £15m after the first round of exclusions before dropping to £7m. The committee queried how the Board can be assured that the top 3 proposals from the divisions presented to Executives didn't mean some of high merit were lost. Assurance was given that as part of a Lessons Learned review further checks will be put in place at Divisional level in the 2023/24 planning cycle.

The Capital Investment Board minutes were discussed.

Confirm or Challenge of the Board Assurance Framework:

The Committee were assured that the BAF represented the level of risk, controls and mitigations.

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and consider whether any further action is required by the Board at this stage.

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(22)131

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	2nd August 2022
Director Lead	Ivan McConnell, Director of Strategic Development
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, HAS Programme Director
Title of the Report	**Key Issues - Strategic & Transformation**
Purpose of the Report and Executive Summary (to include recommendations)	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 1 - 1.3: To give great care** **Strategic Objective 4: To work more collaboratively** The Board is asked to note: • The progress that is being made on the delivery of the Humber Acute Services critical milestones of Programme 2 Core Service Change • The progress that is being made on the development of a Capital SOC to support major capital investment within NLAG and HUTH • Our continued participation in and leadership of collaborative ventures through partnership working The Board is asked to note that whilst significant progress has been made in the delivery of the agreed milestones for Humber Acute Services there are potentially significant risks and key issues that still remain to future implementation and delivery: • The timing for the approval of the Core Service Change PCBC, and the impact on consultation and implementation, that may have • The risk of not being selected as one of the 21 Trusts asked to submit additional information as part of the New Hospitals Programme limiting our potential access to funding under the National New Hospitals Programme
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ✓ Partnership and System Working ☐ Workforce and Leadership ✓ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5

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

Strategic Service Development and Improvement – July 2022
Strategic Objective 1 (1.3) - To give great care
Strategic Objective 4 – To work more collaboratively

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

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

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

    - Humber Partnership Board
    - Acute Collaborative
    - Community Collaborative
    - Place Boards - North and North East Lincolnshire, East Riding of Yorkshire and working groups
    - HNY Cancer Alliance and associated professional networks
    - HNY Clinical and Professional Leaders Group
    - Community Diagnostic Centres

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

Highlights	Lowlights	Risks
Overall • Continued attendance at the Overview Scrutiny Committees (OSC) • Briefings with MP's/councillors • Continuation of wide ranging local authority engagement – CEO/SLT briefings • Capital development options progressed in line with PCBC • NHSE/I monthly assurance reviews continue with positive challenge and support • Assumptions for P2 and P3 being used as part of acute collaborative modelling of planned care recovery planning • Briefing ICS ET • Joint HUTH/NLaG Board Development Session **Programme 2 (P2):** • Focused Obstetrics/Ockenden workshop held to evaluate longer term impact on draft models of care • Evaluation to inform final potential models of care and options to take through to public consultation progressed with additional analysis (Ockenden impacts, travel, access, workforce, funding, displacement, economic) • Integrated Impact Assessment Tool developed and shared with ICS HASR lead and Governance Trust leads for review before use, methodology being developed for staff engagement in assessing due to commence August 2022 • Formal Clinical Senate review complete – final report received, due to be ratified by senate council end July 22 and published • Further draft PCBC complete • Final version due end July 2022 to inform NHSE/I Gateway Review • Initiated discussions with DHSC equalities lead on key areas to consider in PCBC to support detailed EHIA • ORH ambulance impact modelling commenced – EMAS/YAS fully engaged outputs due early August 22 • Continued engagement with Doncaster and Lincoln health systems re potential displacement activity and EMAS/YAS in terms of potential pathway changes • Briefing held with Primary Care Humber Collaborative and regular attendance at Primary/Secondary interface group and Humber Clinical Leaders Group • Joint Trust Board held 5 July 22 to provide board members with an update on the HAS status and key issues	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes • Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase) • Capital funding sources not yet agreed and potential programme capital costs require funding from internal capital resources and need to sit within ICS CDEL envelope • Delays to capital submission outcomes and potential extension of timelines for delivery of NHP – impact on funding short term BLM and CIR costs • Lack of affordability from internal capital for priority capital investment in the short term • Potentially challenging timeline – latest end of November – to go to consultation otherwise will be delayed till July 2023 – linked to NHSEI Gateway and OCB approvals processes	• Potential impact of timing of approval from ICB for consultation - requirement for pre briefings and engagement • Pathways in P2 look beyond hospital boundaries and require out of hospital transformation • Potential options may be subject to OSC, Public challenge resulting in Independent Review (IRP), Judicial Review (JR) or Secretary of State (SoS) review • Potential options may displace activity to neighbouring health economies • Aligning all out of hospitals programmes to avoid duplication • The delivery of changed pathways will require capital investment in digital as well as wider infrastructure • Planned care pathways must align to wider ICS Elective recovery and Community Diagnostic Hub programme implementation • Potential further COVID wave and impacts on elective delivery and ability to continue with engagement and evaluation of key stakeholders • Potential impact on staff who have been engaged in process due to legislation delay – may lose interest and enthusiasm

Programme 3 (P3)

- Following submission of Expression Of Interest (EOI), workshops progressed the development of the Capital Strategic Outline Case (SOC) aligned to the PCBC
- 5-10 year modelling progressing with agreed assumptions linking to PCBC
- Capital requirements drafted and estimated against each of the PCBC models
- Finalising potential capital development options to be included in a Strategic Outline Case for capital investment to include:
  - Do minimum options
  - Do intermediate options
  - Do maximum – aligned to Capital EOI submitted on 9th September 2021

Partnership and System working

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

Highlights	Lowlights	Risks
Humber and North Yorkshire Health & Care Partnership: NLaG is an active member of a number of Boards/Groups across the Humber and North Yorkshire ICS: • Trust is member of HNY Partnership Board • The Trust is an active member of the Collaboration of Acute Providers Board and other members of the Trust leadership community participate in sub groups • The Trust is an active member of the Community Provider Collaborative • The Trust is actively involved various community collaborative (i.e. Outpatients Transformation, Planned Care Programme, Diagnostics, Urgent & Emergency Care Network, Community Paediatrics) • The Trust COO and Head of Cancer are members of the HNY Cancer Alliance Board • Senior leaders from across the Trust are active participants in HNY Clinical Networks • Linkages and alignment to the ICS Out of Hospital Programme Board as part of the HAS Programmes. • The Trust is an active participant in the emerging Place Based Partnerships • HAS leads are part of the primary/secondary care interface groups • The Trust is an active member of the HNY Clinical and Professional Leaders Group **National and regional networks:** • Members of the Trust Board and Senior Leadership Community are active members of national and regional networks. The Trust is an active participant in Getting It Right First Time (GIRFT) reviews and recently participated in the HNY review of ENT, Urology and Orthopaedics • As part of the HAS Programme the Trust is actively engaged with National and Regional Network and GIRFT leads on Urgent Emergency Care, Maternity and paediatrics and a number of planned care specialties	• Pace of design and development of Place Base Partnerships – at different stages of development • Place Based Boards – lack of clarity of role	• Aligning the /strategies/ objectives/ priorities of the PCNs to HASR

Northern Lincolnshire and Goole NHS Foundation Trust

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	2 August 2022
Director Lead	Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee
Contact Officer/Author	Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director
Title of the Report	**HTF Trustees' Committee Highlight Report –** 14 July 2022
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 14 July 2022 and worthy of highlighting to the Public Trust Board.
Background Information and/or Supporting Document(s) (if applicable)	HTF Trustees' Committee Terms of Reference
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	2 August 2022
Report From:	Health Tree Foundation Trustees' Committee held on 14 July 2022

Highlight Report:

Approval of Proposed Revised KPIs

- Following the successful re-tendering of the HTF Management Contract and its award to the HEY Smile Foundation for 3 years from 1July 2022, Clare Woodard, the Charity Manager proposed revised contract KPIs. Under the headings of Finance, Engagement and Patient Centred, the revised KPIs were explained, discussed in committee, and accepted by Trustees with some minor amendments and additions. As is the current practice, the KPIs will be reported upon at each Trustee Meeting by the Charity Manager.

Fairchild Legacy Project Plan

- At the request of Trustees at the May 2022 meeting, the Charity Manager provided a skeleton project plan designed to make SGH more dementia-friendly, using the generous £300k+ legacy from Mrs Elizabeth Fairchild. The Trustees agreed that they would like to hear directly from the Deputy Chief Nurse and NLAG's LD Nurse at the next meeting, in order to understand the benefits of the many different features that can make an acute site more dementia-friendly. Armed with this information, Trustees felt they would be better able to differentiate between the potentially competing features and allocate funding accordingly.

- Trustees also agreed that, when all the potential work was completed, it would be most appropriate to acknowledge the Fairchild Legacy for all to see, perhaps by a plaque situated on the outside of SGH stating clearly that the many dementia-friendly aspects of the hospital were provided by Mrs Fairchild's legacy.

Sparkle Project Officer Contract Extension

- Noting that the new Sparkle Project Officer, recruited in September 2021, had made a significant impact upon the various minor works to smarten the estate, especially where it affected patients, Trustees agreed with the proposal to extend the fixed-term employment contract of the Sparkle Project Officer by one year, from September 2022 to September 2023.

Initiatives to Accelerate Spending of Charity Monies

- Trustees were concerned that despite much publicity, it seemed that the rate of spend of HTF funds to enhance patient experience stayed constant instead of the required increase. At the Chief Executive's suggestion, Clare Woodard readily agreed to further publicise the need for ideas for new appeals and novel ways in which HTF funds could be made to work to enhance the experience of patients. This publicity would involve speaking at TMB, the Senior Leadership Forum and the Monthly Nurse and Midwives Forum. The aim is to reach a wider audience and one that is likely to generate new ideas in this regard.

Confirm or Challenge of the Board Assurance Framework:
Not Applicable
Action Required by the Trust Board:
The Trust Board is asked to note the key points made and consider whether any further action is required by the Trustees at this stage. **Neil Gammon** **Independent Chair of Health Tree Foundation Trustees' Committee**

NHS
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NHS Foundation Trust

NLG(22)133

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	2nd August 2022	
Director Lead	Shauna McMahon	
Contact Officer/Author	Dr Alastair Pickering	
Title of the Report	**Digital Services Board 6-month update**	
Purpose of the Report and Executive Summary (to include recommendations)	To update the Board on the last six months of work within Digital services. This provides an update on our work over the past six months, how regional and national strategy is evolving in relation to digital and data approaches and highlights the key areas of focus in the next few months.	
Background Information and/or Supporting Document(s) (if applicable)	The Digital work undertaken by these teams is overseen by the Digital Strategy Board	
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ☐ Other:
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ✓ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ✓ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Digital Services

Trust Board 6-month Update

August 2022

Shauna McMahon, Chief Information Officer

shauna.mcmahon@nhs.net

Contents

Executive Summary

The start of this year has seen the initiation of some structural changes within Digital Services. Not only within our own team as the CIO role extends across both Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole (NLaG) Trusts, but also with the establishment of the Integrated Care System and the Digital services hub within that. The challenge continues to be managing the internal needs of both organisations as they look to support elective recovery, the ongoing COVID impact and an Urgent and Emergency Care system that is creaking while responding to National initiatives and funding availability.

Under the leadership of the Joint CIO, now firmly embedded on both Trust Boards, and the clinical informatics leads, we are now extending the senior digital team and evolving how the two digital services will work together to support and deliver digital transformation.

We continue to build our digital foundations with a better understanding of our infrastructure and where to target and share investment based on our recent review. We continue to rollout better devices and hardware for staff, improve our network connectivity, move to Office365 to support collaboration and productivity as well as implementing a new IT service management system that will streamline our ability to support services more efficiently.

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

Our Vision:

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

The Digital teams continue to support the PAS implementation which is closely linked to the Interim Clinical Plan work required to support our ten critical specialities as the first phase of the HAS programme. The modelling work done by our information teams is being used in the development of the HASR phase 2 & 3 business case preparation.

Inpatient ePMA rollout is complete, with some ongoing support for staff provided through implementation, the BI teams work delivering accessible and usable dashboards and reports for staff is increasingly being used for service led decisions and the introduction of dedicated "Digital Nurses" under the leadership of Martin Sykes is improving links to frontline clinical staff.

The Digital Aspirant work continues beyond the PAS migration with the initiation of our RPA programme and cross-site enablement of in context patient record access. This work requires ongoing management of the large volume of staff requiring multiple systems access from both sites.

WebV continues its development to meet required standards and upgrade the available modules that support the progression to digital notes and removal of paper-based processes. This work continues mindful of the national drive to EPR convergence and maintaining the use of open standards.

Our Digital Governance structures are now well-established and link into the Trust's approach to planning and business case approvals. We will continue to enforce these processes around digital projects which will provide more clarity for executive teams and staff on what work is being prioritised, support teams

interested in innovating within their clinical areas and allow us to deliver on those elements that are the highest priority at national, regional, and local level.

One of our areas of concern continues to be retention and recruitment challenges. NLaG and many other Trusts are struggling to recruit into digital specific roles and although we have initiated relationships with external providers to build resilience and reduce impact on projects, this still proves challenging. The management team collectively believe the collaboration of our digital services team will naturally lead to a review of staffing and roles, allowing us to use market benchmarking more accurately for some of our current roles where retention has been a challenge. We invest in our staff and support personal and professional development within our teams – but the current NHS pay structures do not reflect the overall market value of staff with digital skills and expertise.

Investment in Digital Services is an investment in transformation and improvement for staff and patients. Digital transformation is about adopting new processes that change how work is accomplished, supports delivery of the organizations' objectives and where we can add qualitative or quantitative value. The Board development day focused on digital in March covered how investing in teams and personnel can support this agenda rather than just investing in products and we continue to support this approach as a way of securing sustainable change for our organisation.

The National EPR usability survey demonstrated similar findings where, regardless of the EPR being used, the system usability scores across different Trusts using the same EPR were based on the quality of the infrastructure (foundations), the training of the staff and the culture of the organisation in embracing digital

change. These are all areas we are focused on delivering at NLaG.

Included with this summary is the project dashboard (Appendix A) showing progress to June 30th, 2022. The digital team and our supporting colleagues are proud of the work we have accomplished and trust you will be encouraged to see the progress made and how we are advancing our patient focused, digital first strategy.

Regional Digital Developments

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

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

Digital Maturity at both Trust and ICS level are already a focus for delivery by the end of 2023, but a financial support plan has been released defining where national and regional funding efforts will be targeted.

National funds will focus on:

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

Regional and local investment will be distributed to support:

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

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

- Diagnostics programme

- Targeted Investment Funding
- Virtual Wards
- Primary and Social Care support

A Federated Data Platform (FDP) will be an ecosystem of connected platforms, placed in and ultimately determined by, individual NHS organisations and will provide decision makers with access to real time information to make informed, effective decisions to transform how we plan, manage, and sustain services.

The WGLL framework for Digital Maturity has 7 success measures that we will be assessed against:

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

One of the early tools being launched in 2023 is an assessment framework which we will use to measure our level of digital maturity. This will help identify gaps and prioritise areas for local improvement. Assessments will be repeatable so organizations can track progress year-on-year. Frontline support in terms of funding and expertise will also be available. In the last quarter of fiscal 21/22 we have started to benefit from the funds through the Targeted Investment Fund (TIF). NLaG has received funds to support Cyber Security work, Connected Health Network, Attend Anywhere, as some examples. In addition, we have a regional maternity system recently procured so all women can access their maternity notes and information through smart phone or other device by 2023/24. The system will provide information in digital format to those that are supporting mums-to-be. We will remove paper processes for this population.

NLaG has also helped to shape the ICS digital and data strategy, establish governance and working on “levelling up” plans for the region.

NLaG has worked with our ICS colleagues to create our ICS funding priorities. As an ICS our digital strategy is based on the principle that we will adopt open standards and an open platform for our digital environment. We do not want to be held to one supplier but prefer to adopt the priority - data and information is to be on an open platform so we can control and manage how we share our data. We are continuing to work with our ICS colleagues to "level up" across our region and make the most of the funding opportunities being presented.

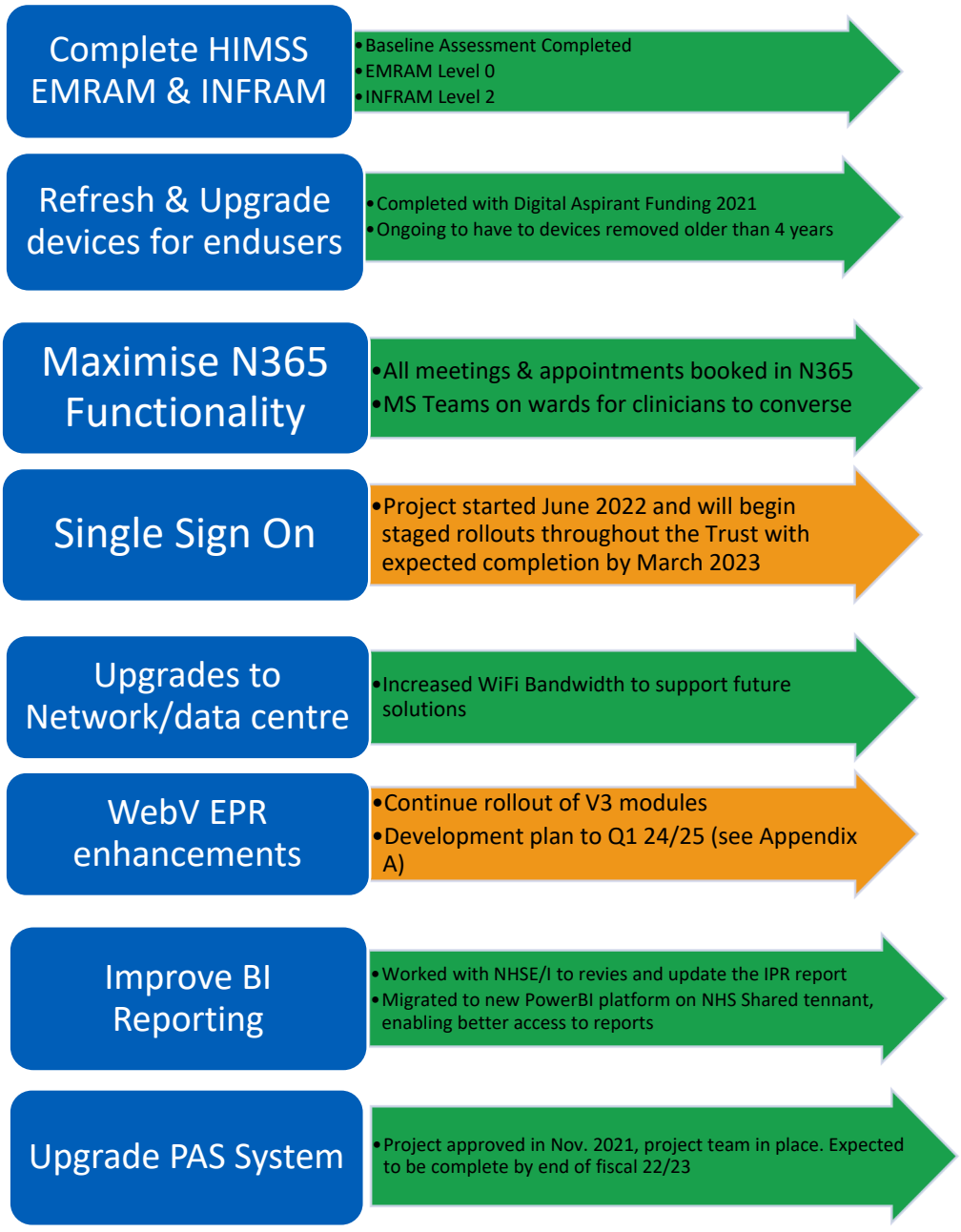
This work is currently focused on the delivery of an ICS wide costed digital and data plan for elective recovery and agreeing an ICS wide approach to EPR procurement and delivery in line with national planning.

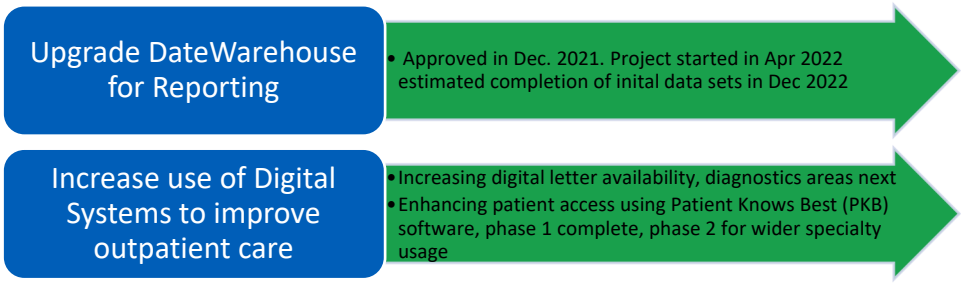
Other areas where our work aligns directly with national strategy is in the local data warehouse work, our systems integration with the regional shared care record and close working relationship with the regional cybersecurity lead.

As the ICS becomes established, digital funding will be allocated through the partnership and place-based systems. It is essential that we maintain our presence at ICS Digital Executive and strategic level to ensure we continue to align in our priorities and secure suitable financial support for local delivery. The need for local investment to support some projects will continue, but a majority of transformation work will become funded through national and regional programmes and our role is to ensure that not only our digital services, but also our staff are in the best position to use this when available to deliver the expected transformation.

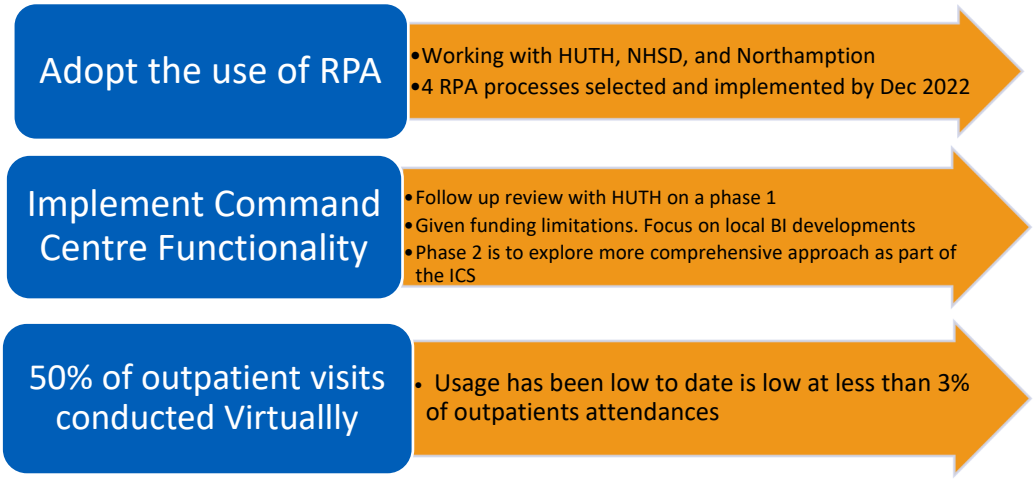
Our Digital Roadmap 2021-2024

Level 1 Maturity Map





Level 2 Maturity Map



Clinical Updates

Martin Sykes, Chief Nursing & AHP Information Officer

Since the past Digital Service update there has been a lot of work behind the scenes happening to ensure we have the foundations ready for a secure digital future.

We have purchased nearly 50 new wristband printers, which will soon start appearing on the wards, these new style wristband printers will be compliant with GS1 standards and will form the first step of a wider goal of achieving the Scan4Safety key principles of Right Patient, Right Product, Right Place and Right Process. If we deploy these wristbands across the trust, we estimate we will save over £19k per year compared to our current method of wristband production, with the added benefit of a clear, readable, washable, and scannable identification band.

We have launched the new Service Desk in IT services, and the next phase of the project is now underway, which will provide clinical staff a single point of contact for any fault reporting or new job requests. There will also be a self-service portal, so simple faults can be resolved by the users quickly and easily, which will in turn allow the service desk team more time to concentrate on other issues and being able to solve them in a timelier manner.

I have been supporting the new Emergency Department move and working with the team from Vocera, and we hope to deploy an additional 100 Vocera devices, so we can maximise the use of the 200 licences already purchased. These devices will be supplied to all members of the ED team so they can be connected to each other wherever they are in the building, which will improve communication between the team and facilitate a smoother pathway for the patients in the ED.

Preliminary work is being undertaken in the Maternity Departments so we can successfully deploy the Clevermed maternity EPR solution, ‘Badgernet’ purchased by the ICS. All the pathways will need to be reviewed by the Digital Midwife, and we are investigating the option of Managed Convergence with our maternity and digital teams at Hull University Teaching Hospitals NHS Trust, so that all patients in the Humber region receive a consistent and high-quality level of care, regardless of the hospital site.

I am leading the clinical conversations for the Single Sign On solution, supplied by Imprivata. This solution will provide clinical teams with the ability to sign on to a device with a tap of their smartcard, giving quick access to the clinical systems that they require, without needing to remember all their usernames and passwords for each system. This project will require a lot of clinical engagement to ensure a smooth and effective deployment, so communications will soon be going out to the trust, asking for clinical digital champions across the organisation to get involved and help in this exciting new service.

There is a long way to go to achieve the digitisation standards required to meet the level that is expected of an acute service, but with collaboration between the digital teams and the clinical services, working together we can digitise and improve the working lives of our staff and the care and safety of our patients.

Dr Alastair Pickering, Chief Medical Information Officer

The mainstay of work for the last few months has been alignment of digital projects between NLAG and HUTH, planning our priority areas for delivery into the end of the financial year and ensuring we (our senior digital team) are embedded at ICS level. This is demonstrated with both Shauna and I being members of the ICS Digital Executive and Strategy Boards and supporting the ICS wide acute collaborative. Martin and I are both involved directly in the regional CXIO meetings for Clinical Informatics leaders across partnership organisations.

We have been focusing on the Interim Clinical Plan Specialties (Phase 1 of HASR) to ensure we support the single service models being developed, and this closely links with the ongoing project work to deliver a single Patient Administration System across the two organisations, as NLAG looks to replace our legacy CaMIS system. This work has delivered systems access across staff groups in each organisation as well as the in context click through links to the relevant areas of the patient's records. More work is needed to manage the volume of access requests coming through and ensuring staff can get the information they need as easily as possible.

A key project within NLAG has been the implementation and rollout of the Results acknowledgement module within WebV, with reports feeding into the Quality Governance Group. This work is transformational in delivering a digital process for acknowledging results

and documenting subsequent actions, creating a transparent audit trail for patient safety and quality purposes. The rollout has not been as smooth as hoped leading to ongoing work to clear a backlog of unacknowledged results and continue to develop the WebV system to better support clinical workflows. It has also identified areas of operational practice that need review and further engagement with clinical staff to improve the uptake rate.

NLAG has been working closely with the ICS Waiting Well Programme, building a risk profile algorithm for our Priority 4 waiting list patients and collaborating with Primary and Community Care colleagues to identify non-medical support opportunities such as social prescribing, wellbeing checks etc..., with this work linking across to the Connected Health Network programme and work to establish the digital confidence of patients that can then drive different pathway approaches.

The Single Sign-on project will change the way our staff access digital systems and is focused on delivering productivity benefits and better information governance across the Trust. This requires an investment of time from clinical staff to work with the project team and deliver the solution as effectively as possible.

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

Although I maintain attendance at the MAC/HCC and medical directors' meetings to discuss specific digital work, I have realised the need for (and will deliver) better communication for clinical staff on what Digital Services are focusing on and specifically what that means for services and individuals. This will be key as Martin and I work together to support staff in understanding their own digital literacy and then building their confidence with digital systems that can directly benefit them and the patients they care for.

Digital Highlights

PAS Replacement Project

The replacement of Trust's CaMIS PAS system with Lorenzo is progressing forward at pace. The work aims to streamline the patient administration processes, allowing far more effective coordination of care that support collaborative clinical models.

Teams from across both NLaG and HUTH have come together and focused on a go-live of the new system in February 2023. The dependencies on PAS for a wide range of other processes need to be carefully mapped out to ensure that unplanned consequences from such a major system change are minimised and that risks are managed appropriately.

Data Warehouse

The project to replace the Trust's Data Warehouse officially commenced with the supplier in April 2022 and several different workstreams are underway. The new Warehouse improves the ability of the Trust to utilise its data more effectively, leveraging benefits for a wide range of activities from service planning through to performance monitoring.

The supplier (Insource) is working with local teams to bring the platform online by mid-September and going-live with the first data flows for community and ESR by Dec 2022.

Robotic Process Automation (RPA)

The RPA project aims to eliminate a large proportion of repetitive data entry in the Trust by using 'bots' to support staff and free their time for more productive tasks. The project is moving forward with 4 identified process between NLaG and HUTH that will be the focus of delivery in 2022/23.

The Trusts are being onboarded into the NHSE RPA UIPath Infrastructure and finishing some local set up. Process Design workshops and testing of each of the processes will be undertaken in a systematic approach to cover all 4 processes by Dec 2022.

WebV

Yorkshire and Humber Care Record – Integration with YHCR regional shared care record is now complete and running a short pilot in Goole before wider roll out. The work allows our Acute Clinical Teams to easily access GP Health Record information from within WebV and has positive feedback from Clinicians.

3-year development road-map – To set out a more robust view of the next 3 years, an indicative development roadmap for future versions and functionality has been created (see appendix A). It gives a vision of how WebV will continue to develop, while the Trust explores ICS opportunities for EPR convergence.

Digital Patient Communication and Patient Portals (PKB)

Digital out-patient appointment letters have been implemented in all outpatient specialities. Phase 2 of the

project in 2022/23, will now focus on other clinical support areas such as diagnostics.

Patient Knows Best (PKB) which delivers the regional patient portal had commenced a pilot in Cardiology. This project is now moving into stage 2 during Q2/Q3 2022/23 which is expanding out to a number of further specialities.

PATIENTS KNOW BEST®
MANAGE YOUR HEALTH

Business Intelligence

The team delivering Business Intelligence and Information Management services has been busy with several initiatives in the recent period. The replacement of the Trust's Data Warehouse has now formally commenced with the project having key stakeholders involved from this area. Work has been successfully completed on the redesign of the Trust Board and Committee Integrated Performance Reports. These now highlight key threads of information across the various levels in a more consistent way. Further work has also commenced on the development of PRIM reporting to align this with more strategic report formats over the next 6 months.

We have seen significant increases in the use of Power BI in the Trust, which has increased 58% over the previous 6 months. This is a key tool within the portfolio for data visualisation and helps support more self-service reporting for our end users. The scope of reports on the platform has also increased to include Ward Assurance and Workforce reporting.

Clinical Coding

The Trust recorded a latest SHMI of 103.63 for the period March 2021 – February 2022, which is the third monthly reduction in a row and the lowest overall score for the Trust on record. Full clinical reviews for all deceased patients with In-hospital and out of hospital deaths have contributed significantly to ensure the data remains an accurate representation of the activity. This process continues to be a significant overhead to both clinicians and staff capacity but goes a long way in delivering benefits to accuracy.

While the benefits of a direct relationships between Clinicians and the Coding Team can be evidenced in the above success, there are still significant challenges around wider engagement between Clinicians and the Coders due to pressures on services and staffing. The turnover of coding staff remains higher than in other areas of digital, given external opportunities for remote/working from home contracts from commercial coding companies. Further development of the team structure and the push for more digital documentation will aim to make our offerings more competitive over the next 12-18 months.

Work is on-track to update to the newest Clinical Encoder system and timescales are currently aligned within the main PAS project. Additional efficiency and a much-improved user experience are expected to be delivered from the new system, which will reduce manual overheads of the coding process. The team are also in the process of procuring the “Monmouth” learning system for the Clinical Coding training. This will offer specialised learning modules that support skills/knowledge development and will provide an advantage in aligning standard training across both NLaG and HUTH, giving a greater level of consistency and peer support.

Information Governance

Data Security and Protection Toolkit 2021/2022 Return

The Trust submitted the final toolkit on the 30th of June 2022. On submission and following the final report, findings from Internal Audit the Trust created an improvement plan. The improvement plan reflected 3 areas with which the Trust were highlighted as having gaps where we were unable met the required assurance. These are:

- The Trust only achieved 91% of staff undertaking Data and Security (IG) training.
- The lack of a Trust wide Training Needs analysis document
- IT procurement processors (to included due diligence)

There are several partial/future actions which were identified, these are where the Trust has solutions in place but is currently improving these solutions and processes.

The process for approving and submitting improvement plans for 21/22 was slightly different as in previous years. Before submitting the plan to NHSD, the regional IT Security Specialist reviewed and approved the plan jointly with NHSD. It is the intention that the Regional Specialist will work with organisations to assist in achieving full compliance.

The improvement plan for 21/22 is also a little different this year, as the Trust included both non-compliant and partially compliant assertions. (Partial meaning that we are either working towards or have a solution in place but are improving that current solution to provide greater assurance). The improvement plan also cross references other action plans that are currently in existence (e.g., MKInsights).

The Improvement plan will be monitored at the Information Governance Steering Group and via the Digital Services SMT. On submitting the Improvement Plan to NHSD the Trust's status was one of 'Approaching Standards.' When all actions on the improvement plan are complete this will be changed to 'standards met.'

Information Technology

Internet of Things (IoT) Cyber Security

We were fortunate in being awarded some Cyber Security national funding in Q4 2021 (£250k) based on a bid that we submitted for a solution to manage and secure unmanaged medical and Internet of Things (IoT) devices (Security Cameras, Smart TV's, etc).

This has allowed us to purchase a three-year contract with Cynerio to provide a solution to passively monitor the network looking for unmanaged devices and allowing these to be identified, managed, and controlled which meets several Data Security and Protection Toolkit standards.

Digital Services worked in collaboration with Medical Engineering on choosing this solution and will be working closely on its implementation and management.

Cyber Essentials+ Accreditation

Digital Services are striving to gain official accreditation in all areas including Cyber Security and as such we have recently ordered a Cyber Essentials+ Gap Analysis. This is booked to take place on the 26th and 27th July 2022. The output will provide us with the information to understand any gaps in meeting the requirement prior to applying for this accreditation.

Single Sign-on Solution

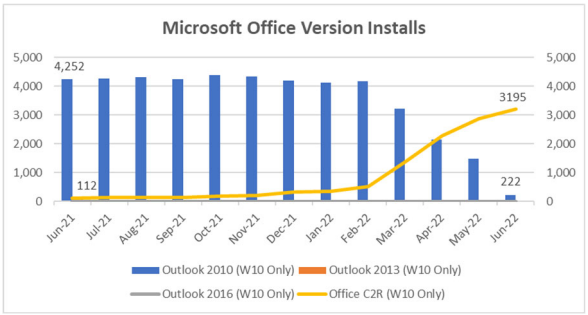
We have purchased a single sign on solution from Imprivata and have just started the project to begin implementation throughout the Trust. Staff will only need to remember one login id

and password to gain access to all the systems that they require. Clinical staff will have the ability to be able to login using a touch device 'tap in' to assist with simpler logins.

imprivata OneSign® This solution will reduce login times for staff as well as reducing the number of login credentials that staff need to remember. This increases the Trust's security by avoiding staff writing down passwords, not sharing accounts, removing generic logins, amongst other things. The project started in June 2022 with the appointment of a project manager and initial kick off meetings have taken place. We are anticipating a phased rollout throughout the Trust with a nine-month implementation time. Full engagement with clinical staff will be undertaken throughout the project to ensure a smooth implementation that meets their requirements.

Microsoft Office 2010 Migration to Microsoft 365

We have been migrating staff from Microsoft Office 2010 which is no longer supported by Microsoft and replacing it with the cloud-based Microsoft 365 office. We are now entering the final phase of this part of the project and forecast completing this by the end of July 2022.



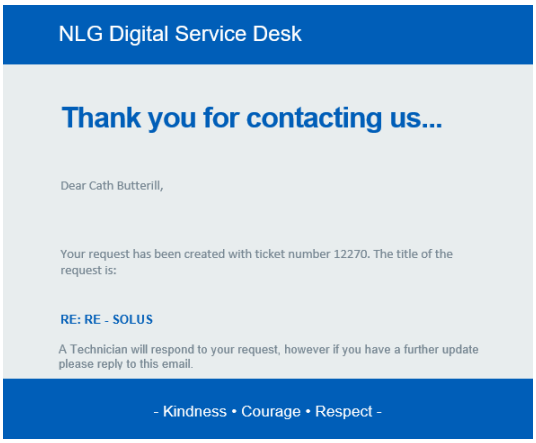
Every Trust staff member now has a Microsoft 365 licence which gives them access to the very latest and powerful Microsoft 365 tools including Teams, Word, Excel, PowerPoint, OneNote, Power BI, Outlook, Publisher, SharePoint Online and OneDrive amongst other things. This provides the foundation for a modern electronic / collaboration suite of office tools to everyone, allowing them to work from anywhere on any device.

We will next be working on deploying Microsoft OneDrive which provides private individual cloud storage for everyone, replacing the SharePoint Hub with a new SharePoint Online allowing access from anywhere on any device and Power Apps and Power Automate which is a powerful set of tools to create intelligent workflow within the Microsoft 365 environment.

NLaG & HUTH Infrastructure Review

As part of the digital aspirant funding, we have engaged an external IT specialist consultancy company to undertake a review of NLaG and HUTH IT infrastructure to assist us with future planning. An initial feedback and sense check meeting has taken place with regards to the information gathered and a review of the draft findings. The draft findings showed there to be some similarity between the two Trusts. The final report is due at the end of August 2022.

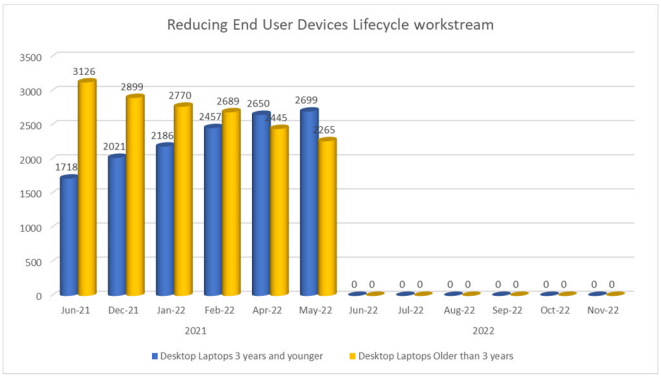
IT Service Management System (ITSM) – Service Desk Plus



This first of the core modules of the ITSM system, Service Desk Plus, has now gone live. This system now allows users to directly log a problem or service request with Digital Services by e-mail, but you can still use the telephone if you wish. Coming soon you will be able to use the self-service web portal to also access our services, this will help direct you to the correct team in Digital Services and even get direct online help and assistance. We will be onboarding all Digital Services sections onto this new platform over the coming months so there will be a single point of contact to gain access to all of our services.

Reduction of Lifecycle on End User Equipment

We continue to roll out new Digital equipment to staff ensuring that they have modern equipment, which is fit for purpose, gives a better user experience, and can handle all the modern software demands that are being placed on it.



Our aim is to make sure all our users have modern equipment which meets their needs, and this means ensuring that we have regular refreshes of equipment. We are therefore aiming to drive down end user devices lifecycle from over 10 years old in some cases.

Developing our Team

Our commitment to developing our most important assets (our staff) continues to be high on the agenda. Our services must be shaped to deliver on the requirements for the organisations we serve, and we must have our staffing resources appropriately skill and trained.

Collaborative Structure Review

In April 2022, the Chief Information Officer (CIO) role became a joint role between NLaG and HUTH. The vision in doing so was to develop a single Digital offering that can support both organisations in a cost-effective way. There are many opportunities ahead to review processes, technology and systems. The work will help align the Digital response, while directly supporting a clinical services development agenda that is focusing on partnerships and collaboration.

By September 2022, the first changes for the new Digital Senior Management Team should be in place, with a wider consultation on the structure coming later in Q3 2022/23.

BCS Memberships

We have enabled two routes for staff to train for both professional certifications and technical qualifications. These offerings should help career development and provide the latest relevant training for individual roles.

Since becoming a member of the British Computer Society (BCS) earlier this year, NLaG Digital now has 39 active members. 29 of these members of staff have successfully completed either a registration for IT Technicians (RITTech), Federation for Informatics Professionals (FEDIP) or Chartered Engineer Registration (CEng).

More applications are underway with some already submitted awaiting approval. The BCS has recently awarded NLaG Platinum Partner Status which “demonstrates the highest level of dedication to the mission of delivering talented, ethical and dedicated professionals for the benefit of the industry and society”. We are currently working with the BCS to host a launch event for our Digital colleagues at HUTH.

We also use an online platform called Udemy which provides training content that covers essential technical skill using cost-effective and scalable learning approaches. Uptake of the offerings continue to be good providing an essential learning resource that is available to staff to support their learning objectives in a way that can fit around busy workloads.

Areas to Focus Improvement

A key component of successful leadership is the ability to clearly communicate and share the vision of what we are trying to achieve. This is something that we need to improve in three areas:

- To Digital services staff - through clear prioritisation and delivery plans for our projects and robust governance around change management
- To Trust staff – from executives to volunteers – creating a clear picture, not only of what we are trying to achieve, but also how, why and when
- To our patients and the public – to share our approach and ensure everyone, regardless of their digital literacy and confidence, can access the care they need from us.

Digital literacy for our staff and our digital maturity of our systems and processes will become part of the operational planning approach as well as being introduced into the regulatory frameworks e.g. CQC. As such, we need to focus on embedding digital into our improvement work, patient safety approaches and service transformations. This is more than just hardware, equipment and better network connections, but using digital systems to transform how we work.

While our governance process are firmly in place, we need to be clear that new proposals and projects must come through our Digital Solutions Group and Digital Strategy Board to allow us to manage the digital work, ensure suitable coordination and actually deliver on work that has already been prioritised.

We will continue the digitisation journey for our clinical services in line with national strategy, through monitoring the use of printing and paper across the Trust – targeting support to high use areas in our move to paperless processes.

The next 6 months

- 80% completion of the PAS implementation
- Completed the new Data Warehouse implementation
- Enable RPA across two priority processes to deliver measurable benefits
- Complete the joint NLAG/HUTH business case and prepare procurement strategy for the Enterprise Document Management Solution (EDMS)
- Complete the implementation of Single Sign On (SSO)
- Undertake the second of three Digital Board Development sessions (March 2022, Cyber Session in Autumn, review in March 2023)
- Complete the shared NLG/HUTH IT Infrastructure Review for strategic alignment
- Complete the first phase of a collaborative Digital Services structure alignment between NLAG and HUTH

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

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

Appendix 1: Digital Programme Details

Digital Transformation Programme

Author(s): Chris Evans/Helen Groke
Date: 18/07/22
Report No: 11
Reporting Period: June 2022

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Summary

Work is ongoing to complete the joint project list between HUTH and NLaG. Blueprinting work for Digital Aspirant projects continues as does benefit capture. Further activities for Blueprinting have been agreed and are being planned in.

A draft programme plan has been proposed for 2022/3. This focuses on continued inflight projects and purchasing Single Sign On. In addition to £923k carried forward from 2021/22, additional external funding will be required to support further projects in year. The programme plan has been re-formatted to align with the HUTH plan and the plans for the two trusts are being consolidated.

The current plan has risks around lack of funding for equipment costs, both as a basic replacement programme and additional support for project related IT equipment. This is particularly noted with the ED new builds where project IT funding allocation has been under estimated.

Programme Rating

Programme RAG Status*

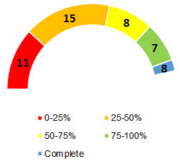
Programme Trend

Digital Transformation Projects Status

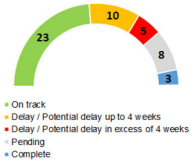
Total Projects (incl closed)

45

Projects by % Progress



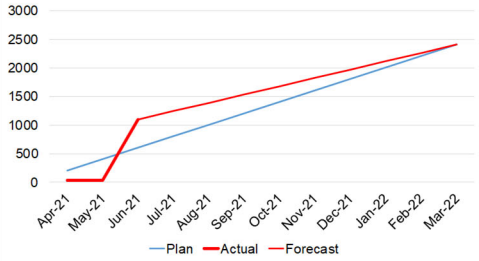
Projects by RAG rating



Milestone Schedule

Milestone	Description	Date	Status
FM1	Funding Milestone 1	Mar-21	Complete
FM2	Funding Milestone 2	Sep-21	Complete

Programme Funding 2022/23

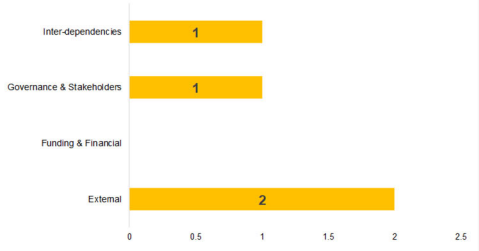


Funding	2,406
Spend to Date	1,176
Orders Placed	292
Remaining	938
Forecast Var	1

Programme Risks

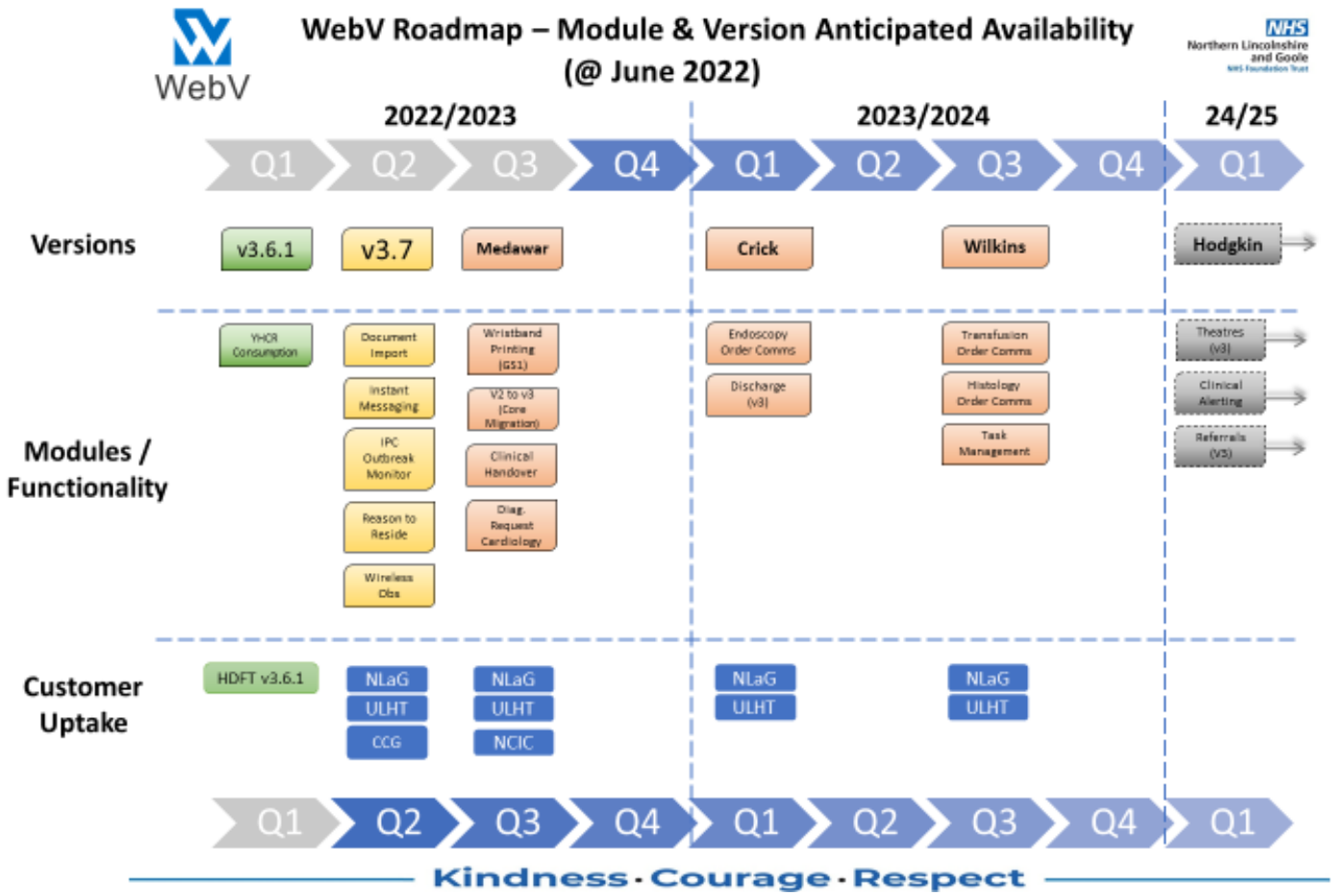
Reported Risks

Risk Categories



Programme Detail

Project Name/ Charter	Project RAG Status	Project Delivery Date	Highlight Report	Project Name	Project RAG Status	Project Delivery Date	Highlight Report
IT Equipment Replacement	Green	August-22	IT Equipment Replacement HLR	New Finance System	Green		New Finance System
IT Network Infrastructure	Green	June-23	IT Network Infrastructure HLR	Next Generation Firewalls (HSCN) / Remote Access Service (RAS) / Two Factor Authentication (RAS)	Green	September-22	Next Generation Firewalls (HSCN) - Care
IT Service Management System	Green	December-22	IT Service Management System HLR	Office M365 Enterprise Migration	Amber/Green	March-23	Office M365 Enterprise Migration HLR
Foetal Ultrasound System	Amber/Green	December-22	Foetal Ultrasound System HLR	Ophthalmology Integration	Initiation		Ophthalmology Integration
Xltek EEG System	Green	July-22	Xltek EEG System HLR	Ophthalmology Digital Processes	Amber	tbc	Ophthalmology Digital Processes HLR
Data Centre Enterprise Architecture	Green	July-22	Data Centre Enterprise Architecture HLR	Opthalmology Community Hub	Amber		Opthalmology Community Hub HLR
Lorenzo PAS Replacement	Amber/Green	January-23	Lorenzo PAS Replacement HLR	Pathology Integration Engine (PIE)	Amber		Pathology Integration Engine
Enterprise Content Management (EDMS)	Amber	March-23	Enterprise Content Management (EDMS) HLR	Pathology Long Term Storage	Red		Pathology Long Term Storage HLR
Single Sign On	Amber	March-23	Single Sign On HLR	Patient Knows Best - Patient Portal	Green		Patient Knows Best - Patient Portal HLR
Robotic Process Automation (RPA)	Green	July-22	Robotic Process Automation (RPA) HLR	PRISM/Solus migration (Medical Physic	Initiation		PRISM/Solus migration (Medical Physics)
Data Warehouse	Green	December-22	Data Warehouse HLR	Rapid AI	Amber		Rapid AI
Augmented reality glasses - Community nurses	Green	Aug-22	Augmented reality glasses - Community nurses HLR	Results Acknowledgement	Green		Results Acknowledgement HLR
Clinical Noting	Green		Clinical Noting HLR	Staff Lottery	Green		Staff Lottery
Comorbidities	Amber		Comorbidities HLR	Symphony SDEC 111	Pending		Symphony SDEC 111
Connected Health Network (CHN)	Initiation		Connected Health Network (CHN)	Virtual Server Farm Hardware	Red	Mar-21	Virtual Server Farm Hardware HLR
CT Gamma Camera DPoW	Initiation		CT Gamma Camera DPoW	WebV Outpatients Outcomes	Amber/Green		WebV Outpatients Outcomes HLR
Diagnostic Requesting	Green		Diagnostic Requesting HLR	WebV V3.7	Amber/Green		WebV V3.7 HLR
DictateIT Upgrade	Green	Jul-22	DictateIT Upgrade HLR	Windows 10 Enterprise Migration	Red	Jun-21	Windows 10 Enterprise Migration HLR
Digital Radiography Community Dental	Amber		Digital Radiography Community Denta	Yorkshire and Humber Care Record	Amber		Yorkshire and Humber Care Record HLR
Digitial Comms - Digital Letters	Red		Digitial Comms - Digital Letters HLR	Zebra Wristbands	Green		Zebra Wristbands
ECC Bed Requests	Amber		ECC Bed Requests HLR				
ED New builds Tech Workstream	Amber/ Red	Jul-22	ED New builds Tech Workstream HLR				
Fairwarning	Initiation		Fairwarning				
ICS Maternity System	Pending		ICS Maternity System HLR				
IoT Enterprise Management	Green		IoT Enterprise Management HLR				


WebV Roadmap – Module & Version Anticipated Availability (@ June 2022)
WebV
NHS Northern Lincolnshire and Goole NHS Foundation Trust
2022/2023
2023/2024
24/25
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
Versions
v3.6.1
v3.7
Medawar
Crick
Wilkins
Hodgkin
Modules / Functionality
YHCR Consumption
Document Import
Instant Messaging
IPC Outbreak Monitor
Reason to Reside
Wireless Obs
Wristband Printing (GS1)
V2 to V3 (Core Migration)
Clinical Handover
Diag. Request Cardiology
Endoscopy Order Comms
Discharge (v3)
Transfusion Order Comms
Histology Order Comms
Task Management
Theatres (v3)
Clinical Alerting
Referrals (v3)
Customer Uptake
HDFT v3.6.1
NLaG
ULHT
CCG
NLaG
ULHT
NCIC
NLaG
ULHT
NLaG
ULHT
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
Kindness · Courage · Respect

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

Data Saves Lives: reshaping health and social care with data
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What Good Looks Like?
https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

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

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

Net Zero Carbon
https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf

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

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

Professional Records Standards Body (PRSB)
https://theprsb.org/standards/

Who Pays for What?

https://www.nhsx.nhs.uk/digitise-connect-transform/who-pays-for-what/

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	2 August 2022
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Audit, Risk & Governance Committee Highlight Report – June 2022**
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk and Governance Committee at its meeting on 10 June 2022: 1. **Audited Annual Accounts 2021/22**: Received and discussed by the Committee and approved for submission. **For Board to Note.** 2. **2021/22 External Audit Completion report and Management Letter of Representation**: Unqualified opinion for the accounts. Two on-going significant weakness in relation to VFM arrangements. **For Board to Note.** 3. **Annual Governance Statement 2021/22**: Approved, subject to one minor adjustment. **For Board to Note.** 4. **Head of Internal Audit Opinion 2021/22**: 'Significant Assurance' rating received. **For Board to Note.** 5. **Trust Annual Report 2021/22**: Approved subject to final adjustments and insertions. **For Board to Note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 10 June 2022
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ☐ Quality and Safety ☐ Estates, Equipment and Capital Investment ✓ Finance ☐ Partnership and System Working ✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ **Oversight of entire BAF process, completion and achievement**
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	2 August 2022
Report From:	Audit, Risk & Governance Committee – 10 June 2022

Highlight Report:

1. **Audited Annual Accounts 2021/22** – received and approved on behalf of the Trust Board under formal delegated authority. The accounts were previously reviewed in detail by the Committee at its April 2022 meeting**.** The Assistant Director of Finance – Planning and Control provided a written list of minor changes made to the draft accounts. The External Auditor stated that it was one of the cleanest audit reports they had issued this year and this was testament to the good work of the Finance team in consistently delivering a quality set of draft accounts each year, particularly when considered in the context of the financial challenges faced. The Chair congratulated the Finance team on this achievement and placed on record his thanks.

2. **2021/22 External Audit Completion Report and Management Letter of Representation** – unqualified audit opinion, without modification, for the annual accounts. In respect of the Trust's VFM arrangements the External Auditor continues to report two significant weaknesses from 2020/21 (i.e. Trust remaining in special measures and financial sustainability), however there are no new significant weaknesses or new recommendations. The Committee understood and accepted this, but it is hoped that the VFM weaknesses would be removed for next year's audit. The Chair placed on record the Committee's thanks to the External Audit team for their work on the year-end audit.

3. **Annual Governance Statement (AGS) 2021/22 –** The Committee approved the AGS subject to the minor rewording of a paragraph in section 10.1 – Finance and Sustainability. The Chief Executive placed on record his thanks to Alison Hurley, Assistant Director of Corporate Governance, for her efforts in producing the AGS this year in the absence of the Director of Corporate Governance.

4. **Head of Internal Audit Opinion (HoIAO) 2021/22** – The Committee received the final HoIAO for 2021/22, giving an overall opinion of '*Significant Assurance*'. A much improved position with overdue recommendations was also reported. The Committee placed on record their thanks to the Internal Audit team for their work over the last year.

5. **Trust Annual Report 2021/22** – Approved, subject to some minor adjustments resulting from observations by the Committee, and final considerations (e.g. insertion of AGS, audited accounts, etc.) before the required deadline.

Confirm or Challenge of the Board Assurance Framework:

The Committee received the Q4 BAF report, however due to the timing of the meeting this report had already been to the Board for consideration. Committee discussion took place in relation to business continuity plans (stemming from a question around possible supply chain risks as a result of external factors).

Action Required by the Trust Board:

The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed.

Simon Parkes
Non-Executive Director / Chair of Audit, Risk & Governance Committee

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2022 / 23

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

Risk Appetite Statement - 2022 / 23

Context

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

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

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

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

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

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

The Trust recognises it has a responsibility to manage risks effectively in order to:
• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Risk Appetite Assessment

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

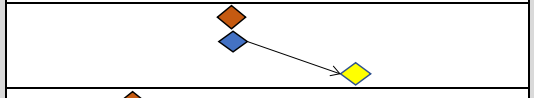
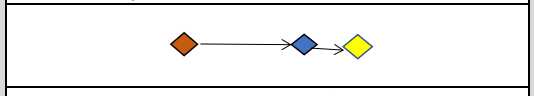
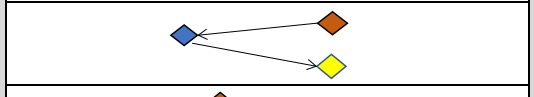
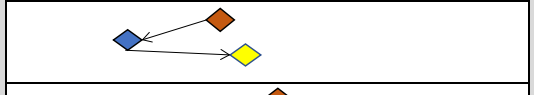
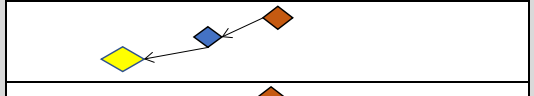
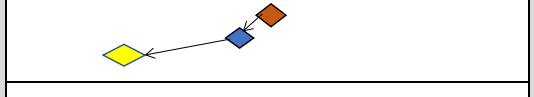
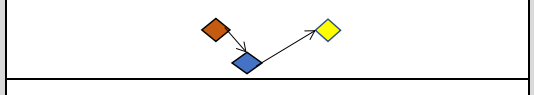
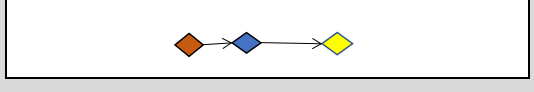
Based on this scoring methodology broadly the Trust's risk appetite is:

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

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

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

Strategic Risk Ratings

Strategic Risk	High Level Risk Description	Risk Consequence / Likelihood Assessment	Risk Appetite	Risk Rating 2021-22	Target Risk	Risk Rating 2022-23				Target Risk	Owner	Assurance Committee
				Q4	31.03.22	Q1	Q2	Q3	Q4	31.03.23		
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		Low	15	15	15				15	Medical Director and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets		Low	20	20	20				15	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy		Low	12	8	12				6	Director of Strategic Development	SDC
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate		Low	20	20	20				20	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care		Low	9	9	9				6	Chief Information Officer	ARG
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope		Low	16	16	16				8	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.		Low	20	8	20				12	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities		Moderate	5	5	15				20	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		Moderate	12	15	12				20	Director of Strategic Development	SDC
SO4	The risk that the Trust is not a good partner and collaborator		Moderate	12	8	12				8	Director of Strategic Development	SDC
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives		Moderate	12	8	12				8	Chief Executive	WC

KEY	
	Inherent risk score
	Current risk score
	Target risk score

KEY TO COMMITTEE NAMES

Quality and Safety Committee - Q&SC
Finance and Performance Committee - F&PC
Audit Risk and Governance - ARGC
Workforce Committee - WC
Strategic Development Committee - SDC

Strategic Objective 1 - To give great care

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

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

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	3	3	3	3	2
Risk Rating Score	15	15	15	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed: July 2022
11 April 2022
11 January 2022

Lead Committee:
Quality and Safety Committee

Risk Owners:
Medical Director and Chief Nurse

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

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan (approved Trust Board 1/6/2021)
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- -Risk Management Group
- Trust Management Board
- Quality Board, NHSE/I
- Quality Review Meetings with CCGs
- SI Collaborative Meeting with CCGs
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare
- Daily staffing meetings
- Serious Incident Panel and Serious Incident Review Group, Patient Safety Specialist and Patient Safety CHampions Group

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- 15 Steps Accreditation Tool
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- Nursing and Midwifery dashboards
- Ward Assurance Tool
- Nursing Metric Panels
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Friends and Family Test (FFT) platform
- Board Development Sessions - Monitoring CQC Progress
- Risk Stratification Report to Q&SC
- PPE Audits and IPC Dashboard
- Health Scrutiny Committees (Local Authority)
- Insights survey
- Stop and Check Safety Huddle
- Intentional rounding
- Nursing and Midwifery Red Flags
- Falls Huddles
- OPEL staffing levels
- Nursing assurance safe staffing framework NHSI

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance

Planned Actions

Q4 2021/22
- Implement supportive observation
- Continued roll out of stop and check safety huddle
- Birthrate plus review

Q1 2022/23
- Preparation for trust requirements in DOLs by 31 April 2022
- Continue to develop metrics as data quality allows

Q2 2022/23
- Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2022 (later due to national delays).

Q4 2022/23
- Delivery of deteriorating patient improvement plan

Ongoing
- Implementation of End of Life Strategy
- Annual establishment reviews across nursing, midwifery and community settings continue
- Update IPC BAF as national changes and requirements
- Continued management of COVID19 outbreaks
- Workforce Committee undertaking Workforce Planning linked to Business Planning.

Future Risks

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

Strategic Threats

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

Adverse impact of external events (ie. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core service.

Workforce impact on HASR.

Gaps in Controls

- Estate and compliance with IPC requirements - see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Fully funded Learning Disabilities team across both sites
- Attracting sufficiently qualified staff - see BAF SO2

Gaps in Assurance

- Mandatory training
- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Ophthalmology Waiting List remains sizeable

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
- Failure to meet constitutional targets in ECC (2562) Medicine (20) - Mandatory training compliance for medical staff (2898) - Medicine (16) - Lack of Changing Places facility at SGH (16) Chief Nurse Office (16), Risk of Harm in ED due to length of stay in department (3036) Medicine (16)
- Risk to overall performance - Surgery (2245 rated 20) - Risk to overall cancer performance - Clinical Support Services (2244) - Risk Rating 16 (previous risk rating 16), Joint Oncology Risk for HASR (2949) - Medicine (20) - Follow up of out patients who cancel repeatedly and have not been risk stratified (2997) Surgery (16)
- Deteriorating patient risks - Medicine (2388) - Risk Rating 15, Surgery (2347) - Risk Rating 15, Paediatrics (2390) - Risk Rating 12 (previous risk rating 15) - Delays in Children being seen at DPoWH by Paediatric Endocrine Service (3018) Family Services (15), Medical Workforce vacancies in Gastroenterology (3045) Medicine (16)

There are high level risks pertaining to other strategic risks, referenced elsewhere on the BAF, eg BAF SO2 staffing risks

Divisional / Departmental Risks Scoring <15;
- Management of formal complaints (2659) - Risk Rating 12 (previous risk rating 12, before that 15)
- Inequitable division of LD Nurses (2531) - Risk Rating 12 (Previous risk rating 20)
- Mortality performance (2418) - Risk Rating 10 (previous risk rating 15).
- Ceilings of care and advance care planning (2653) - Risk Rating 9 (previous risk rating 12)
- Child Protection Information System (2914) - Risk Rating 6, (previous risk rating 15)

(69 Moderate Risks and 8 Low Risks linked to quality and safety; previously 27 Moderate and 8 Low).

Future Opportunities

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

Strategic Objective 1 - To give great care

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

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

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	4	3	2
Risk Rating Score	20	20	20	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed: July 2022
11 April 2022
24 January 2022

Lead Committees
Finance and Performance Committee

Risk Owners:
Chief Operating Officer

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

Current Controls

- Operational Plan 2021-22 (Trust Board approved 1/6/2021)
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- Strategic Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Planned Care Board
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)

Assurance (internal & external)

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

Positive:
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.

External:
- NHSI Intensive Support Team
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Humber Cancer Board

Planned Actions

Q4 2021-22
- Consultant job plans to be updated..
- Workforce and resources to Humber Cancer Board.
- Develop divisional dashboards.
- Public Health England guidance (cancer diagnosis) reviewed and implemented.
- Further development of the ICP with HUTH.
- Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties.
- Consultant led ward rounds, further development and implementation (ECIST).
- Community 2 Hour Urgent Crisis Response (UCR) service and performance reporting to be implemented.
- Introduction of Advanced Conscious Sedation and Community Inhalation Sedation in Community Dental Services
- Diversion of Category 5 EMAS calls to North Lincolnshire SPA to enable local response and avoid admission
- Establishment of pathway for YAS to access the North Lincolnshire SPA in the same way as EMAS

Q1 2022-23
- Outpatient transformation plan by 2022.
- Development of Phase 2 three year HASR Plan by 2022.
- Revision and Development of QSIS plans
- Progress P1 of HASR Plan - Haematology, Oncology, Dermatology
- Implementation phase 3 of AAU business case
- Validation of all RTT Clock Stops back to 75%
- Confirmation of contracting rules for 22/23 for use of IS providers

Q2 2022-23
- Job plans complete for 22/23
- Opening of new ED build at DPoW
- Implementation of the UCS Model (funding based on Business Case agreement) On hold - Review of South Bank Urgent Care Services taking place
- Outcome of the Urgent Care Services Review for South Bank of ICS agreed

Q3 2022-23
- Development of ward 25 at SGH to provide addition single rooms
- Validation of all RTT Clock Stops back to 100%

Q4 2022-23
- Diagnostic and cancer pathways reviewed and implemented.
- Opening of new ED build at SGH

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 62 days and 104 days breaches, due to COVID-19.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to COVID-19.
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Risk of independent sector providers not providing required capacity due to workforce issues (as they use NHS Consultants).
- Risk to Dermatology Service if HASR doesn't progress (retirement of 1 of the 2 wte consultants in March 2022)
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS from April 23
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times
- Risk of no contracting for independent sector work
- Risk to gastroenterology service due to 2 WTE consultant vacancies
- Risk that funding will not be approved for further use of Independent Sector
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Mutual Aid

Strategic Threats

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

Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Capacity to Reduce 52 week, 104 day and over 18 week waits to meet the trusts standard of 0 waits over 40 week in 2022.
- Limited single isolation facilities.
- Review of effective discharge planning.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- Validation of RTT Clock Stops is being undertaken in high risk areas specialties only due to ongoing capacity pressure as a result of COVID
- Reduced bed capacity due to IPC compliance requirements and high levels of norovirus (DPOW) and Covid within the Trust
- High levels of staff sickness
- Ensuring the trust is utilising its current capacity

Gaps in Assurance

- QSIS Standards improvement plans.
- Demand and Capacity planning for Diagnostics.
- Meeting national standards
- Increase in Serious Incidents due to not meeting waiting times.
- Patient safety risks increased due to longer waiting times.

Links to High Level Risks Register

- Cancer 62 Day Target (2592)
- Risks of non-delivery of constitutional cancer performance (2160)
- COVID-19 performance and RTT (2791)
- Constitutional A&E targets (2562)
- Instability of ENT Service (2048)
- Overdue Follow-ups (2347)
- Shortfall in capacity with Ophthalmology service (1851)
- Accuracy of data of business decision making for RTT (2515)
- Delayed or missing internal referrals (2826)
- Shortage of radiologists (1800)
- MRI Equipment (1631)
- Replacement of X-Ray Room (2646)
- SGH Main MRI Scanner capacity and waiting lists (2499)
- Failure to meet 6 week target for CT/MRI (2210)
- Failure to review ophthalmology patients in specified timescales (2347)
- JAG Accreditation in housing enema room within clinical area (2694)
- Impact on Medicine Divisional business plan / service delivery (2700)
- Paediatric Medical Support Pathway for ECC (2576)
- Breast Oncology Services (2948)
- Depleted Consultant workforce (Breast Team) - (2999)
- Decrease in Max Fax Capacity at HUTH (3009)
- Oncology Service (2949)
- Failure to meet constitutional standards for Cancer (2569)

Future Opportunities

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

Strategic Objective 1 - To give great care

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

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

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	3	3
Likelihood	3	3	2	2	2
Risk Rating	12	12	8	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 23/6/22
13 April 2022
12 January 2022

Lead Committees: Strategic Development Committee

Risk Owner: Director of Strategic Development

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

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2022/23
- Humber and North Yorkshire Health Care Partnership (HNY HCP).
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS.
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board*(JDB)*
- Committees in Common (CIC)
- Strategic Development Committee (SDC)

Assurance (internal & external)

Positive:
- NHSE/I Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review

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

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).

Planned Actions

Q3 2021/22
- To formulate a vision narrative (PCBC) for Humber Acute Services review that is understood by partners, staff and patients by December 2021 (Draft complete)

Q4 2021/22
- To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review
- OSC - reviews.
- NED / Governor reviews
- Citizens Panel reviews
- To undertake continuous engagement process with public and staff.
- Evaluation of the models and options with stakeholders

Q1 2022/23
- Draft report from Clinical Senate review (end May 22)
- Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case (end June 22)
- NHSEI Gateway review
- ICS Board Approval

Q2/Q3 2022/23
- Public Consultation

Future Risks

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

Strategic Threats

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

Gaps in Controls

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

Gaps in Assurance

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

Links to High Level Risks Register

- Clinical Strategy (RR no 2924).

Future Opportunities

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

Strategic Objective 1 - To give great care

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

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

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	4	4	4
Risk Rating	20	20	20	20	20

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: July 2022, 12 April 2022, 11 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Director of Estates and Facilities

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

Current Controls

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

Assurance (internal & external)

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

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

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

Planned Actions

Ongoing Actions:
- Continue to produce and revise our 3 year business plans on an annual basis in line with Clinical & Estates & Facilities Strategy. Prioritisation is reviewed and updated as part of the business planning cycle - Action date; ongoing
- Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing
- Allocation of Core Capital Funding assigned to infrastructure and engineering and equipment risks through the monthly E&F governance process - Action date; ongoing

Q1 2022/23
Start Backlog Maintenance programme
Continue Ward 25 refurbishment
Start Core Capital Programme
Start refurbishment of old DPOW ED
Q2 2022/23
Continue Backlog Maintenance programme
Continue Ward 25 refurbishment
Continue Core Capital Programme
Continue refurbishment of old DPOW ED
Q3 2022/23
Continue Backlog Maintenance programme
Complete Ward 25 refurbishment
Continue Core Capital Programme
Continue refurbishment of old DPOW ED
Q4 2022/23
Continue Backlog Maintenance programme
Complete Core Capital Programme
Complete refurbishment of old DPOW ED

Future Risks

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

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes
- Within the next three years a significant (60%) proportion of the trust wide estate will fall into 'major repair or replacement' 6 facet survey categorisation
- A further breakdown of strategic risk detailed in the 2019/20 6 Facet Survey Report: 22% of SGH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'
- 19% DPoW total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'
- 29% GDH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'

Gaps in Controls

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

Gaps in Assurance

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

Links to High Level Risks Register

There are approximately 21 Estates and Facilities risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the physical infrastructure and engineering equipment being inadequate or becoming inadequate. Of particular note, there are a number of high risks relating to workforce, water infrastructure, medical gases, electrical and fire compliance that place increased risk to the Trust's overall strategic ability to provide patient care in a safe, secure and suitable environment.

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP) - possible updated in July 2022

Strategic Objective 1 - To give great care

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

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

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	3	3	3
Likelihood	4	3	3	2	2
Risk Rating	16	9	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed: July 2022
11 April 2022
11 January 2022

Lead Committees:
Audit, Risk and Governance Committee

Risk Owner:
Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

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

Assurance (internal & external)

Internal:
- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board

External:
- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Limited Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019

Positive Assurance:
The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reportin

Planned Actions

Q3 2021/22
- Development of a comprehensive IT BC / DR Programme including monitoring of adherence to the programme. Results of BC / DR tests recorded and formally reported by 31 December 2021. External Project Manager appointed to undertake further work on the IT BC/ DR Programme to be completed by 30,Sept. 2022 (extended from 30 April 2022) DSPT Ref: IA-20724
- Digital Reporting schedule/Work plan for Board Committees completed as of the 4th Qtr 21/22

Report to ARG July 27

Q4 2021/22
- The Data Warehouse options appraisal was approved through governance structures by February 2022
- Implementation of the Data Warehouse commenced in April 2022
- Year 2 Digital Aspirant Funds available to support funding Digital Programs (20/21 & 21/22)

Q2 2022/23
- IPR - further development of Digital, Finance and Estates KPIs to be reported, by September 2022
- Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (2nd Qtr 22/23 -July 2022)

Other:
- Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Digital Aspirant Funds £5 M secured with additional internal Capital to deliver projects 21/22 & 22/23. Depending on when NHSX releases funds for the Unified Tech Fund, we work with the ICS to bid for funds to continue our "levelling strategy" across the ICS
- £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical Devices and other unmanaged IT devices on the Trust network

Future Risks

- COVID-19 surge and impact on adoption of digital transformation
- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

The recent DSPT has 3 assertions not met, 12 partial. The Partials will be met relatively quickly. The 3 assertions - are being worked addressed.

1. Business Continuity Plans and Asset Register

Two contractors have been secured who will work on these dedicated projects for an 8-week period with a completion date of end of Sept. 2022

2. Training needs analysis - this is under development. Training met was 91% out of a target of 95%. This requires operations to ensure staff have taken the training.

3.. Attack Detection and Response

Cyber funding was awarded from NHS Digital in October 2021 for Medical Device management on Trust Network. Procurement is in progress for an 'Attack Detection and Response (ADR) for Healthcare'. Expected completion end of March 2022. Being implemented, due to some technical challenges it will be completed in July 2022.

Strategic Threats

- Capital funding to deliver IT solutions and establish a 3 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit and mandatory training compliance - in progress

Gaps in Assurance

- Integrated Performance Report - the Digital and Estates
- Data Warehouse solution to support outcomes from BI review

Links to High Level Risks Register

- Accuracy of Data of Business Decision Making. Finalizing spec to procure new data warehouse. (2515) med Risk (10)
- Risk of non-compliance with the Data Protection Act 2018 due to the Trust not having sufficient resource and technical tools to conduct forensic searches on use of data. Currently rolling out 365 and discussing wiht NHS D on recommened search tools. (2676) Medium Risk (10)
- Data & Cyber Security: (2) Cyber Infrastructure (2408) - Risk High (16)
- Updated Business Continuity & Disaster Recovery Procedure (2299) Risk Medium (9)

Future Opportunities

- Humber Coast and Vale ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HASR and Acute Care Collaborative

Strategic Objective 1 - To give great care

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

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

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4
Likelihood	2	4	4	2	1
Risk Rating	8	16	16	8	4

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: July 2022
11 April 2022
24 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

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

Current Controls	Assurance (internal & external)	Planned Actions	Future Risks
• Winter Planning Group. • Strategic Planning Group. • A&E Delivery Board. • Director of People - Senior Responsible Owner for Vaccinations. • Ethics Committee. • Clinical Reference Group • Influenza vaccination programme. • Public communications re: norovirus and infectious diseases. • Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group. • Ward visiting arrangements changed and implemented, Red and Green Zones, expansion of critical care faciliites. • COVID-19 Executive Incident Control (Gold Command). • Patient Flow Improvement Group (PFIG) • Discharge System Improvement Group • Planned Care Improvement and Productivity (PCIP)	**Internal:** • Regional EPRR scenarios and planning exercises in preparation for 'Brexit' have been undertaken alongside partners, including scenarios involving transportation, freight and traffic around local docks with resulting action plan. • Business continuity plans. • Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP **Positive:** • Half yearly tests of the Major incident response. • Annual review of business continutiy plans. • Internal audit of emergency planning compliance 2018/19 (due 2021/22). **External:** • Emergency Planning self-assessment tool. • NHSE review of emergency planning self-assessment 2019/20. • Internal audit of emergency planning compliance 2018/19 (due 2021/22).	Q4 2021/22: • Capacity to meet demand workforce) • Introduction of 24/7 Operational Matron rota for Scunthorpe General Hospital and Diana Princess of Wales Hospital Ongoing: • Lateral flow testing staff is ongoing. • Business Intelligence monitoring re: pandemic.	• COVID-19 third surge. • Availability of dressing, equipment and some medications post Brexit. • Costs and timeliness of deliveries due to EU Exit. • Additional patients with longer waiting times RTT, Cancer and Diagnostics due to COVID-19. • Risk to Oncology Waiting Times due to HUTH operational pressures. • Risk to Dermatology Service if HASR doesnt progress (retirement of 1 of the 2 wte consultants in March 2022) • Longer waiting times for pateints due to HUTH Mutual Aid work • Risk to gastroenterology service due to 2 WTE consultant vacancies **Strategic Threats** A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Gaps in Controls	Gaps in Assurance	Links to High Level Risks Register	Future Opportunities
• Capacity to meet demand (workforce). • Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into January 2022		• Cancer 62 Day Target (2592) • Risks of non-delivery of constitutional cancer performance (2160) • COVID-19 performance and RTT (2791) • Constitutional A&E targets (2562) • Instability of ENT Service (2048) • Overdue Follow-ups (2347) • Accuracy of data of business decision making for RTT (2515) • COVID-19 Isolation (2794) • C-19 Equipment (2793) • C-19 Patient Safety (2792) • COVID -19 pandemic - surgery & critical care (2706) • COVID -19 pandemic - community and therapies (2708) • Impact on Medicine Divisional business plan / service delivery (2700) • Risk arising as a result of COVID-19 - clinical support services (2704) • Breast Oncology Services (2948) • Oncology Service (2949) • Quality of Care (due to nurse staffing position) (2145)	• Closer Integrated Care System working. • Provider collaboration.

Strategic Objective 2 - To be a good employer

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

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

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	4	4	
Likelihood	3	4	2	3	
Risk Rating	15	20	8	12	

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 6 April 2022
March 2022 July 2022

Lead Committee: Workforce Committee

Risk Owner: Director of People

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

Current Controls

- Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, Remuneration and Terms of Service Committee
- NHS People Plan
- NLAG People Strategy approved by the Board June 2020
- NHS Staff Survey - annual
- Collaborative engagement with CCG, forum established to support closer working and transformational changes.
- Holistic requirements of Humber Coast and Vale workforce led by People Lead for Humber Coast and Vale (HCV) Integrated Care System (ICS)
- People Directorate Delivery Implementation Plan 2021-22 (Workforce Committee approved 27/4/2021)

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, Remuneration and Terms of Service Committee.
- Workforce Integrated Performance Report
- Annual staff survey results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

Planned Actions

Q1 22/23
- Developing Recruitment plans for 22/23 to recruit to non registered and registered nursing vacancies
- Review of Recruitment Processess to ensure that they are streamlined, inclusive, responsive and timely
- Health and Wellbeing plan offer rolled out to staff
- Just and Learning Culture Framework to be introduced/piloted as part of the roll out of the new disciplinary policy – subject to approval of disciplinary policy
- Setting up a working group to oversee payment processes to ensure streamlined processes between People/Operations and Finance Directorate
- Set up Culture Transformation Board to develop plans to address issues identified through staff survey, FTSU and other data on staff morale and culture
- Review of Statutory and Mandatory training is underway to clarify what staff need to undertake in line with national benchmarks

Introduction of Team Brief Live to directly communication with staff

Q2 2022/23
- Culture Transformation Launch event - 4th August
- Development and Sign off of Performance Metrics to support roll out of Leadership Strategy and Culture Transformation

Development of Recrutiment Dashboard to support recrutiment delivery
Implementation of Clever Together to support staff engagement
- Continued implementation of People Strategy by 31 March 2024
- Delivery against NHS People Plan - ongoing.
- Continue collaboration between NLAG and HUTH and the HCV wider network.
- Outputs from the currently live Staff Survey and quarterly Pulse Survey
- Continued review of the Health and Wellbeing offer to staff
- Review of the Educational /Leadership Development offer and future roll out of programmes
- Staff Survey 22/23 roll out

Future Risks

- COVID-19 third surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes / EU Exit.
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda

Strategic Threats

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

Gaps in Controls

- Slower international recruitment of clinical staff due to visa backlogs

Gaps in Assurance

- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits

Other Significant Risks & Links to High Level Risks Register

There are approximately 14 staffing risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the haematology workforce, staffing (nurse, midwife, medical, radiologists) that place an increased risk to the Trust's overall strategic ability to provide a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) and to provide the levels and quality of care which the Trust needs to provide for its patients.

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment

Strategic Objective 3 - To live within our means

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

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

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	2	3	1	4	4
Risk Rating	10	15	5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 19 July 2022
18 May 2022
31 January 2022

Lead Committees: Finance and Performance Committee

Risk Owners: Chief Financial Officer

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

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning
- Humber Acute Services (HAS) engagement to redesign fragile and vulnerable service pathways at system and sub system level.
- Monthly ICS Finance Meetings
- Finance Meeting - HAS
- Operational and Finance Plan 2021-22 (approved at Trust Board June 2021)
- Financial Special Measures Meeting with NHSE/I
- Counter Fraud and Internal Audit Plans

Assurance (internal & external)

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

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSEI

External:
- Financial Special Measures Meeting - Letter from NHSE/I related to financial special measures and achievement of action plan
- ICS delivery of H1 financial plan
- HASR Programme Assurance Group
- Approval received for AAU business case from NHSE/I

Planned Actions

Q4 2021/22
- Undertake financial planning as part of HNY HCP exercise and agree a balanced financial plan for 2022/23 - this is still work in progress with a plan deficit of £6m currently. Included within this are two key actions: productivity improvement plans to return the Trust to 19/20 activbity levels as a minimum, and a robust and recurrent cost improvement plan which is capable of being delivered in year

2022/33
- Develop plans for 2023-25 to demonstrate return to underlying financial balance
- Agree financial implications of P1 specialties for transacting as and when work is complete
- Work with system partners, specifically community and local authorities to ensure that our local systems are working in unison to tackle the issues of system flow

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- National policy changes
- Impact of HAS plans on NLaG clinical and non clinical strategies
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems

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

Gaps in Controls

- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on application of long term financial framework.
- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process

Gaps in Assurance

- Integrated Performance Report - Finance
- Delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the pandemic
- Individual organisational sustainability plans may not deliver system wide control total

Links to High Level Risks Register

- Unable to meet CIP delivery - surgery (2599).
- COVID-19 Expenditure (ref: Financial Plan 2021-22)
- Savings Programme (ref: Financial Plan 2021-22)

Future Opportunities

- Closer ICS working
- Provider collaboration
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

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

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

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	5	5	5
Likelihood	2	3	3	4	4
Risk Rating	10	12	15	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 23/6/22
13 April 2022 (DoSD)
14 February 2022

Lead Committees:
Finance and Performance Committee
Strategic Development Committee
Committees in Common

Risk Owners:
Chief Financial Officer and
Director of Strategic Development

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

Current Controls

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

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE/I attendance at AAU / ED Programme Board
- NHSE/I Assurance Review Feedback
- CiC Minutes

Planned Actions

Q4 2021/22
- Agree forecast spend for current year as part of wider ICS capital planning exercise.
- Find a solution to address BEIXS/Salix funding issues with regards to year end cut off.
- Develop 2022/23 capital plan as part of comprehensive service planning exercise - to be completed by end February 2022
- Secure approval for Acute Assessment Unit, Full Business Case
- Develop HASR Programme 3 proposition to Pre Consultation Business Case stage

Q4 2021 - Q1 2022/2023
- Develop Capital Investment Strategic Outline Case for development of SGH/DPoW
- Develop TiF submission through acute collaboratives for Elective Hub
- Develop integrated bid across N and NE Lincs for implementation of CDH aligned to ICS Core Programme

Future Risks

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

Strategic Threats

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

Gaps in Controls

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

Gaps in Assurance

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

Links to High Level Risks Register

- Salix funding gap
- HASR Capital EOI risk of not being part of Top 30 and subsequent 8

Future Opportunities

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

Strategic Objective 4 - To work more collaboratively

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

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

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	4	4	3
Likelihood	3	3	2	2	2
Risk Rating	15	12	8	8	6

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 23/6/22
13 April 2022
12 January 2022

Lead Committee: Strategic Development Committee

Risk Owner: Director of Strategic Development

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

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Strategic Development Committee (SDC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY HCP.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common (Trust Board approved 1/6/2021)
- Acute and Comunity Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process

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

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Q3 2021/22
- Recruit to Strategic Development - Associate Medical Director to support the ICS collaboration - Dec 21 (complete and in post)

Q4 2021/22
- HAS two year programme (current to March 2023) - 12 month rolling.
- Options appraisal for HAS Capital Investment to be approved

To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review
- OSC - reviews.
- NED / Governor reviews.
- Citizens Panel reviews.
- Clinical Senate reviews
- To undertake continuous engagement process with public and staff.
- Evaluation of the models and options with stakeholders.

Q1 2022/23
- Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case.
- NHSEI Gateway review.
- ICS Board approval.

Q2/Q3 2022/23
- Public Consultation.

Future Risks

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

Strategic Threats

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

Gaps in Controls

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

Gaps in Assurance

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

Links to High Level Risks Register

- Clinical Strategy (RR no.2924).

Future Opportunities

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

Strategic Objective 5 - To provide good leadership

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

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

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	
Likelihood	4	3	2	2	
Risk Rating	16	12	8	8	

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 6 April 2022
March 2022 July 2022

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

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

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS
- CQC and NHSE/I Support Teams
- Board development support programme with NHSE/I support.
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders and more programmes in development
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSI Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair and Chief Financial Officer, with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, HCV HCP and CCG

Assurance (internal & external)

Internal:
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Letter from NHSE/I related to financial special measures and achievement of action plan.
- Chief Executive Briefing (bi-monthly) to Trust Board

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan.

External:
- CQC Report - 2020 (rated Trust as Requires Improvement).
- Financial and Quality Special Measures.
- NHS Staff Survey.

Planned Actions

Q1 2022/23
- Introduction of x3 Portfolio Governance Boards including one for leadership and career development with representation from all stakeholder staff groups, leadership development programmes we design in-house, commission, or subscribe to, align with our People Strategy aims of attracting, developing and retaining leaders as a preferred employer. From April 2022, subject to funding
- Continued development of the Leadership Development Model for all leaders and managers towards building a culture of compassion-centred, collective leadership. This programme, modular in approach, will include Leading with Kindness, Courage and Respect, underpinned with processes and skill development in difficult conversations, embodying the Trust values, and improving what it feels like for staff to work at NLaG. From April 2022, subject to funding

Q2 2022/23
- Refreshing of the coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring. All participants on leadership development programmes will have a coach for the duration of their development course. We aim to introduce mentoring, both peer to peer, role and career, and reverse, during 2022 with some small scale pilot programmes including a pilot EDI-centric reverse mentoring programme to further strengthen inclusion. September 2022, subject to funding

Q3 2022/23
- Refresh of our PADR process referred to in the Training & Development submission, will include process components and skills training to enable identification of talent, development of potential, and proactive planning for succession. Refer to the Leadership and Career development draft schematic in the Appendices for concept. December 2022
- Introducing a managerial core skills programme for newly appointed managers 2022 and beyond. December 2022

Q1 2023/24
- As part of both leadership development and succession planning, we will be seeking collaborative team working across the ICS for the introduction of a HCV Shadow Board programme. From April 2023

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Current vacancy for the Head of Education which is currently being covered by temporary resource

Strategic Threats

- Non-delivery of the Tr+L21ust's strategic objectives
- Continued quality/financial special measures status
- CQC well-led domain of 'inadequate'
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

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

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

NLG(22)135

Name of the Meeting	**Trust Board (public)**	
Date of the Meeting	2 August 2022	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Board Assurance Framework (BAF) 2022-23, Quarter One Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To present the BAF to the Trust Board for assurance. The Trust Board is asked to: a) note the BAF in Appendix 1 b) note the risk scoring for each strategic risk c) note the following Committees have reviewed the strategic risks: Finance and Performance Committee – 20 July 2022 Workforce Committee – 19 July 2022 Quality and Safety Committee – 25 July 2022 Audit Risk and Governance Committee – 27 July 2022 Trust Management Board – 1 August 2022	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Trust Board Committees
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	

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

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

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

Board Assurance Framework – Quarter One 2022-23

1. Purpose of the Report

1.1. To present the BAF to the Trust Board for assurance and for the Board to review current scoring of the strategic risks.

1.2. All strategic risks have been reviewed by the Executive Owners and the Trust Board Committees.

2. Strategic Objective Risk Ratings: 2021-22 Quarter Four and 2022-23 Quarter One

2.1. The table below illustrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2023:

Strategic Objective	2021-22		2022-23		Risk Appetite Score
	Risk as at Quarter 4	Target Risk by 31/03/2022	Current Risk Rating as at Quarter 1	Target Risk by 31/03/2023	
SO1-1.1	15	15	15	15	4-6
SO1-1.2	20	20	20	15	4-6
SO1-1.3	12	8	12	6	4-6
SO1-1.4	20	20	20	20	4-6
SO1-1.5	9	9	9	6	4-6
SO1-1.6	16	16	16	8	4-6
SO2	20	8	20	12	4-6
SO3-3.1	5	5	15	20	8-12
SO3-3.2	12	15	12	20	8-12
SO4	12	8	12	8	8-12
SO5	8	8	12	8	8-12

2.2 The Board is to note that several strategic risks remain at a high level of 15 and above.

2.3 The full BAF is available at Appendix 1.

3. Recommendations

The Trust Board is asked to:

a) note the BAF in Appendix 1
b) note the risk scoring for each strategic risk
c) note the Committees have reviewed the strategic risks at the most recent meeting:
Finance and Performance Committee – 20 July 2022
Workforce Committee – 19 July 2022
Quality and Safety Committee – 25 July 2022
Audit Risk and Governance Committee – 27 July 2022
Trust Management Board – 1 August 2022

Name of the Meeting	**Trust Board**
Date of the Meeting	2nd August 2022
Director Lead	Jug Johal- Director of Estates & Facilities
Contact Officer/Author	Bill Parkinson – Associate Director of Safety & Statutory Compliance
Title of the Report	**Trust Annual Fire Report 1st April 2021 – 31st March 2022**
Purpose of the Report and Executive Summary (to include recommendations)	An annual report of fire safety management covering the period specified is required to go to the Trust Board in accordance with the HTM requirements. Summary – A significant amount of work in relation to fire safety management has been undertaken in the year. Not least is the replacement of the fire alarm system at DPOW. The performance of the SGH fire alarm system is showing an increasingly deteriorating performance and consideration needs to be given to replace the system in its entirety. Face to face training that was suspended due to Covid restrictions is recommencing and fire wardens training is being rewritten and launched in 22/23. Fire door inspection systems are also being reviewed to look to introduce in 22/23
Background Information and/or Supporting Document(s) (if applicable)	Fire Safety (Regulatory Reform) Order 2005 (as amended) and 05-01 Managing healthcare fire safety (including associated HTM 05-03 documents)
Prior Approval Process	☐ TMB ☐ PRIMs ✓ Divisional SMT ✓ Other: Health, Safety & Fire Group, Audit, Risk & Governance Committee
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working ☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Capital costs for SGH fire alarm replacement
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A

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

*Board Assurance Framework (BAF) Descriptions:

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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates & Facilities

Annual Fire Report

1st April 2021 to 31st March 2022

CONTENTS

1.0 INTRODUCTION

The Regulatory Reform (Fire Safety) Order 2005 (FSO) came into force in October 2006 and required "general precautions" to be implemented where "necessary and to the extent that is reasonably practicable" for the protection of "relevant persons".

The responsibility for compliance with the FSO rests with the "responsible person" which in the case of Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) is the Chief Executive Officer or in the event of remote buildings off site buildings this may be the person in control of those premises.

Generally, the CEO is responsible for ensuring that, through appropriate delegation, current fire statutory requirements are met. In addition, for areas within the definition of clinical activities, that the requirements of Health Technical Memorandum (HTM) 05-01 (Fire Safety Management within Healthcare) are also complied with (as well as the accompanying HTM's linked to 05-01.

Day to day responsibilities for fire safety management are delegated to the Director of Estates & Facilities with appropriate competent persons (as indicated within the HTMs) in place to assist them to achieve compliance.

This report has been developed to provide information to the Trust Board of Directors concerning the management of fire safety for the period **1st April 2021 to 31st March 2022** and to also identify potential issues for the next 12 months.

This report will also assist with the formulation of annual statement within this report and may also assist with demonstrating performance against Regulation 15 of the Care Quality Commission (CQC) Essential Standards of Quality & Safety. This report should therefore be retained along with the workplan as the assurance to external authorities in terms of fire safety management within the Trust.

2.0 EXECUTIVE SUMMARY

Fires within acute Trusts are not common but should they occur then there could be significant risk to life and so the fire safety management strategy should be to:

- Prevent fires occurring
- Detect them at the earliest stage possible
- Ensure appropriate responses are made when a fire is detected
- Contain a fire to the immediate area and reduce the risk of spreading to other areas
- Should a fire spread then ensure that there is the ability to move to a safe place as soon as possible
- Ensure areas of high dependency such as Intensive Care Units (ICU) are constructed with additional measures, so the evacuation of these patients is regarded as the last resort

There has been some significant investment at the DPOW site in the last 12 months in that the Auto Fire Detection & Alarm (AFD) system has been replaced. Work to remove the old system will be completed by end of May 2022.

The incident where the main DPOW fire panel on the old system suffered a temporary failure, prompted a review of fire safety management and responses which has been undertaken in collaboration with Hull University Teaching Hospitals (HUTH) and a work plan for 2022-23 has been developed and is attached (see Appendix 2).

There are a number of risks relating to fire safety management on the Trust Risk Register. These are summarised below along with details of controls and work currently being undertaken.

The formation of a Fire Safety Technical Group to consider various detailed technical aspects relating to fire safety is seen as a positive step in ensuring that the correct oversight of fire safety management is in place. The Group reports to the Health, Safety & Fire Group (HSFG) which in turn has been aligned to report to the Trust Management Board (TMB) to allow for escalation where appropriate to the Trust Sub Board level and in accordance with HTM 05-01.

3.0 REPORT

3.1 Fire Risks on Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating
2038	Trust-wide	Risk of failure of Auto Fire Detection (AFD) system allowing fires to become developed and possible risk of serious harm/loss of life to patients/staff	• AFD system in DPOW being replaced and currently final soak testing and commissioning being completed. • SGH showing signs of increasing deterioration (as highlighted by the number of alarms due to system faults and will need replacing within 3 -4 years (based on similar experience of	20

			the old fire alarm system at DPOW) • GDH system stable currently but will need replacing at some future date	
2464	Trust-wide	Trust estates alarms not being effectively covered especially within the boiler-house which requires monitoring 24/7. Gaps in switchboard cover and estates staff cover difficulties are raising concerns that cover can be maintained	• Currently gaps are covered but are resources are increasingly strained due to illness and vacancies. • Upgrades to BMS ongoing including notifications of alarms to on call staff	12
2952	Trust-wide	Water Safety Compliance – fire ring main. Currently there are a number of Domestic Water Systems (DWS) connected to the fire ring main making it non-compliant with water safety and fire safety requirements	• Upgrades to water systems ongoing to remove DWS connections from fire ring main • Testing of fire hydrants for pressure and flow ongoing	16

Table 1 - Fire risks on Trust Risk Register

In addition, there are number of estates operational risks involving fire safety management. Currently, these are being developed into an E&F operational risk register which will be based on a 10 x 10 matrix and include costings to allow appropriate prioritisation processes to be implemented and more effective use of any additional funding that may be released during the 22/23 period.

Risks that have been addressed within the 21/22 period include significant risks associated with the Coronation Block building at SGH. A number of floors have now been successfully refurbished for staff administration activities after agreement with Humberside Fire Search & Rescue (HFSR) services that the building can continue to be used for administration activities only (due to the construction of the building meaning that the requirements of the HTM 05-01 for clinical services could not be met).

NB Agreement with HFRS currently allows the fracture clinic to operate within this building until an opportunity arises to re-locate this area.

3.2 Fire Safety Technical Group

The need for a technical fire sub group has been identified during the 21/22 period as the information relating to capital schemes, BLM work (e.g. fire alarm replacement at DPOW), cause and effect review etc. has been at an unprecedented level and at times has resulted in decisions to be

made at short notice and limited consultation. Some instances also identified that additional requirements needed to be considered and potentially this current process may result in risks being identified that take longer to resolve.

The formation of a fire technical safety group will allow all the relevant disciplines to consider fire safety management issues together and agree solutions to reduce risks and move items forward.

Reporting to the HSFG the Terms of Reference have now been approved and the first meeting will be scheduled from the beginning of 22/23.

The HSFG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the TMB to enable issues to be escalated when appropriate.

3.3 Fire Safety Management Polices

During the 21/22 period there was a failure of the main Fire Alarm Panel at DPOW for the old AFD system that is being replaced and the result of this failure was a number of alarms occurring in different parts of the main building. A number of concerns were raised in relation to the fire safety management policy and responses to alarm activations.

This resulted in a review of the existing policies being undertaken by Hull University Teaching Hospitals (HUTH) Fire Safety Advisor (an ex HFRS manager of the business safety section). There were a number of suggested changes to the policies and information which have been incorporated. However, overall the policies and information was in keeping with the HTM 05-01 requirements.

A number of other points were raised in terms of responses to fire alarm activations and these have been incorporated in the work plan attached to this report (see Appendix 2).

In terms of compliance with the requirements of the HTM an audit is shown in Table 2 below

Requirement	Status	Compliance Rating
Clearly defined policy.	The policy has recently been reviewed externally and suggested changes incorporated.	
Board Level Director – accountable to Chief Executive for fire safety.	Director of Estates & Facilities is assigned as the Board Level Director.	
Fire Safety Manager (FSM) – takes lead on all fire safety activities.	Associate Director of Safety & Statutory Compliance is the nominated Fire Safety Manager and trained in HTM 05-01 requirements.	
Fire Safety Officer (FSO) – assists the FSM in fire safety activities.	Fire & Safety Compliance Officer appointed – training to HTM to be completed in 22/23.	
Fire safety policies reviewed and appropriate groups	Health, Safety & Fire Group (HSFG) oversees fire safety issues and reports to TMB.	

monitoring fire safety issues.	Newly formed Fire Safety Technical Group (FSTG) will report to the HFSG and deal with the technical details and recommendations for the HSFG.	
Adequate means for quickly detecting and raising alarm in case of fire.	Fire alarm system is being replaced at DPOW. Current system at SGH is deteriorating and is likely to need be replaced within the next 3-4 years. The system at GDH is likely to need replacement within the next 5 years to maintain the integrity of the AFD system (based on alarm activations due to system faults).	
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas without reliance on external services.	Current procedures and training are being revamped. Also look at response teams and information for each area so able to initiate a suitable response in the event of an alarm activation	
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform.	Face to face training resuming and fire response for fire warden response being revised and trial of system to maintain fire wardens register.	
Reporting of fires and unwanted fire signals.	All alarm activations are registered via switchboard and notifications sent to the FSM and FSO for investigation	
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Collaborative working with HUTH, ongoing informal discussions with fire authority. No enforcement action undertaken in the last 12 months.	

Table 2 - Compliance with HTM requirements

3.4 Management of Fire Risks

There are currently 158 fire risk assessments covering the Trust and units which are currently being used by NLaG staff.

At present due to covid and capital projects work there are 27 assessments that are in the process of being reviewed which should have been completed in 21/22. In addition, there are 10 assessments identified as no longer required due to:

- Areas which have been refurbished and new assessments completed
- Areas/buildings no longer used by NLaG
- Buildings which have been sold or demolished

The current review periods for assessments are:

- In-patient areas - 12 months
- Out-patient areas - 24 months
- Admin areas - 36 months

Unfortunately, areas which are covid areas have been affected some review periods but these will be addressed during the 22/23 period.

The assessments are maintained on an electronic system which is cloud based system containing a number of assessment types (service provided by Evotix) and updated by the FSO and FSM. New areas such the new ED and SDEC projects are due to be added during the 22/23 period.

3.5 Structural Fire Protection

There are number of issues relation to structural protection against fire that are outlined below. In respect of the Grenfell Inquiries none of the buildings owned by NLaG are subject to the cladding restrictions which were introduced as a result of the fire. However, the Building Safety Act is currently going through the parliamentary process to become law during the 22/23 period. The Act is currently in the parliamentary committee stage after the second reading in the House Of Lords where changes voted in the second reading are under consideration for inclusion or rejection.

Present proposals have resulted in the Act now involving “High Rise High Risk Buildings” whereas previously this was restricted to residential buildings this is now not the case. There is a current debate as to what constitutes “high rise” and the proposed 18m level is the subject of debate (as in Scotland a height of 11m is used in existing legislation). Until the Act is published in its final form it is difficult to determine the impact on NLaG but there are areas which may require structural protection to be checked in existing buildings and it is proposed that the requirements are applied retrospectively so all buildings falling within the definition will be subject to the new Act. Once the Act is laid before the Rolls any actions identified will be incorporated into the work programme detailed in Appendix 2).

There is the requirement to use modern technology and in complex buildings it is advocated that the use of Business Information Modelling (BIM) systems for use where complex buildings are operated. This would include hospital buildings which due to the varied and numerous infrastructure services are generally regarded as being complex and such systems would also incorporate AFD systems. The use of BIM systems is currently being reviewed within the Estates & Facilities Directorate.

During the 21/22 period further work has been undertaken to confirm the 60 min compartment lines and update drawings to ensure the structural protection for Progressive Horizontal Evacuation (PHE) to be undertaken in the event of a fire. This work will be ongoing for the next few years and including reviewing the penetrations through compartments to ensure that they are appropriately fire stopped reducing the risk of fire migrating from one compartment to the next.

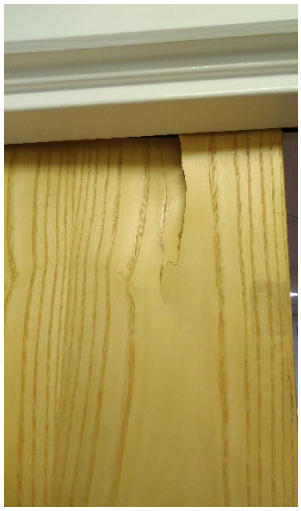
3.6 Fire Doors Inspection & Maintenance

The maintenance of fire doors is important as they are potentially the weakest element within the strategy of fire compartmentation. Damage to the door or the architrave itself can mean the fire retaining properties of the door set are severely compromised. Fire doors when damaged beyond repair will be required to be replaced as a door set and this can cost the Trust between £3,000 to £6,000 per door set.

In the 21/22 period damaged occurred to a number of door sets including that shown in Figs 1 & 2. It is claimed that the damage initially caused was not noticed but as can be seen in Fig 2 the door frame has split from front to back and a fire would penetrate through this door in a few minutes compared to the guaranteed 30 mins for the un-damaged door. The force required to inflict this damage is significant and the sound of the door frame splintering alone should have been noticed let alone the fact that the door would not be able to close properly.

Whilst noting that this damage could have been caused accidentally the fact that it was not reported for a number of months cannot and managers of areas should be undertaking visual checks in their areas to identify any such damage within the space of days and not months.

In order to try and reduce the amount of resources that have to be diverted from normal maintenance budgets to replace damaged doors the Trust during 21/22 commenced a pilot door inspection scheme which utilises a microchip/microdot connected to the wireless system. This allows for fire door to be inspected and any issues identified immediately. In addition a full history of the door including manufacturing details and test certificate can be placed onto the system and enable the Trust to demonstrate compliance with the requirements of the HTM in relation to door inspections. There will still be a need for informal weekly visual checks to be undertaken by managers within their own departments. However, a more formalised and documented system will be implemented should the pilot scheme prove successful. The pilot scheme is to be extended in 22/23 to include high risk areas such as ITU and HDU etc. and in addition training of estates staff to undertake authorised repairs is being reviewed during the 22/23 period.



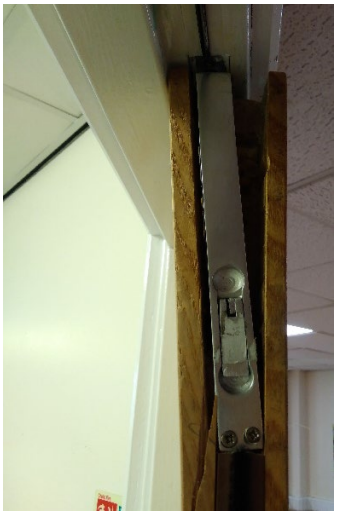


Figure 1 - Damaged fire door

Figure 2 - Damage to door at ceiling bolt

An awareness campaign directed at Manager level will be undertaken in the 22/23 period to ensure that managers are fully aware of what they can do to reduce these types of incidents and assist with making effective use of resources.

3.7 Fire Response Management

The FSO and HTM requirements in relation to a response to an alarm activation require organisations to deal with the initial stages of fires and alarm activations without relying on the attendance of the fire services. As a result of the Covid pandemic the responses and teams which were in place have now been dispersed over a number of areas, have resulted in staff working from home more or less permanently and have also resulted in staff retiring or leaving NLaG.

This has meant that the ability of the Trust to respond to alarms etc. needs to be refreshed and areas identified where more staff are needed to be trained to be able to respond. On a positive note, however, fire response teams are not the only staff members trained in the use of fire extinguishers as all staff receive this as part of their fire lecture refresher training.

However, during the 22/23 period areas where there are insufficient staff to be able to respond effectively, additional staff will be identified and trained to give the assurance that suitable and resilient resources are in place to respond within the initial stages of a fire alarm/incident occurring.

More details are also included in the sections below and timescales shown within the workplan attached in Appendix 2.

3.8 Fire Training

It should be noted that for the entirety of the 21/22 period no face to face training has been able to be undertaken due to covid restrictions. This has meant an acceptance that staff have been able to undertake the e-learning training during consecutive training periods.

This does not meet the requirements of the HTM which require staff to undergo a “fire lecture” with a competent fire safety person/trainer at least once in a period of 4 years. The period of validity for this training is two years so staff are required to undertake some form of training at least every two years. If one of the forms of training is via e-learning that this cannot be repeated in consecutive training periods. This requirement was temporarily suspended (after informal agreement with HFRS) until such time face to face training could be resumed.

The fire training compliance for the 21-22 period is shown in Table 3 below.

Period	16/17	17/18	18/19	19/20	20/21	21/22
% staff trained	80	79	78	84	84	91*

Table 3 - Fire Training Compliance

* - no face to face training

It can be seen that 21/22 showed a significant increase in compliance the elements of training that are included in the face to face training cover areas such as practical extinguisher training, responses, designated roles including activating PHE to an adjacent ward etc. Therefore, the subsequent increase does not indicate increased compliance due to factors which are local to the site and the ability to raise queries in relation of when to evacuate etc. that were not delivered during the 21/22 period. This will be addressed during the period 22/23 when face to face training is resumed.

3.9 Fire Alarm Activations and Unwanted Fire Signals

There is a lot of discussions in relation to fire alarm activations and the term Unwanted Fire Signals (UwFS). In some instances information submitted through the ERIC returns has identified these as the same but there is a difference and the Chief Fire Officers Association (FCOA) highlighted this in their guidance published in 2014 and defined them as such:

- Fire Alarm Activation (known as false alarms) – where an AFD system is activated either via the sensor head or via a manual call point activation (or system fault)which sends the main fire panel (and local panels) into alarm.
- UwFS – where an alarm activation causes a requirement for the local fire & rescue services to attend the organisation's premises un-necessarily and which impacts on the fire cover for the local population potentially putting lives at risk.

In terms of UWFS within local legislation the fire & rescue services are allowed to charge the organisation for each fire appliance that attends. The minimum level of attendance for NLaG is for three fire tenders for a fire call and current charges would mean a charge of £501 per call out.

These costs would only be charged to an organisation where there is a growing number of UwFS and it is therefore unlikely that NLaG would face these charges in the 2022/23 period as the number of fire call activations and UwFS are set out in Table 4 below.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22
SGH	3	7	4	3	10	10	7	7
DPOW	4	9	8	9	8	17	3	9
GDH	0	0	2	2	0	1	0	0
Total	7	16	14	14	18	28	10	16

Table 4 - UwFS for NLaG

If charges had been made under the legislation there would have been a cost of £8016 to the Trust.

In order to reduce the number of UwFS the Trust operates a 5 min delay in the alarm being picked up by the third party monitoring station. This process is known as call filtering and this has meant for the period 21/22 the amount of UwFS is only 5% of the total fire alarm activations. This is a good performance in comparison to known UwFS at other Trusts.

In terms of total alarm calls there were 234 for the period and these can now be broken down in different categories due to updated recording processes. The breakdown is shown in Figure 3 below.

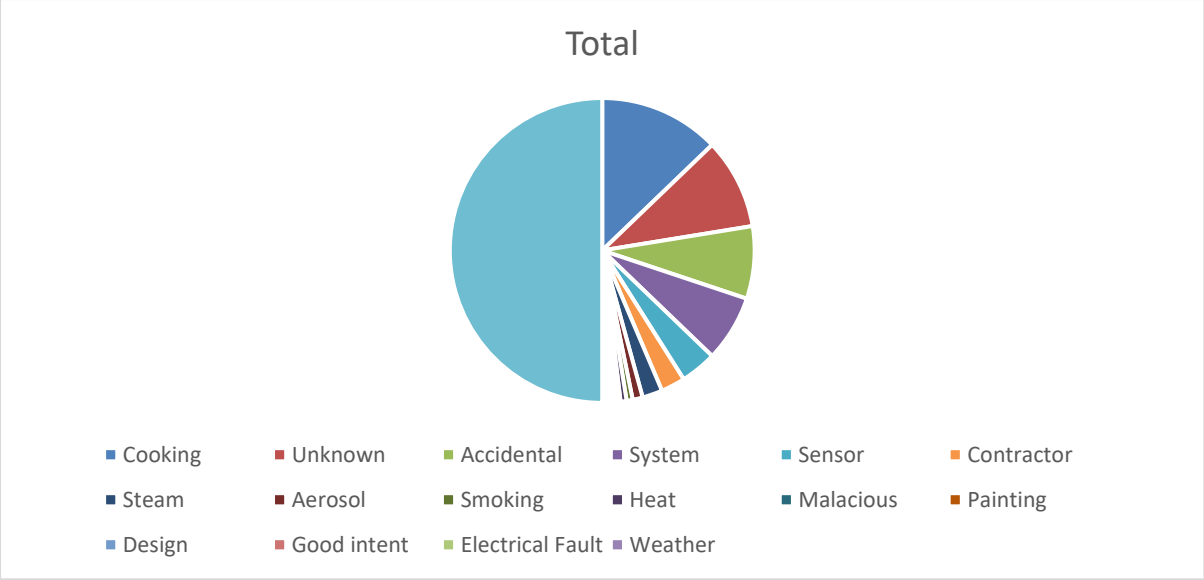


Figure 3 - Breakdown of alarm calls

It can be seen from Figure 3 that the majority of alarm calls are due to "cooking" and invariably linked to burning toast in ward areas. At DPOW the Roost accommodation accounts for a significant number of calls and these are being further investigated in terms of why the alarm is being activated.

When considering the alarms, it can be seen in Figure 4 that 80% of the alarm activations fall into 5 categories ("unknown" is where a system fault has been cleared due to the alarm reset as this clears the fault log so it cannot be identified as to location for checking).

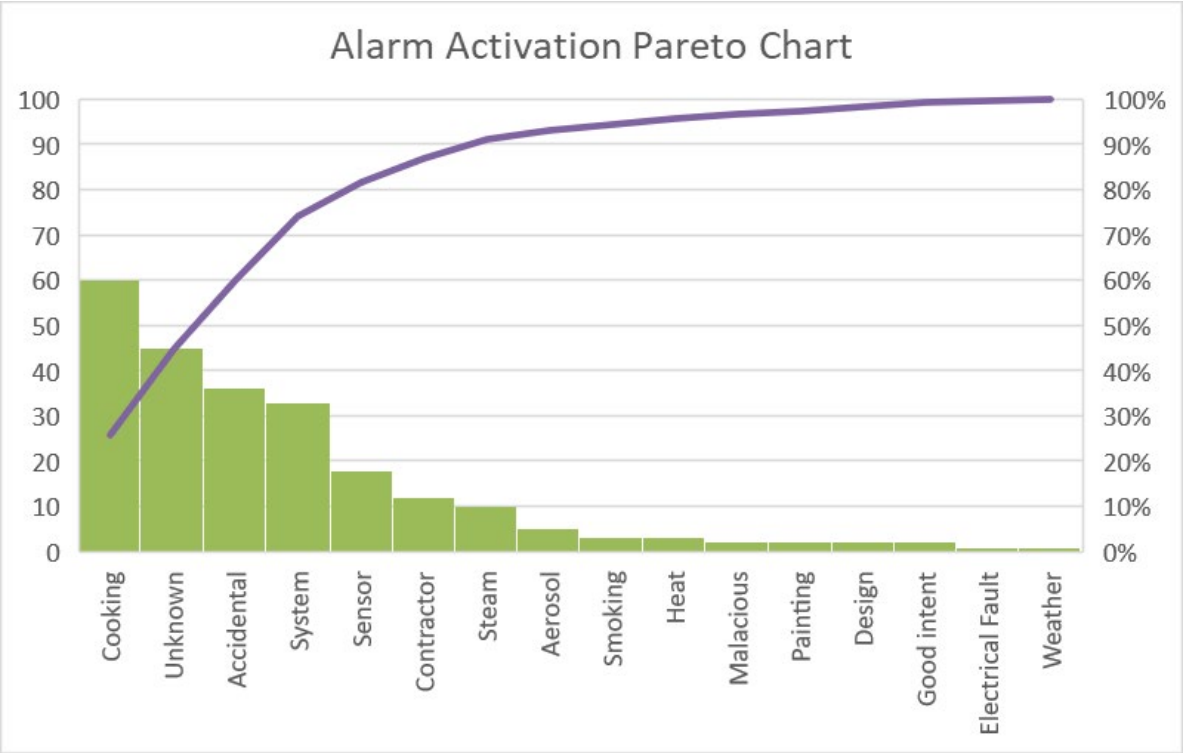


Figure 4 - Pareto Chart of alarm activations

Two of the categories (i.e. unknown and system faults) are indications of the performance of the alarm systems and during the 21/22 period there are some which are attributable to the installation of the new fire alarm system. However, there are a growing number related to the fire alarm system for SGH which is indicating that the system is deteriorating in its performance and will need to be replaced in the next few years.

Accidental activation can occur in a number of ways but one of the primary ways is that staff, visitors and patients accidentally press the manual call point to deactivate doors that are access controlled. In order to resolve this the alarm call points that have been replaced as part of the new system are fitted with manual call points that have a plastic cover fitted which has to be lifted to activate the alarm. In addition call points when replace are not being located near to door release buttons to reduce the number of accidental alarm activations.

Activations due to sensor heads should be minimised by the rolling replacement of sensor heads which have a working life of 10 years before they start to develop faults leading to false detections and alarm activations. The Trust has a rolling programme of replacing 10% of detector heads per year to mitigate the sensor issues.

3.10 Enforcement Activities by Local Fire Authorities

There has been no enforcement action undertaken by HFRS in respect of fire safety within NLaG premises. A physical audit of GDH has been undertaken during the 21/22 period with only minor issues identified. A telephone audit for DPOW was undertaken and the responses given to HFRS did not result in any actions being identified. It was noted by HFRS in relation to construction work and new alarm system replacement work that was underway at DPOW and SGH which would require an update to their operational plans when work was completed on various projects.

In relation to surrounding areas there no current enforcement/prohibition notices within HFRS for hospitals. In regards to United Lincolnshire Hospitals there are two Improvement Notices currently still in place in regards to Lincoln County Hospital and Boston Pilgrim Hospital (issued in 2017) and in South Yorkshire there is still a Prohibition Notice in place for a number of clinical areas within Sheffield Teaching Hospitals (issued in 2018) this means that currently 4 wards are completely closed and not able to be occupied for clinical or non-clinical activities.

As acute healthcare trusts return to post covid operational activities there may be an increase in the level of physical auditing undertaken by fire authorities which may lead to more enforcement action in the future.

3.11 Capital Investment

The installation of a new fire alarm system at DPOW was identified a number of years ago and work commenced at the end of the 20/21 period and installation completed at the end of the 21/22 period. This represents an investment of nearly £3.5m and means that the new alarm system meets all the requirements of the HTM and FSO. The system also uses multi-programmable heads so instead of fitting either a heat detector or smoke alarm etc. the head can be programmed to act as

one means of detector or multiple means (e.g. smoke and heat etc.) and the system is more flexible in the means of addressing and interface with third party systems such as Building Management Systems (BMS) to ensure alarm detection is notified to the appropriate parties and graphical information gives accurate information.

The working of a commercial AFD is between 20 – 30 years and does become dependent on the availability of fire panels (when existing ones need to be replaced) etc. The system at DPOW was nearly 40 years old and there had been a number of system failures prompting the decision to replace the system. The system at SGH is over 40 years old in some parts and although some areas have been refurbished, alarm panels replaced etc. the system is shows signs of reaching the end of its working life. Persistent faults on the system and the inability to add detectors on some of the existing loops etc. indicate that the risk of the alarm system failing increases each year. Given the experience seen with the deterioration of the alarm system at DPOW the level of risk for the SGH alarm failing catastrophically is likely to reach an unacceptable level in 2 – 3 years and the level of investment required to replace the system needs to be considered and allocated within the 2-3 year period.

Other capital investment is being utilised through work to improve the water systems and the separation of Domestic Water System (DWS) connections from the fire ring main. This currently means that the fire ring main should be flushed weekly rather than 6 monthly, (if it was a dedicated fire ring main) and this impacts on water usage. The HTM requirement for dedicated fire ring mains is likely to be completed for DPOW during the 22/23 period whereas for SGH the additional issue is that the site is fed by water reservoirs and activation of a fire hydrant could cause the reservoirs to empty rapidly causing supply issues to the water systems used. Work is ongoing to resolve this issue but is spread over several years so as not cause a significant impact on the water infrastructure.

4.0 Work Plan for 22/23

In light of the incident relating to the old Morley fire Panel at DPOW a work plan was developed as a result of the investigation and this has been transformed into a more comprehensive work plan for fire safety covering the whole 12 month period. This is contained in detail in Appendix 2 and going forward will be updated on an annual basis to enable information to be communicated in regard to fire safety management.

5.0 Conclusions & Recommendations

Management of fire safety within NLaG is an ongoing development and the workplan shown in appendix 2 gives more detail on the various elements that need to be further developed. There is no doubt that the covid pandemic has impacted on how the Trust has managed fire safety and especially in the area of training requirements. The 22/23 period is should be seen as a period of

reinstating the training programme required to be in place and consolidating and improving the fire safety strategy across a number of elements.

The investment of capital money to replace the fire alarm system at DPOW should be seen as a significant positive step forwards and will improve fire safety at DPOW significantly.

The main recommendation of this report is that further investment will be needed to be sought for the replacement of the fire alarm system at SGH as the fire calls being noted for this site are indicating a deterioration in the performance of the AFD system. Due to the amount of capital funding likely to be required is such that ways of get funds allocated should be considered and finalised during the 22/23 period.

Appendix 1 – Annual Fire Safety Statement

ANNUAL FIRE STATEMENT FOR PERIOD – April 2021 – March 2022	NHS Northern Lincolnshire and Goole NHS Foundation Trust

I confirm that for the period 1st April 2021 to 31st March 2022, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)

1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessment (see appendix 2)	✓
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	N/A

* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk
Date:

4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	No
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.	✓

Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail: bill.parkinson@nhs.net	Date:
Chief Executive	Name: Peter Reading Signature:	
	Contact e-mail	Date:

Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any proposed further actions need to comply, costs incurred and additional costs required to comply.
NB Statement to be retained for external fire authority audits.

As a Foundation Trust annual fire safety statements are not required to be submitted to the Department of Health & Social Care. However, the completion of an annual statement signed off my the Trust Board is seen as good practice and allows the Board to gain assurance in relation to fire safety that adequate systems and controls are in place to reduce the risk of fire within the Trust premises.

2022/23 Work Plan for Fire Safety Management

Item	Area	Task / Objective	Target Dates	Completed Date
Review of Policies				
1.1	Review fire safety management policies and guidance with external review and report to appropriate groups actions identified.	• Report findings from external review to Trust Management Board • Update fire safety management policies and evacuation guidance and re-issue. • Develop overall annual work plan for fire safety as part of annual report. • Present annual report & workplan to appropriate groups prior to submitting to Trust Board • Submit annual report and workplan to Trust Board	March/April 2022 April 2022 April 2022 May 2022 August 2022	**Completed** **Completed**
1.2	Humberside fire & rescue services need to keep their operational plans for each site up to date	• HFRS contact to be identified and contacted • Arrange meeting with HFRS for DPOW site operational plan to be updated. • Arrange meeting with HFRS for SGH site operational plan to be updated. • Arrange meeting with HFRS for GDH site operational plan to be updated.	April 2022 May 2022 June 2022 July 2022	**Completed**
1.3	Finalise terms of reference for Fire Safety Technical Group to oversee workplan	• Terms of reference to be approved by Health, Safety & Fire Group • Schedule meetings for 22/23 period	March 2022 April 2022	**Completed**
1.4	Review annual report to Trust Board and requirements of HTM that need to be within the report.	• Review annual reporting requirements within HTM • Complete draft annual report for consultation • Finalise annual report and send to TMB for recommendation for Board Approval • Approval by Trust Board	March 2022. April 2022 June 2022 August 2022	**Completed**
Fire Training				
2.1	Review and revise face to face training content for delivery of fire lecture	• Revise and update training presentation and content • Recommence face to face training	March 2022 April 2022	**Completed** **Completed & ongoing**

2.2	Review fire wardens training and methods of maintaining register of fire wardens to ensure appropriate cover	• Review methods of maintaining register • Arrange trial of software for fire wardens • Undertake 1 month trial of software and evaluate to decide if appropriate • Review and revise fire warden training content • Identify areas where no cover and request nominations for fire warden training • Commence fire warden training across the Trust	March 2022 April 2022 June 2022 April 2022 May 2022 June 2022	**Completed**
Fire Drills and Exercises				
3.1	Fire drills or desktop exercises need to be undertaken (where fire drills cannot be held due to potential risk to patient)	• Identify areas for fire drills or desktop exercises • Draw up schedule for fire drills for 22/23 • Draw up schedule for areas where desktop exercises will be undertaken • Implement schedules for fire drills and desktop exercises	April 2022 May 2022 May 2022 June 2022	
Fire Alarm Tests				
4.1	Regular fire alarm tests are required to be undertaken and testing of manual call points (MCP)	• Weekly test schedules to be revised and times and days of tests to be finalised • Review DPOW new alarm system and testing capabilities to enable all site MCPs to be tested annually • Review SGH & GDH MCP testing schedules and work towards MCP testing requirements	May 2022 May 2022 March 2023	
4.2	Communication regarding alarm testing schedule will need to be sent on regular basis to all areas	• Liaise with communications when schedule finalised • Monthly publication of date & time of testing to be drawn up	May 2022 June 2022 & onwards	
Fire Action Plans				
5.1	Localised fire action plans are required to assist with emergency responses in the event of a fire	• Local action template to be finalised to enable areas to draw up localised plan • Fire action cards to be located in each area	May 2022 June 2022	
5.2	Fire safety response kits should be developed and rolled out to each area	• Collaborate with HUTH to determine contents • Roll out response kits to all areas	May 2022 March 2023	
Fire Strategy Development				
6.1	Development of fire strategy to improve fire safety across the Trust	• Working in collaboration with HUTH to further develop strategy • Fire strategy drawings to be drawn up on MiCad • Undertake fire stopping surveys and ensure appropriate fire stopping in place	March 2023 March 2023 December 2022	

		• Use MiCad to develop appropriate “layers” of information to enable fire strategy drawings to be available to all areas/ • Update and maintain fire risk assessments in-line with the fire safety policy • Continue and further develop working relationship with HFRS to avoid any enforcement action	March 2023 Ongoing Ongoing	

Name of the Meeting	**Trust Board**	
Date of the Meeting	2nd August 2022	
Director Lead	Jug Johal- Director of Estates & Facilities	
Contact Officer/Author	Phil Young – Local Security Management Specialist	
Title of the Report	**Trust Annual Security Report 1st April 2021 – 31st March 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	An annual report of security management covering the period specified is submitted for the Trust Board to approve. Summary – There has been an increase in violence and aggression incidents within the period stated but ongoing work to foster greater working relationships with Humberside Police has resulted in closer collaboration in dealing with incidents and actions being taken where appropriate. Work nearing completion for upgrading all CCTV systems.	
Background Information and/or Supporting Document(s) (if applicable)	Standards to reduce violence and aggression within healthcare	
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ✓ Other: Security Group, Health, Safety & Fire Group, Audit, Risk & Governance Committee
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates and Facilities

Annual Report for Security Management 2021/22

Report Date:	01/04/2022
Number of Pages:	21
Report Author:	Philip Young, Local Security Management Specialist
Director Sign-Off:	Jug Johal, Director of Estates and Facilities (Security Management Director (SMD)

Contents

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Executive Foreword

Security affects everyone who works within the NHS. The security and safety of staff, patients, visitors, and property are a priority to enable the effective delivery of healthcare services. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has continued to develop its security management arrangements as part of a structured work programme identified in last year's Annual Report. This has included the:

- A proactive approach to the issuing of informal warning letters to aggressors of violence and abuse against staff
- Review of Trust wide CCTV system, a new system is currently being installed at Grimsby with new cameras which provide enhanced footage, the CCTV system will now be fit for purpose.
- The organisation to develop and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property, and assets, the LSMS is working closely with Humberside Police, Local Authorities and Safeguarding teams. There is also Improved sharing and analysis of crime data between NLAG and Humberside Police
- The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises, this has taken place with he upgrading of the CCTV system and the new Accident and Emergency buildings that are currently under construction.

There have been several criminal sanctions and Trust policy sanctions applied during 2021/22. The criminal sanctions include convictions against offenders for verbal and physical assaults. The Trust has issued 5 informal warning letters which were sent to patients and visitors warning them of inappropriate behaviour towards staff. The Trust issued 0 formal warning letters to patients due to the severity of their behaviour towards staff, no exclusions have been issues to any patients or visitors during 2021/22.

The 6 Point Promise for victims of intentional physical assaults whilst at work was implemented late 2021, we continue to work within the Joint Working Agreement (JWA) between the Trust, the Yorkshire and Humberside Crown Prosecution Service, and Humberside Police.

The announcement in October 2018 from the Secretary of State for Health and Social Care detailed a renewed approach to tackling violence and abuse against NHS staff coupled with the potential for a new national lead for security management within the NHS. A new national lead (NHSE/I) and associated standards were released late 2020. This has closed the gap that was created by the disbanding of NHS Protect, and allow for NHS Trusts sharing key security information and the central collection and analysis of security incident data.

Jug Johal
Associate Director of Estates and Facilities (Nominated Security Management Director)

1.0 Background and Introduction

This report covers all aspects of Security Management at a local level and provides an update on the work streams that have been completed between the 1st April 2021 and the 31st March 2022.

The Trust is committed to improving the provision of a secure environment for staff, patients and visitors and the security and protection of its premises and assets, whilst recognizing the need for accessible clinical services and the desirability of a welcoming non-threatening environment. The Trust aims to achieve this objective through the implementation of appropriate systems and arrangements which meet national, legislative and code of practice requirements issued from various bodies.

In accordance with the NHS Standard Contract, in respect of services provided to NHS Commissioners and the Standards that were previously set by NHS Protect, the four priority areas for the Trust to develop a secure environment are:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

The Trusts Security Strategy, which is coordinated at a local level by the Local Security Management Specialist (LSMS), focuses on seven generic areas for action:

- **Creating a pro-security culture** – to promote a culture in which the responsibility for security, including timely reporting of security incidents, is accepted by all
- **Deterrence** – Identifying and implementing ways to deter security incidents and breaches
- **Prevention** – Identifying and implementing ways to prevent security incidents and breaches
- **Detection** – Ensuring security breaches are detected and appropriate reporting systems are in place
- **Investigation** – Initiating post incident reviews and criminal investigations
- **Sanctions** – Providing advice on relevant sanctions and utilising Trust policies
- **Redress** – Support the Trust to seek redress in all appropriate circumstances and assessing the true cost of security incidents to the NHS

2.0 Security Management Structure

The Trust's security management structure sits within the Directorate of Estates and Facilities and consists of the nominated roles of Security Management Director (SMD), held by the Director of Estates and Facilities, and the Local Security Management Specialist (LSMS) role held by the Local Security Management Specialist (figure 1). These roles work closely with the operational security functions that are managed by the Associate Director Facilities & Sustainability Facilities Services Management and delivered through the Bidvest security contract.

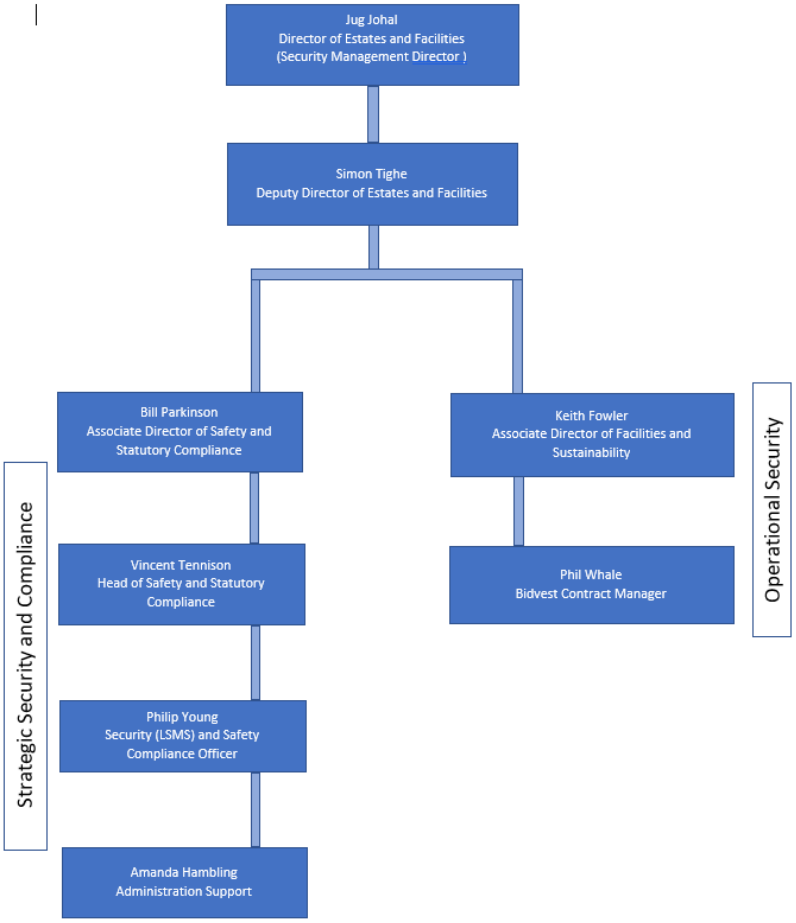


Figure 1 – Security Management Structure

2.1 LSMS Introduction and update

Hello my name is Phil Young and I am the LSMS Officer for the Trust, I started in post on the 14th February 2022, I have worked at the Trust since 2018 in a variety of operational and directorate roles which has given me a valuable insight into operational working and the business side of the Trust, prior to joining the Trust I was a Police Constable for 11 years with Lincolnshire Police before being medically retired in 2017, during his time as a Police Constable I worked as a response officer, rural policing officer and on secondment to the Criminal Investigations Department, I obtained further qualifications in investigation and interviewing and specialised in specific incidents and offences, I have a vast amount of operational tactical experience, operational pre-planning experience and Investigation experience.

I am very keen to build good working relationships with all departments and staff at the Trust, Humberside Police, Safeguarding at both the Trust and Local Authority, NHS Fraud Officers, and other neighbouring Trusts as part of the LSMS network.

I continue to work closely with the Local Counter Fraud Specialist and an Interaction protocol is in place regarding information sharing, the protocol is a framework for general interaction between the LCFS and LSMS to aid the prevention, deterrence, detection and investigation of any potential fraud and security issue within the organisation. To reduce the risk of fraud in the Trust and to avoid the potential for an investigation to be compromised, there needs to be close and supportive liaison between the LCFS and LSMS. The LCFS and LSMS meet biannually to discuss areas of risk and potential duplication of work. This ensures that fraud and security issues are linked and both areas of work benefit from mutual interaction

I am also working closely with Humberside Police at Grimsby and Scunthorpe to build on information sharing in order to improve provision of a secure environment for staff, patients and visitors and the security and protection of its premises and assets and deter and detect crime, since starting in post I have met with the Neighbourhood Policing Inspector and Sergeant at Scunthorpe and discussed how we can form ma closer working relationship with a better information sharing process, I am carrying out site visits at SGH, DPOW and GDH with the Security teams and Neighbourhood Policing teams on a regular basis.

Whilst conducting site visitors I also visit work area and wards which I note have a high number of Ulysses Incidents with regard to abuse/violence to offer my support and guidance and make myself know to the staff, I am very focused on supporting staff and showing that the Trust does care and will take action against offenders when it is appropriate.

I am a member of the Community Safety Partnership at North East Lincolnshire Council which is being supported by the Safeguarding team at the Trust.

I have regular meetings with the Safeguarding team, and I feel that we are becoming more supportive of each other through working together whenever possible, I also attend the Vulnerability's oversight Board meetings.

Youth Offending Service offer a diversion programme if the offender has committed a first offence, it provides an opportunity of working on victim awareness and consequences of their behaviour. As part of this we have an opportunity to explain the real impact of their behaviour and the drain on services either via a face to face meeting or a letter from persons involved, I am working closely with the Youth Offending Team to progress this route of rehabilitation for offenders, the Trust will then be working closely with the Community and partner agencies by taking part in this programme to work with offenders in a positive way to deter reoffending.

I am in the process of reviewing the Standard Operating Procedures and policies in relation to Security at the Trust that I have responsibility for as the author.

2.2 Violence and Aggression against Staff

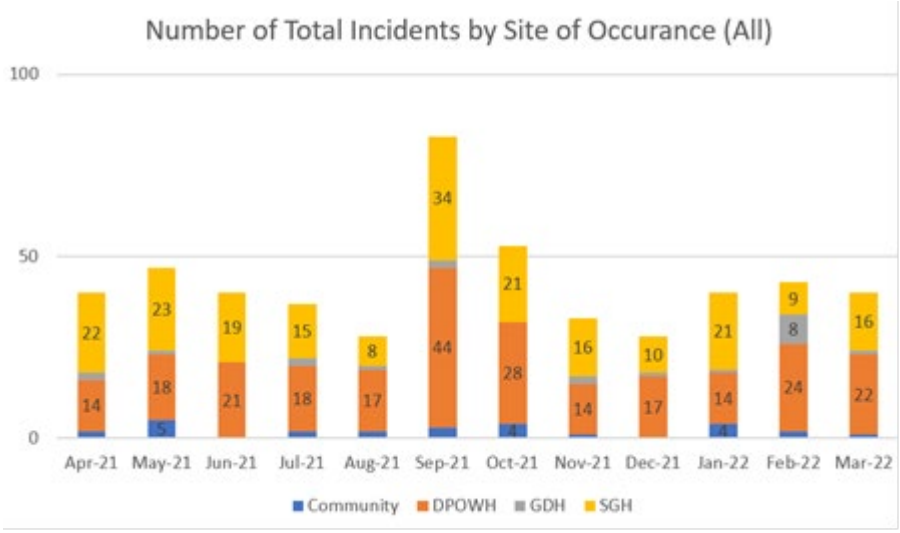
The number of reported incidents of security coded incidents during 2021/22 was a total of 512 incidents Trust wide, this is down from 1038 in 2020/2021. This is broken down by 251 down from 462 in 2020/2021 at DPOWH, 214 down from 478 in 2020/2021 at SGH, 21 down from 37 for 2020/2021 at GDH and 26 down from 53 in 2020/2021 in the Community. This includes all incidents that are now coded as security including behaviour that is related to medical condition, absconding from wards and is not just coded to violence and aggressive behaviour. There appears to of had a significant decrease on the figures that was reported during 2020/21. The year period of 2021/22 is a very difficult period to show similarities to other years due to the effect of the Covid-19 Pandemic and the impact this has had on the National Health Service nationally and locally, we also transferred from Datix to the Ulysses incident reporting system during October 2021, due to this the Coding lists changed slightly so the above figures are from both coding lists of Datix and Ulysses combined.

The chart below (figure 2) shows the number of incidents per month by site. The reported numbers show that there has been a steady number of incidents reported at both DPOW and SGH though out the year, with September 2021 seeing the largest number of incidents reported at DPOW and similar with SGH this is likely to have been caused by the lifting of restrictions that had been in place for a number of months in relation to the Covid-19 pandemic, with visitor numbers into the local economy at their highest for that year.

SGH had a drop in numbers in August 2021 and February 2022

Community figures sit in single figures each moth with the highest in a month being 5 in May 2021.

GDH have 1 to 2 incident a month however in February 2022 they had 8 incidents, this was because of the amount of DOLS patients that were present on the Wards, the LSMS visited the wards involved and spoke with the Ward Managers and offered support and advise.



Calender Month	Community	DPOWH	GDH	SGH	Total
Apr-21	2	14	2	22	40
May-21	5	18	1	23	47
Jun-21	0	21	0	19	40
Jul-21	2	18	2	15	37
Aug-21	2	17	1	8	28
Sep-21	3	44	2	34	83
Oct-21	4	28	0	21	53
Nov-21	1	14	2	16	33
Dec-21	0	17	1	10	28
Jan-22	4	14	1	21	40
Feb-22	2	24	8	9	43
Mar-22	1	22	1	16	40
Total	25	229	20	207	512

Figure 2 – Number of incidents per month by site

It should be noted that of the total 508 behaviour incidents reported during 2021/22, 40.16% related to behaviour that included violence or aggression this is down from 51.93% in 2020/2021, of this 48.43.2% was classed as Inappropriate /Aggressive Behaviour towards staff by patients and staff by staff.

The remaining 11.41% was relating to absconders and monies and valuable held in safekeeping and removal of trespassers from Trust Premises.

The next chart (figure 3) shows the percentage of incidents per category for the year.

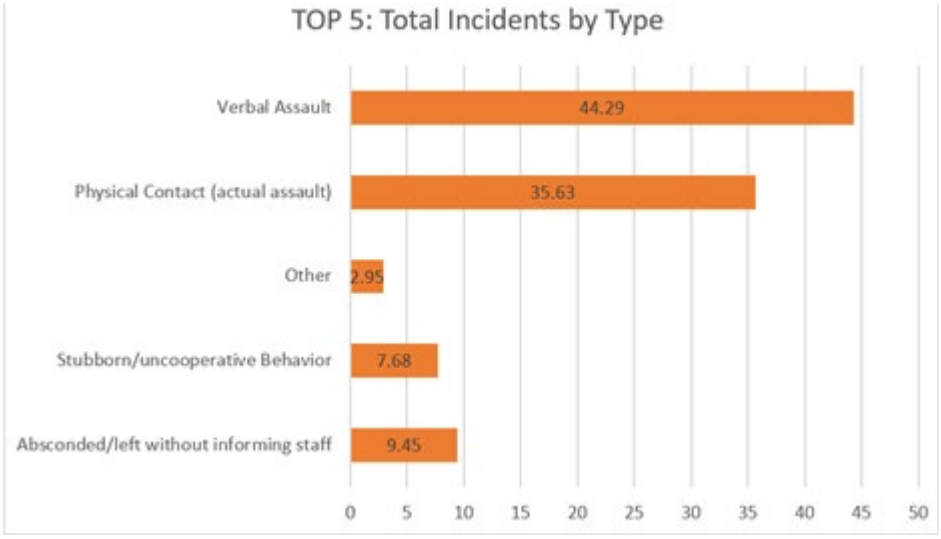


Figure 3

The percentage of reported physical assaults is 23.63%. The type of physical violence ranges from pushing and lashing out to punching and kicking. A number of these incidents will relate to patients that are suffering from a medical episode so lack capacity to understand their behaviour so no action is taken by the LSMS but should be reviewed by the medical team in charge of their care to ensure correct care package is been provided to support the patient and staff.

The reasoning for the 512 total incidents but 508 behaviour category incidents is Ulysses sometimes double counts when there is 2 category types entered onto one incident.

The majority of incidents that are reported relate to both of the Emergency Care Centres this could be due to the patient and visitors they have within their departments and the acute treatment and care been delivered. The incidents that don't include clinical factors the LSMS and Police will endeavour to take strong action to try to prevent these incidents reoccurring.

Work is undertaken to support victims of these incidents and to put relevant actions in place against the aggressors in the hope of positive outcomes and to try and prevent reoccurrence. Details of some of the work in progress are included in other sections of this report.

The LSMS is keen to promote to staff that they are supported if they are a victim of Violence and aggression and that the LSMS can be a point of contact for them throughout the investigation, every report will be taken seriously by the Trust.

2.3 Joint Working Agreement

The Joint Working Agreement (JWA) between the Trust, the Yorkshire and Humberside Crown Prosecution Service, and Humberside Police underwent a full review and rewrite and was re-launched in March 2018. The LSMS has worked closely with Inspector Richard Mirfin from Humberside Police to implement the JWA and ensure it makes an impact at frontline services. Work has continued with the implementation and awareness of the JWA and its principles to frontline policing and NHS staff. A 6-Point Promise has been agreed between NLAG and Humberside Police that details the six key points that NLAG staff will receive should they become a victim of an intentional physical assault whilst at work. These include the support that will be made available to them and that NLAG and Humberside Police will work together to achieve a positive outcome for the victim wherever possible. The 6-Point Promise was due to be launched during 2019 alongside a joint media release for awareness but there has been a delay in this been signed off by Senior Officers within Humberside Police. Due to the on-going Covid-19 pandemic the role out of the 6-point promise was slightly delayed and was rolled out date for late 2021, the role out did happen as planned and is now signed off and active.

2.4 Warning Letters for Unacceptable Behaviour

The Trust does not tolerate any acts of criminal violence and aggression against our staff and in support of this the Trust has the Policy for the management of Violent, Aggressive and Intimidating Behaviour which contains an exclusion procedure. The exclusion procedure consists of four stages, verbal warning, informal warning letter, formal warning letter and then an exclusion letter.

The LSMS has taken a proactive approach to challenging unacceptable behaviour as an early intervention to try and prevent the escalation of behaviour and reoccurrence of incidents. This proactive approach has led to 5 informal warning letters being sent to patients and visitors warning them of inappropriate behaviour towards staff during 2021/22. The Trust also issued 0 formal warning letters to patients due to the severity of their behaviour towards staff. The Trust has not issued any exclusions to patients or visitors during 2021/22. The types of behaviour that can lead to the informal and formal warning letters being issued include being verbally aggressive, threatening staff, physically assaulting staff, and racial abuse.

This year’s figures are down from 2020/21 which is excellent news, however consideration must be given to the restrictions that have been in place due to Covid-19 causing less foot fall within the Hospitals.

The LSMS reviews Body Camera footage and CCTV footage on a weekly basis which provides valuable evidence and Information for the purpose of the exclusion procedure and its four stages, the footage is also valuable if reported to the Police.

Previous monitoring of the number of incidents that occurred prior to the warning letter and after the warning letter, the data showed that in the majority of cases there has been no reoccurrence of incidents involving the individuals after the letter has been issued.

2.5 Community Lone Working

There are approximately 599 staff that have received face-to-face training and been issued their new device, this figure is up from 549 in 2020/2021. Currently there is 346 active devices assigned to staff with a mixture of individuals and pooled units, this is down from 399 in 2020/2021, this may be because the Gap Analysis commenced on the 15th March 2022, this is taking place as there is evidence of units not being used or being allocated to staff that have either left the Trust or moved to alternative posts they have been returned back to the department, no audit has been carried out recently so it is being done to confirm users that have an account and update the system.

The audit is still in its early stages and already 60 users have already been identified as needing to be removed from the system as they no longer have a device and have either moved to alternative posts or left the Trust.

The devices contain the latest lone working technology, are linked to a 24/7 specialist alarm receiving centre and feature GPS locating technology that can be directly linked to the Police Command Centre Dispatchers during an emergency to ensure the quickest response possible for staff requiring help. The feedback received from staff has been positive regarding training, service provided by People-Safe and the new device functionality.

Due to the change in working practices caused by the Covid-19 pandemic the usage of the devices fell sharply during the year, as less staff where working in lone working situations. As lockdown restrictions begin to be lifted and working practices change this usage will be monitored and actions taken to ensure usage of the device increases.

The LSMS is currently undertaking a root to branch Gap Analysis on the lone working devices and carrying out a full review of the People Safe Lone working devices that we currently have in use, this includes reviewing the list of the devices and who they are allocated to, how often they are used and how many alarm activation we have, the LSMS is wanting to identify and locate every device, and if the device is allocated but hasn't been used for a while, enquires will be made as to why it hasn't been used and who has it, the staff member/Line Manager will then be contacted in relation to the usage if the device.

There are also numerous users who do not have a device allocated, each member of staff will be contacted to confirm if they still need to be a user.

People Safe is providing supporting this piece of work via their website and our Trust dashboard which is provided by People Safe.
An online training package is now also available and is easily accessible to users, there is also supporting user guides that can be sent to them via email.
Once the audit is concluded the LSMS will promote the use of the devices with users so that the devices are being used to their full potential.

2.6 Surveillance Systems

The Trust currently operates 3 Security Surveillance Systems, CCTV, Body Worn Video (BWV) devices and non-recording patient cameras and monitors. The Trust also has Automatic Number Plate Recognition (ANPR) in use on our car park barriers which, although not a security system, is still classed as a surveillance system.

The current CCTV system is Digital at DPOWH and GDH, and SGH, we are also using Digital Cameras. The systems at DPOWH and GDH used to regularly fail with issues associated with the hardware, including the recording units, the cameras and the controller units. The system is now in the process of being upgraded with new software and cameras, new cameras are being replaced within the buildings and outside, numerous camaras are being replaced or repositioned to provide better coverage both in and outside the Hospital at DPOW, the new cameras provide a much better quality picture and can also take still shots.
16 fisheye Camaras have also been installed throughout DPOWH which give a full 360 degree view and they can also be broken down into zones so more than one view can be monitored at any one time, the 1 camera can put up to 6 different screen zones up for the controller to view.
The fisheye cameras can give a 360-degree view and the image quality is good.
Cameras are being installed in the new Emergency Department and they will also be linked to the Security Office that is constantly monitored.
The old system was out-dated, no longer supported or replaceable from the manufacturer and did not offer the modern functions found as standard on many CCTV systems. The old CCTV system often resulted in a lack of evidential quality footage to provide to the police, the inability to provide footage post-incident due to system failures, or the inability to record the minimum 30 days of footage due to recorder storage constraints, this is no longer the case due to the ongoing upgrade and we can now record a minimum of 30 days footage.
The CCTV System at SGH is due to be upgraded very soon.
The CCTV system at Goole has been upgraded.
No covert cameras were deployed during this year financial year.

Work is currently being carried out to identify how we can use the capabilities of the new CCTV system to our advantage due to the extra functions and capabilities of the new system.

2.7 National NHS Security Management

NHS England and NHS Improvement department released a new set of Standards for security management late 2020 which have replaced the previous ones issued by NHS Protect before they were disbanded in 2018. The Trust continues to review these new standards to ensure they are meeting the requirement set out within them.

2.8 NHSE/I Standards

In December 2020 NHSE/I released a new set of standards for security management, Violence Prevention and Reduction Standard to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence.
The Trust continues to work to these standards and the work plan for the coming year is in line with the standards, the work plan is attached as Annex A.

2.9 Counter Terrorism

The many terrorist incidents that have occurred in the UK over the past few years reminds us of the continued need to ensure our sites and staff are prepared to respond to an incident and to be aware of the warning signs leading to an event. The Trust has worked closely with the National Counter Terrorism Policing: North East Counter Terrorism Unit in providing appropriate training sessions for Trust staff. The Trust was in the process of arranging new counter terrorism training for all staff using the new SCAN training provided by our local counter terrorism officers, this was unfortunately affected by the Covid-19 pandemic and had to be cancelled, this is currently being looked at by the Training Department with a view to having the SCaN (See, Check and Notify) Training available on ESR as a E-Learning package. Due to the severity of the Covid-19 pandemic this training could not be completed within the original planned time period and will hopefully be live on ESR very soon depending on the pandemic and operational pressure been experienced by the Trust.
The LSMS is currently working with the Police, Training Department, and The Communications Team to put a package together around Action Counter Terrorism, this will also incorporate the SCaN Training as a package, the staff will be made aware of the

available training via a communication release on the Hub in the first instance and sign posted to the Counter Terrorism Policing website whilst work is carried out to make the training available via ESR is progressed.

2.10 County Lines

County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs. Importing areas (areas where the drugs are taken to) are reporting increased levels of violence and weapons-related crimes as a result of this trend. The 2018 Home Office Serious Crime Strategy states the NPCC definition of a County Line is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move [and store] the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

County Lines is an issue within the trust area and the LSMS is currently working with the communication team to promote training and information that is available to staff on County Lines, it will provide them with the skills and knowledge of signs to look out for and how to escalate any concerns they may have. The Communications teams promoted County Lines training and signposting for information via the Hub, this coincided with Humberside Police's Intensification week on County Lines which commenced on the 7th March 2022.

3.0 2022/23 Work Plan for Security Management

The 2021/22 Work Plan for Security Management, which outlines the key actions against each security management objective, has been attached at Appendix A.

4.0 Summary and Next Steps

In summary, there continues to be a considerable amount of work in developing the Trust's security management arrangements to improve the safety of our services for staff, patients, and visitors, and to protect NHS property and assets. The focus areas incorporated into the 2022/23 Work Plan for Security Management are continuing the close collaborative working

with partner agencies to increase incident reporting and investigation outcomes, support for staff who become victims of crime, and progressing new technology and improvements to surveillance systems. The renewed national focus on reducing violence against NHS staff is likely to see a new set of security management standards and improved sharing of incident data and analysis across NHS organisations.

There is also focus on providing Trust staff with up to date training on County Lines and Anti-Terrorism and working with partner agencies to promote positive community involvement with regard to the rehabilitation and the diversion from committing further crime of people that commit offences on trust property when this is suitable via the Restorative Justice process.

5.0 Trust Board Action Required

The Trust Board is asked to:

- Note the contents of the report
- Note the 2021/22 Work Plan for Security Management at Appendix A

Appendix A

2021/22 Work Plan for Security Management

Standard	Area	Task / Objective	Target Dates	Completed Date
Strategic Governance				
1.1	A member of the Executive Board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation. This person is nominated to NHS England	• LSMS to meet at least quarterly with SMD or as required • Quarterly Security Group Meeting • Investigation or management reports to be provided as required • Security Management Annual Report to the Trust Board	Quarterly Quarterly As required April 2022	
1.2	The organisation employs or contracts a qualified, accredited and nominated security specialist(s) to oversee and undertake the delivery of the full range of security management work	• LSMS to attend relevant conferences and CPD events • LSMS to attend Regional LSMS Forum	As required Quarterly	
1.3	The organisation allocates resources and investment to security management in line with its identified risks	• Funding is allocated to security issues as identified through security risk assessments and incident reporting • LSMS to support the Trust wide CCTV review and upgrade.	Ongoing In progress	
1.4	The organisation reports annually to its Executive Board, or equivalent body, on how it has met the standards set by NHS England in relation to security management, and its local priorities as identified in its work plan	• Self Review Tool (SRT) against the NHS Protect Standards completed and submitted to Security Group • Results of SRT against NHS England Violence Prevention and Reduction Standards to be included in Security Management Annual Report to the Trust Board	No new standards since NHS Protect was disbanded, still awaiting update. No new standards since NHS Protect was disbanded, still awaiting update.	
1.5	The organisation has a security management strategy aligned to NHS England Violence Prevention and Reduction Standards. The strategy has been approved by the executive body or equivalent body and is reviewed, evaluated and updated as required	• Review Policy and Strategy for Security in line with review schedule • Security Management Annual Report to the Trust Board	February 2022 April 2022	
1.6	LSMS to monitor Trust Policies and TOR'S – • DCP203 Policy for the Security and Management of Assets. • DCT077 Security Group – membership and terms of reference. • DCP154 Policy for the Management of Violent,	• LSMS to review policies and TORS when made aware of any legislation, change to guidance or changes to Trust sites that will require the document to be updated. • To action required changes to the document. • To review Documents periodically before the review	DCP203 – April 22 DCT077 – Jan 24 DCP154 – Feb 24 DCP197 – March 22 DCP148 – March 22	**Completed** **Completed**

	Aggressive, and Intimidating Behaviour. • DCP197 Security Policy & Strategy. • DCP148 Internal & External Surveillance systems policy. • DCP149 Policy & Procedure for bomb threats and suspect packages. • DCP150 Policy & Procedure for deployment of armed Police officers. • DCP162 Policy & Procedure for the use of directed Surveillance. • DCP195 Policy & Procedure for Lockdown.	date in case of any required changes.	DCP149 – July 24 DCP150 – July 24 DCP162 – Oct 24 DCP162 – Oct 24 DCP195 – March 22	**Completed**

Standard	Area	Task / Objective	Target Dates	Completed Date
Inform and Involve				
2.1	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets	• Joint Working Agreement in place with Humberside Police and CPS • LSMS meets with senior Police representative to progress collaborative working • LSMS attends relevant Community Safety Partnership work groups	Completed Quarterly Bi-Monthly	**2021**
2.2	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff. As part of this, the organisation participates in all national and local publicity initiatives, as required by NHS England Violence Prevention and Reduction Standard, to improve security awareness. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective	• LSMS to update all security related posters throughout the Trust with latest contact details • Security bulletins and alerts to be published in the weekly all-staff team brief newsletter • LSMS to provide security stands on each site during national security awareness month • Security bulletins published on the Trust Intranet Hub • Staff to be made aware of crime trends including County Lines and anti-terrorism training and sign posted to relevant training and information.	June 2021 Ongoing October 2022 Ongoing Ongoing	
2.3	The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises. The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external stakeholders to discuss security weaknesses and to agree a response	• LSMS to liaise with project teams of new builds and refurbishments • LSMS to liaise with Humberside Police Safer by Design Officer • LSMS to conduct security assessments on existing buildings as required	As required As required As required	
2.4	All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary	• LSMS reviews all security incidents reported through the Ulysses reporting system, coding and grading where appropriate • Feedback provided to incident reporters • LSMS to support relevant incidents reported on Ulysses and if required be lead investigator • Awareness campaign to be launched to provide guidance to all staff on which incidents should be reported to the Police	Ongoing Ongoing Ongoing Ongoing	
2.5	All staff who has been a victim of a violent incident have access to support services if required	• Victims of physical assault while at work to be sent a letter from CEO that contains the contact details of the LSMS and support on offer • LSMS proactively contacts those identified as victims through Ulysses reporting	Ongoing Ongoing	

2.6	The organisation uses the Security Incident Reporting System (SIRS) to record details of physical assaults against staff in a systematic and comprehensive manner. This process is reviewed, evaluated and improvements are made when necessary	• Trust Ulysses incident reporting system is used for Security related incident reporting, these are no longer submitted externally since NHS Protect was disbanded • LSMS to review all reports of physical assaults • LSMS reports physical assault data to the Trust Security Group	N/A Ongoing Quarterly	
Prevent and Deter				
3.1	The organisation risk assesses job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the level of training on prevention of violence and aggression is delivered to them in accordance with NHS guidance on conflict resolution training. The training is monitored, reviewed and evaluated for effectiveness	• Training compliance to be monitored through the Trust Security Group • Another Project Argus exercise (Now SCAN) to be delivered by Counter Terrorism Unit Officers to senior managers and key decision makers and security officers • Counter Terrorism training to be published on the Hub and all staff signposted to available information and e-learning training, work with Training to design and create a training package that can be available on ESR • County Lines information and guidance published on the Hub to coincide with Humberside Polices Intensification week on 07.03.22 • County Lines training package to be created and also training sessions to be arranged with support from Humberside Police for Trust staff	Quarterly Late 2022 Delayed due to Covid-19 June 2022 December 2022 March 2022 December 2022	**March 2022**
3.2	The organisation ensures that staff whose work brings them into contact with NHS patients are trained in the prevention and management of clinically related challenging behaviour, in accordance with NHS England Violence Prevention and Reduction Standard. Training is monitored, reviewed and evaluated for their effectiveness	• Training compliance to be monitored through the Trust Security Group • LSMS to link in with clinically challenging behaviour restraint training project • New project launched to develop to risk assess patients on admission for risk of violent/aggressive behaviour and security incidents – VAS Score	Quarterly In progress Delayed, being looked at now (April 2022) and is on work plan for LSMS	
3.3	The organisation assesses the risks to its lone workers including the risk of violence. It takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness	• Issuing and training staff in the lone working devices • Community lone working device usage to be monitored through the Trust Security Group • Gap Analysis of lone working devices to review allocation and usage	In progress Quarterly Ongoing – June 2022	
3.4	The organisation distributes national and regional NHS alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored reviewed and evaluated	• LSMS to review alerts received from other NHS organisations and partner agencies and disseminate within the Trust as appropriate • LSMS to receive alerts from the Cross-sector Safety and Security Communications (CSSC) and disseminate as appropriate	Ongoing Ongoing	

3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds	• LSMS to advise on access control as areas are refurbished or risks identified • LSMS to support the Trustwide CCTV review • LSMS to complete annual audit of CCTV releases • Review Policy for Use of Directed Surveillance	As required In progress In Progress Completed	**March 2022**
3.6	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal	• Review of the Policy for the Security and Management of Assets	April 2022	
3.7	The organisation operates a corporate asset register for assets worth £5,000 or more	• Review of the Policy for the Security and Management of Assets	April 2022	
3.8	The organisation has departmental asset registers and records for business-critical assets worth less than £5,000	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.9	The organisation has clear policies and procedures in place for the security of medicines and controlled drugs	• Any breaches of medicines security are notified to the LSMS	Ongoing	
3.10	The organisation has policies and procedures in place to ensure prescription forms are protected against theft and misuse. These policies and procedures are reviewed, evaluated and updated as required	• The Medicines Code and associated policies are in place	N/A	
3.11	Staff and patients have access to safe and secure facilities for the storage of their personal property	• Patient lockers / SAMPOD digital lock upgrades being installed at DPOWH	Completed	
3.12	The organisation records all security related incidents affecting staff, property and assets in a comprehensive and systematic manner. Records made inform security management priorities and the development of security policies	• The Trust uses the Ulysses incident reporting system for all incidents and security related incidents are reviewed by the LSMS	Ongoing	
3.13	The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is included in the organisation's policies and procedures	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.14	In the event of an increased security threat level, the organisation is able to increase its security resources and responses	• Bidvest Noonan Contract Review meetings • Review of Policy for Bomb Threats and Suspect Packages	Quarterly July 2024	
3.15	The organisation has suitable lockdown arrangements for each of its sites, or for other specific buildings or areas	• Review the Policy and Procedure for Lockdown	March 2022	**March 2022**
3.16	Where applicable, the organisation has clear policies and procedures to prevent a potential child or infant abduction, and these are regularly tested, monitored and reviewed	• A test of the child abduction procedures to be completed at DPOWH and SGH • LSMS to work closely with Safeguarding when risks are identified	Completed Ongoing	**2021**
3.17	People safe Lone Worker Device full audit	• Full audit of user accounts and devices to make sure that the Lone worker device Trust dashboard is fully up to date and the devices are allocated and accounted for, this will also make sure staff registered as users have a device available	Ongoing, planed completion June 2022	

3.18	LSMS to work with Youth Offending team and create a working partnership for the rehabilitation of first-time offenders who are eligible to take part in the diversion programme as it is their first offence, work on victim awareness and consequences of their behaviour. As part of this, explain to them the real impact of his behaviour on staff, other patients and visitors and the impact it has on services we provide for care and treatment of other patients, the programme can be carried out via a face to face meeting or letter from persons involved to the offender. The Trust will be supporting the Community in the rehabilitation of Offenders of Crime which occur on Trust Sites and will positively work with offenders to actively deter reoffending.	• Build a working relationship with the Youth Offending Team • Create a working agreement with the Youth Offending Team. • Once the programme is operational with the Trust and Youth Offending team with the assistance of the Trust Communication team promote it to the Trust staff.	Ongoing – Target date of August 22	

Standard	Area	Task / Objective	Target Dates	Completed Date
Hold to Account				
4.1	The organisation has arrangements in place to ensure that allegations of security related incidents are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated	• LSMS reviews all security incidents reported through the Ulysses reporting system, coding and grading where appropriate	Ongoing	
4.2	The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents	• LSMS to assist Police with investigations and be primary police liaison for the Trust • LSMS to attend court, case conferences and other sanction hearings • LSMS to manage the warning letter system for unacceptable behaviour as part of the Trust's exclusion process • LSMS to send informal / formal warning letters on behalf of the Trust and support managers in sending informal warning letters	Ongoing As required Ongoing Ongoing	
4.3	Where appropriate, the organisation publicises sanctions successfully applied following security related incidents	• Criminal sanctions to be published internally and externally as appropriate	As required	
4.4	The organisation has a clear policy on the recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness	• Standing Financial Instructions are due review by the Finance Directorate	Ongoing	
4.5	Protect Duty is a new legislation under Government consultation that will require many businesses to formally assess terrorism risk for the first time. The Home Office estimates that 650,000 UK businesses could be affected by Protect Duty. Government response to the consultation published January 2022.	• LSMS to monitor the consultation findings and guidance from the Government whether Protect Duty will be legislation we need to work to.	Ongoing	
4.6	Collaborative working with Safeguarding team for – • Post incident reviewing	• Communication with Safeguarding team when a risk is identified.	Ongoing	

	• Planning for potential incidents • Advise and guidance with safeguarding team when supporting at risk/vulnerable patients are visiting a Trust site.	• Written a operational plan with safeguarding and Security when required. • Attending Vulnerabilities Oversight Board meetings • Being a member of the NEL/NL Community Safety Partnership Board.		

NLG(22)138

Name of the Meeting	**Trust Board (public)**
Date of the Meeting	2 August 2022
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Chair's Action – Approval of Trust Management Board (TMB) Terms of Reference**
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is to note that the Chief Executive sought a Chair's Action for the approval of the Trust Management Board Terms of Reference on 4 July 2022, approved by the Trust Chair on 8 July 2022. The changes to the Terms of Reference are: Section 1.4: Divisional Medical Directors (previously Divisional Clinical Directors) Section 1.6: Risk Management Group (was Risk Register Confirm and Challenge) Divisional Board Meetings now includes the following wording – Medicine, Surgery, Family Services and Community and Therapies Health, Safety and Fire Group (previously Health and Safety Committee Job Planning Committee (new committee reporting to TMB) Section 5: Amended to Divisional Medical Directors Section 8.4: Quoracy amended to two voting Executive Directors, and two Divisional Medical Directors from two separate Divisions
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Chair's Action
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable

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

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

Trust Management Board (TMB)

Membership and Terms of Reference

Reference:	DCT182
Version:	3.0
This version issued:	20 June 2022
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Management Board / Trust Board
Date for next review:	June 2023
Owner:	Peter Reading, Chief Executive
Document type:	Terms of Reference
Number of pages:	7 (including front sheet)
Authors / Contacts:	Helen Harris, Director of Corporate Governance and Heidi Forster, Personal Assistant to the Chief Executive

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

1.0 Constitution

1.1 To be the senior operational decision making body of the Trust, determining or overseeing the determination of key operational policies, business cases, and decisions which need to be made at Trust level, but which are not matters reserved for decision by the Trust's Board of Directors.

1.2 To manage the clinical, operational and financial performance of the Trust on behalf of the Trust's Board of Directors, so that the Trust achieves the objectives set for it by the Board of Directors, by its regulators and by its commissioners, and meets (so far as is possible) the expectations of its other stakeholders.

1.3 To manage on behalf of the Trust's Board of Directors the development and delivery of the Trust's overall strategy and all its supporting and enabling strategies. This will include ensuring that there is appropriate integration, co-ordination and cooperation - between individual clinical services; between clinical and corporate functions; and with the Trust's key stakeholders and partners.

1.4 To support individual Executive and Divisional Medical Directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues, and achievement of agreement between Trust Management Board (TMB) members.

1.5 To assure the Trust's Board of Directors that, where there are issues and risks that may jeopardise the Trust's ability to deliver its objectives, these are being managed in a controlled way with the interests of patients and tax-payers are the heart of decision-making.

1.6 To be the senior formal committee of the Trust through which all other committees (except committees and sub committees of the Trust's Board of Directors) report (directly or indirectly). The groups reporting into TMB are:

- Quality Governance Group
- Risk Management Group
- Digital Strategy Board
- Business Case Review Group
- Capital Investment Board
- Nursing and Midwifery Board
- Operational Management Group
- Emergency Planning and Business Continuity
- Divisional Board Meetings – Medicine, Surgery, Family Services and Community and Therapies
- Medical Education Committee
- Health, Safety and Fire Group
- JNCC
- JLNC
- Job Planning Committee (from June 2022)

1.6.1 The Chairs' of the above groups will be required to submit a highlight report to TMB. TMB reserves the right to request the Chair(s) of a group(s) to attend on an ad hoc basis.

2.0 Authority

2.1 TMB is authorised by the Trust's Board of Directors to manage the clinical, operational and financial activities and performance of the Trust within the overall Scheme of Delegation and subject to adequate reporting to the Board and its assurance committees.

2.2 TMB is authorised by the Trust's Board of Directors to develop and deliver the Trust's strategy and supporting enabling strategies, subject to those strategies being approved by the Board and subject to adequate reporting to the Board on their delivery.

3.0 Accountability and Reporting Arrangements

3.1 TMB is accountable through the Chief Executive to the Trust Board. Where required, reporting from the TMB will be to the Trust Board.

3.2 The Chair of TMB (the Chief Executive) has the overall responsibility for the performance of TMB and also has the final decision on actions required in order to comply with the Terms of Reference, or where a potential conflict may arise with the Trust's Board, or with their responsibilities as Accountable Officer.

3.3 Full members of the TMB may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie, but any such vote is advisory to the Chief Executive and not binding. Votes will be recorded in the minutes, including the votes of individual TMB members.

3.4 The Chair of TMB shall prepare a summary report to the Trust Board detailing items discussed, actions agreed and issues to be referred to the Trust Board.

3.5 The minutes of the meetings shall be formally recorded and presented to the Trust Board.

3.6 TMB shall refer to the Trust Board any issues of concern it has regarding any lack of assurance in respect of any aspect of the running of the TMB.

3.7 Where the Chair of the TMB considers appropriate, they will escalate immediately any significant issue to the Trust Board.

4.0 Responsibilities

4.1 To develop and agree objectives for submission to the Trust Board, in the form of the Trust's Priorities and Annual Business Plan.

4.2 To deliver the agreed strategy and agree detailed capital and revenue business plans to deliver the objectives.

4.3 To ensure, where appropriate, the alignment of the Trust's strategy with the strategy of key stakeholders and other key partners.

4.4 To develop the Trust's clinical and non-clinical service strategies, ensuring co-ordination and alignment across the clinical divisions and corporate directorates.

4.5 To develop, agree and monitor implementation of plans to improve the efficiency, effectiveness and quality of the Trust's services.

4.6 To monitor and manage standards of care, quality and safety, ensuring appropriate actions are taken where necessary to maintain and improve these.

4.7 To identify and mitigate risk by monitoring the corporate risk register and board assurance framework, agree resourced action plans, and ensure their delivery, compliance and appropriate escalation in accordance with the Trust's risk management systems and processes.

4.8 To monitor the delivery of the Trust's service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Trust's objectives or other obligations.

4.9 To monitor and ensure the delivery of all specific actions agreed by the Trust Board, the TMB and by committees of both.

4.10 To devise the Trust's annual and longer term capital programme, submit to Trust Board for approval and monitor its delivery.

4.11 To oversee the agreement of all relevant policies (principally through sub groups) – other than those retained by the Trust Board - to ensure the delivery of external and internal governance, compliance and best practice requirements.

4.12 To commit resources, subject to approved business case(s), as detailed in the Trust's Scheme of Delegation.

4.13 To approve the Terms of Reference for all the sub committees and groups of the Committee, delegate work as appropriate and hold the respective Chairs to account.

5.0 Core Membership

TMB will include the following members:

- Chief Executive (Chair)
- All Executive Directors (voting and non-voting Trust Board members):
  - Chief Nurse
  - Chief Operating Officer
  - Medical Director
  - Joint Chief Financial Officer
  - Joint Chief Information Officer
  - Director of Estates and Facilities
  - Director of People
  - Director of Strategic Development
- Divisional Medical Directors for Family Services, Surgery and Critical Care, Community and Therapies, and Medicine (joint)

6.0 Responsibility of Members

6.1 Members of the TMB have a responsibility to:

- Attend at least 80% of meetings, having read any papers in advance.
- Identify agenda items for consideration to the Chair/administrator at least five working days before the meeting. The Chair of TMB will have discretion whether to accept items submitted later than this.
- Prepare and submit papers for the meeting, using the Trust's agreed template, at least three working days before the meeting.

7.0 Attendees (Non-Voting)

7.1 Chairs of HCC and MAC, the Director of PGME, Chief Pharmacist, Director of Corporate Governance and the Associate Director of Communications and Engagement.

7.2 In exceptional circumstances, deputies may be nominated to attend prior to the meeting, with the Chair's approval.

7.3 The Chair of the TMB may also extend invitations to other staff (or representatives of outside organisations) with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such staff will be in attendance and will have no voting rights and should only attend for the item for which they have been invited.

7.4 The Chair of the TMB may also invite other individuals to attend as observers from time to time (eg as part of their induction or development, or as part of external review or scrutiny).

8.0 Procedural Issues

8.1 Frequency of Meetings

8.1.1 Meetings will be held as a minimum on a monthly basis. Two meetings will normally take place per month (typically in the first and third weeks).

8.1.2 The business of each meeting will normally be transacted within a maximum of two hours.

8.2 Chairperson

8.2.1 The Chair of the TMB is the Chief Executive.

8.2.2 If the Chair is not present, then the Chair will nominate an Executive Director to chair the meeting in their place.

8.3 Secretary

The Personal Assistant (PA) to the Chief Executive (or if they are on leave, another Executive Director's PA) will act as secretary to the meeting and will be responsible for:

- Ensuring correct and formal minutes are taken, and distributing minutes.
- Keeping a record of matters arising and issues to be carried forward.
- Providing appropriate administrative support to the Chair and TMB members.
- Agreeing the agenda with the Chief Executive prior to sending the agenda and papers to members, no later than three working days before the meeting.

8.4 Quorum

8.4.1 A quorum will normally be seven members in attendance. Of these members:

- At least three must be Executive Directors, of whom at least two must be voting Trust Board members and one must be the Chief Operating Officer or the Medical Director or the Chief Nurse; and

- At least two must be Divisional Medical Directors from two separate Divisions.

8.4.2 When considering if the meeting is quorate, only those individuals who are members (or their deputies) can be counted, attendees cannot be considered as contributing to the quorum.

9.0 Decision Making

9.1 Wherever possible members of the TMB will seek to make decisions and recommendations based on consensus.

9.2 Full members of the TMB may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie, but any such vote is advisory to the Chief Executive and not binding. Votes will be recorded in the minutes, including the votes of individual TMB members.

9.3 In the event of a formal vote, the Chair will clarify what members are being asked to vote on – the 'motion'. Subject to the meeting being quorate, a simple majority of members present will prevail. In the event of a tied vote, the Chair of the meeting may have a second and deciding vote.

9.4 Only the members of the TMB (or their deputies) present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

10.0 Review

The Terms of Reference will be reviewed annually, with recommendations on changes submitted to the Trust's Board of Directors for approval.

11.0 Equality Act (2010)

11.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a proactive and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

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

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

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

NLG(22)140

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	2 August 2022	
Director Lead	Gill Ponder, Non-Executive Director / Chair of F&P Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Finance & Performance Committee – Minutes of the meetings held on 20 April and 25 May 2022.**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Finance & Performance Committee Meetings held on 20 April and 25 May 2022 and approved on 25 May and 22 June respectively.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**20 April 2022 – via Teams Meeting**	
PRESENT:	Fiona Osborne	Associate Non-Executive Director/Chair
	Gill Ponder	Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Shaun Stacey	Chief Operating Officer
	Jug Johal	Director of Estates & Facilities
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Jennifer Moverley	Head of Compliance and Assurance (For item 6.1)
	Ashy Shanker	Associate Director of Planning and Operational Performance (For item 10.2)
	Richard Peasgood	Executive Assistant – Operations Directorate
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Fiona Osborne noted that she would be chairing the meeting as part of her ongoing development.

Item 1 04/22 Apologies for absence were noted from: Lee Bond

Item 2 04/22 **Quoracy**

Fiona Osborne noted there were sufficient Executive Directors and Non-Executive Directors in attendance to ensure quoracy.

Item 3 04/22 **Declarations of Interest**

Fiona Osborne noted that no declarations had been received prior to the meeting. There were no new declarations of interest made.

Item 4 04/22 **To approve the minutes from the previous meeting held on 23 March 2022**

The minutes from the meeting held on 23 March 2021 were reviewed and the following amendments highlighted.

Page 2 – 5.2 – "*Fiona Osborne flagged* ……." - Should read "*Fiona Osborne queried why full reports from Estates were reviewed at F&P when the committee reporting line noted in the reports was Audit, Risk & Governance Committee".* Gill Ponder explained that it had been agreed at the meeting that this was a misprint and should have been F&P and not ARG Committee.
Page 4 – "*Fiona Osborne added that* ……." - Should read "*Fiona Osborne queried if there was a possibility that Clinicians were not engaged …."*
Page 5 – "Cancer target and Ashy Shanker was to provide details of the plans to the Committee". This had not been highlighted as an action. To be added to the action plan. **Action**: Anne Sprason
Page 7 – Brian Shipley advised that there was a plan ….. Should read *"Brian Shipley advised that temporary staffing was reviewed as part of the plan".*
Item 9 – Reference in this section to improvement notices should read "*infringement notices".*

Page 9 - "Fiona Osborne reminded the Committee that action 7.1 would be re-addressed" should read "Fiona Osborne reminded the Committee that action 7.1 had not been addressed.

Fiona Osborne asked that a final spell check was undertaken. Subject to the above amendments the minutes were agreed as an accurate record.

Item 5 04/22 **Matters Arising**

5.1 Action Log

The action log was reviewed.

7 (25 08 21) – Benchmarking of ED – Included on the agenda. **Item Closed**

6 (24 11 21) – Finance Report – Covid Expenditure – Has been addressed under the 22/23 Finance Plan. **Item closed**

8.3 (22 12 22) – Shaun Stacey advised that the information was contained within the deep dive report at the last meeting. To note on the action log and item to be closed.

7.1 (18 02 22) – IPR unplanned Care – It was noted by the Committee that the trajectory had not been updated. Shaun Stacey explained the issue that information is included by the analysts in Digital Services and submitted to Divisions for their input; this sometimes caused confusion. It was agreed that the teams would be asked to include an indication of the trajectory to deliver each target within their action and mitigation commentary. **Action**: Shaun Stacey / Richard Peasgood.

7.5 (18 02 22) – Cancer – Delays in the PTL caused by paper-based system used by diagnostics. Gill Ponder advised that she has written to Chris Evans in Digital Services for an update. It was agreed that the action should remain on the action log. Shaun Stacey also asked for his name to be removed as owner as it was a Digital issue. **Action**: Anne Sprason

10 (18 02 22) – BAF Risk – Estates Strategy – Gill Ponder had written to Mike Proctor for his views who had agreed that Q&S should have some oversight given the links to patient experience. A full review was to be undertaken of oversight to each sub-committee by Helen Harris, and until then it would remain on the F&P workplan.

11 (18 02 22) – BAF – Removal of some risks from F&P's remit. Gill Ponder had written to Alison Hurley, in Helen Harris' absence. Changes needed to be made to the BAF and the TOR and once agreed the workplan would be updated to reflect those changes. Gill Ponder had subsequently spoken with Alison Hurley but this had not led to updated TOR in time for the Committee.

9 (23 03 22) – E&F – BAF Risk Review – Water – Jug Johal advised that a summary table of notices would be included in the next report for the Committee. **Item closed.**

7.2 (23 03 22) – Financial & Operational Plan 2022/23 – Cancer. Shaun Stacey advised that a plan for cancer and non-cancer delivery would be available following submission of the operational plan. The teams are currently working through elements to clarify what funding would be available. The Plans and trajectories would be brought to the next meeting.

Following review, the Action Log was noted.

5.2 F&P Workplan V4

The workplan was reviewed and still required updating. It had been agreed that Facilities Services, that had been added onto the workplan for update in August, should now be called Facilities Services & Sustainability. As identified earlier, the workplan needed to be updated once changes to the BAF and TOR had been made.

Action: Gill Ponder

Item 6 04/22 **Presentations for Assurance**

6.1 CQC Progress Report

Jennifer Moverley presented the paper and highlighted changes since the last report including the current position of 81% of 145 actions either blue or green. Five quarterly action updates had been received since the last report which provided assurance that the actions remained closed and improvements sustained.

There were 27 actions aligned to F&P Committee and Jennifer Moverley briefly highlighted the amber actions as listed in the summary document.

Gill Ponder noted that one of the amber actions was nearing closure where for some others the narrative indicated could take several months i.e. waiting lists with the ongoing issues with levelling up causing further increases. Gill Ponder asked if this would be taken into account and get to a point where the CQC would be assured.

Shaun Stacey explained that as part of regular feedback with the CQC the Trust continued to be open and transparent. Once the operational plan was signed off it would be easier to see the different positions; any activity inheriting from other areas would be distinguished on the PTL. Shaun Stacey highlighted that 200 patients on waiting lists had been transferred to NLAG that month with 100 per month to get HUTH where they needed to be.

Maneesh Singh queried the implications if the target was not achieved. Shaun Stacey explained that a Section 31 would be served because of a poor history of waiting list management noting that the target position was last achieved in March 2020. There was a risk that remained in place, but this has been mitigated through being open and transparent.

Fiona Osborne stated that it would be useful for the amber actions to have the target delivery dates within the notes. Jennifer Moverley advised that most of the actions had position papers submitted to the CQC.

Action: Jennifer Moverley

There were no further questions raised and Jennifer Moverley left the meeting.

Item 7 04/22 **Estates & Facilities**

7.1 BAF Risk Review – Ventilation

Jug Johal presented the report and highlighted areas of note. A new Ventilation HTM was published in June 2021 which resulted in changes to the number of Air Changes per Hour (ACH) and more Carbon Efficient plant. As a result, a Governance Ventilation Safety Group had been set up.

In terms of PAM the risks identified related to the HDU and ITU due to the closure of ITU and relocation to the day surgery. There had also been issues with leaks in the modular building that had been addressed including repairs to the roof. Work is being planned through the capital programme for ITU refurbishment.

The current risks associated with ventilation related to the infrastructure, with the plant being over 20 years old. A ventilation matrix was in place which captured all mechanical ventilation plant ACH. New ventilation plant was factored into ward/area redevelopments.

The risk to Theatres 7, 8 and A at SGH were highlighted and Jug Johal advised that funding had been awarded with a plan to complete the OBC with completion in 2022/23 financial year.

The recent 2021 audit resulted in 18 outstanding actions which the team had cleared. It was noted that the level of maintenance undertaken exceeded the minimum requirement to mitigate the condition and age of plants.

Gil Ponder asked if funding that had been awarded for upgrading theatres would have an impact on the risk score currently at 20. Jug Johal explained that it would have very little impact on the estates risk although in Shaun Stacey's area it would reduce the score, noting the massive impact to the area of having two theatres at both sites.

Gill Ponder noted that upgrading theatres had a track record of both taking longer than anticipated and experiencing issues afterwards and asked if lessons had been learned. Jug Johal stated that issues could occur when upgrades are incorporated into old infrastructure and with theatres specifically ventilation. Lessons learned from Theatre E would be picked up by the design team as it would be the same engineering team.

Gill Ponder referred to the action plan embedded within the document and stated that every action had dates put back at least once and in some cases more than once. Jug Johal explained that this was due to non-critical action and were tracked through the governance group.

Maneesh Singh stated it was a good paper, easy to read and highlighted and explained the risks to the Committee, which Jug Johal would feed back to the team.

Fiona Osborne queried the ventilation timescales and how those fit in with the capital business plan. Jug Johal explained that the capital programme was already committed for 22/23 based on high risk clinical areas. The ED/AU schemes would incorporate some of that ventilation work at the same time.

Item 8 04/22 **Integrated Performance Report**

8.1 Unplanned Care

Shaun Stacey highlighted issues to note including the continued ambulance handover challenge. Patient flow and discharge was an obstacle with increasing numbers of patients with no right to reside in a hospital bed. A&E performance for the urgent care service continued to perform well and were seeing patients swiftly. Emergency care standard continued to deteriorate which was directly linked to the flow of patients through the hospital, with secondary issue of demand.

SDEC continued to be stable which demonstrated that the model was working. There had been a slight issue with reporting which was affecting the performance target due to some patients not being included; this would probably take a couple of months to resolve.

Maneesh Singh acknowledge the ongoing work to improve flow through the hospital and that the numbers shown did not reflect the patient care. He expressed concern that given we are heading towards summer and despite Covid being downgraded it could still have a negative impact.

Shaun Stacey agreed and stated that demand for emergency beds had grown and the Trust were seeing an increase in acuity of illness, more chronic conditions and by not recording activity through the pathway used, the Trust were not demonstrating the good work that was being done. Shaun Stacey explained the difficulties of the numbers of patients coming through ED requiring admission and due to the lack of availability of hospital beds this was taking between 8-14 hrs.

There were development changes being made to the management of patients, but this would take three months to complete, although some minor changes were being made in the interim. Shaun Stacey commented that over the last 24 hrs 30 stranded patients had been discharged but had been replaced by a further 28. Working differently was the approach needed to help that problem. The Trust was in the top quartile for DTA (Discharge to Assess) but with the new emergency department that would mean double the capacity and double ambulance holding area designed to meet the demands of today although workforce would continue to be a challenge. Shaun stated he had been asked to share the model in the ICS and wider.

Gill Ponder noted the change to the report which now included three highlights and three lowlights which gave a good snapshot of key issues and asked if timescales could be included against the improvement actions and outcomes. Some actions would come to fruition in the longer term and it would be helpful to be able to see trends reversing, acknowledging that it did not need to be scientific just to give some assurance. Richard Peasgood to feedback to the team for the IPR for next month.

Action: Richard Peasgood

Gill Ponder queried urgent care (page 15) where the narrative referred to January's data in April. Shaun Stacey explained that urgent care service data was manually collected, and the action referred to UCS in January to demonstrate the position at that time and suggested the wording could be more explicit describing an outcome rather than an action. Shaun Stacey added that performance was 98.5% in March and currently 99% in April so a sustained service which is what the text should have shown. Richard Peasgood to feedback to the team.

Action: Richard Peasgood

Fiona Osborne also noted the additional page with the highlights and lowlights but was disappointed that the "key issues to address" did not seem to address the lowlights, acknowledging that it would be in the wider plans but would like to see the action if in current month.

Action: Shaun Stacey

Fiona Osborne referred to the ambulance handover delays which seemed to plateau with the 4hr waiting time. Shaun Stacey explained the different categories of patients i.e., categories 3,4, and 5 diverted to single point of access; patients of higher acuity i.e. categories 1 and 2 to hospital. The reference in the report was not clear and this would also be addressed.

Action: Shaun Stacey

8.2 Planned Care

Shaun Stacey highlighted the headlines as follows:

- Elective - continued to reduce 52 waits
- Cancer – Concern of patients over 62 days or 104 days as not seeing a significant shift in programme with a number of patients still outstanding for follow up, so this continued to be a clinical risk
- DM01 – improvement seen and understand the risks
- DNA rates – text message service reinstated which had seen a slight reduction in DNAs and would expect that to continue
- Levelling up – 604 on waiting list from HUTH with first 200 received and then 100 a week until balanced waiting time across the system

Maneesh Singh queried the elective work and the financial implications of using independent providers. Shaun Stacey explained that contracts with independent providers do not include follow-up activity as this does not earn money. Brian Shipley referred to ERF funding and explained that to gain ERF required delivery of 100% of 2019/20 baseline and the transfer of patients could attract a higher tariff irrespective of whose patient it was.

Gill Ponder referred to a comment in the recent committee self-assessment exercise she was undertaking, which had suggested the Committee could focus on one or two areas that were underperforming and asked what more the Committee could do to help drive improvements in some of those areas.

Fiona Osborne suggested a similar approach to Q&S and speak with individual Divisions at the meeting. Shaun Stacey supported that approach. It was pointed out however that only questions relating to performance should be asked by the F&P Committee. It was suggested that a small group from the F&P Committee members could discuss a way forward.

Action: Gill Ponder

Gill Ponder referred to contracting with the independent sector which was due to end in April and asked that given all the pressures to continue to tackle waiting lists and the need for extra capacity was this being progressed or does the financial plan need to be signed off first. Shaun Stacey advised that approval was given earlier that week at TMB to continue, and contracts would be going out shortly.

Item 10 04/22 **Finance Update**

Ashy Shanker had joined the meeting and it was agreed to take item 10.2 first.

10.2 Financial & Operational Plans 2022/23

Brian Shipley referred to the last meeting and the draft plan with a deficit of £32m. Since then, an update had been presented to Trust Board with a deficit of £5.6m. Confirm and challenge sessions had taken place with the ICS and CCGs which resulted in an assumption from ICS that additional funding from out of area would be available of £1m bringing down the deficit to £4.8m. There were additional discussions on the model referred to by Shaun Stacey earlier and a broader review would be undertaken which would result in a revised deficit position to £3.3m. It was not envisaged that the figure would change significantly unless any additional funding received further down the line.

Gill Ponder noted that UCS had delivered a very good outcome, so continuation of funding for that service would be beneficial to those patients who were within the scope of the UCS, even though that would not result in an improvement in the overall A&E 4hr standard, or in ambulance handover times.

Brian Shipley highlighted that there was an element of improvement in the system financial position and CCGs reviews that were being proposed delayed the process further, but it was more about the £50m-£60m system deficit. Shaun Stacey stated that the UCS delivers consistently at 99%. 4hr wait was a standing problem because of lack of beds. There were a number of ways to access emergency care but the 4hr wait was mainly down to availability of beds, but overall performance should improve.

Fiona Osborne asked if there was any likelihood of the ICS rebalancing the deficit between the member Trusts. Brian Shipley explained that Lee Bond was due to meet with DOFs across the region later that day as submission date was end of that week. This would trigger a second meeting with Stephen Eames so could see a couple more days of toing and froing to understand next steps.

Fiona Osborne noted the extremely tight margin of errors, with nursing difficulties of recruiting and retaining and she understood Lee Bond was going to look at the staffing side and asked if that had been completed. Brian Shipley explained that the nursing establishment was nearing completion with one outstanding element in terms of HOBS which was being worked through with Ellie Monkhouse. Other elements including managing rosters, the level of unused shifts and to live within the financial envelope and the need to tighten controls on temporary staffing; also, recruitment, beds and return to level of pre-pandemic numbers in terms of absence.

Ashy Shanker highlighted the activity figures and the total targets that were unchanged. The main change was core activity from the independent sector. The next steps were designing a robust performance monitoring system.

Ambitious targets had been set for the Divisions but required a change in mindset and was not going to be easy to achieve however the Divisions were on board with what was submitted.

15.40pm Ashy Shanker left the meeting.

10.1 Finance Report M12

Brian Shipley presented the finance report for M12 and highlighted key areas to note:

- It was the third consecutive year that the control total was achieved with a slight surplus of £40k
- In month variances included exceptional items for nationally held pension changes and central DOH consumables and PPE with income offsetting expenditure.
- Covid expenditure £13m marginally within funding received with concern that March did not appear to be decreasing
- Stretch CIP plan from £11.99m delivered against £10.5m target, noting a large element of that was non-recurrent
- ERF from H1 perspective expenditure covered the cost base; H2 had higher targets
- ERF - Delivery for activity recovery was quite good but not judged just on the organisation's performance but on ICS so due more than £1m but reduced because of ICS position. Flagged as a risk with additional funding of £5.9m mitigated the risks.
- 2022/23 would see a change in the rules whereby ERF was given up front but still judged on ICS but also our own base line.

- Capital – considerable amount of spend in March to hit the capital programme in year, apart from SALIX delays throughout the year and excluded that item from the I&E position. The core programme hit trajectories
- Underlying position saw a slight movement due to car parking recovery which was based on assumptions of less footfall and some activity being delivered remotely

Gill Ponder commented on temporary staffing being the biggest risk to delivery of the financial plan with some areas worse than others i.e., surgery. Brian Shipley advised that ownership of the risk was in place through workforce meetings where vacancies and recruitment were discussed. Whilst there were high volumes of recruitment the difficulties arose with the process of getting them in place and commencing work. He went on to explain that there were control measures in place on agency spend but some rates drift, and some were dictated by the market, but it did need more rigour particularly on long-term locums. Nursing had seen improved rates and compliance with rates and framework use; unfortunately, Drs had reversed that trend and may need a deep dive on those prices. Shaun Stacey added that check and challenge took place through PRIMs on agency rates, noting that recruitment of Drs was good it was the onboarding and accommodation had caused problems due to reliance on hospital accommodation.

Nursing Agency controls had lapsed as daily reviews for staffing had worsened with Covid, but more work was needed on the use of high-cost agencies. An audit would be undertaken on bank and agency use to control the approach.

Gill Ponder queried how non-recurrent CIP delivery in 21/22 was being managed in the 2022/23 CIP plans and Brian Shipley explained that most of the non-recurrent delivery was in back-office functions which would have a lower budget to live within.

Fiona Osborne queried the EBITDA being £46m away from target noting significant staffing costs overspent and asked if the CIP target was challenging enough. Brian Shipley explained that SALIX was excluded from EBITDA which had a significant impact on the resulting £44m; and £1m funded for slippage to capital programme. The CIP target was approximately 2% i.e., H1 efficiency target of 0.9% and H2 an average of 1.1% for whole year with some stretch target. The target was challenging and only delivered because of non-recurrent back-office functions.

Fiona Osborne queried how divisions that had over-delivered in 21/22 had been reacted to 22/23 schemes being scoped based on 21/22 CIP delivery. Brian Shipley explained that a 2% target had initially been set across the board for the planning process, but it would end up with differentiated target. Jug Johal commented that E&F had overdelivered but having the same targets set was becoming challenging and had asked for that to be taken into consideration. Brian Shipley explained that it had been recognised the effect of a blanket approach but had to do that within the Covid financial framework. The plan tried to recognise performance on recurrent basis along with historical performance and benchmarking data.

10.3 Recovery Support Programme for finance (RSPf) Letter

The recent letter had been provided on the SharePoint site and Brian Shipley highlighted that the focus was temporary staffing and the workforce analyses which showed that the organisation was in the upper quartile across the country. Whilst NHSE/I recognised the vacancy position, they would be looking at grip and control of temporary staffing usage.

10.4 Capital Investment Board Minutes

None available due to timing of the meeting.

10.5 Efficiency Update

Use of Resources – No update available due to model hospital data not received. Item deferred.

Benchmarking statistics were presented comparing costs of running NLaG and HUTH EDs – A late paper had been provided which showed a high-level analysis with the caveat of not comparing apples for apples. The paper highlighted that NLAG was spending £4m more than HUTH but that was for 2 EDs against 1 at HUTH. Brian Shipley talked through the paper in detail.

Gill Ponder noted the huge differential on locums and agency and asked what HUTH were doing to get the substantive staff and whether NLAG could learn from that. Shaun Stacey explained that HUTH was a major trauma centre so a good place for Drs to be. In terms of A&Es as Drs completed their training programme were choosing Sheffield or Hull. The new builds at NLAG would help and more marketing on that was being undertaken by the recruitment team.

Fiona Osborne stated that it was useful data and commented she thought there was merit in further investigation to identify evidence for the reasons in the discrepancies. Brian Shipley explained that the paper was prepared from the financial position, but more focus would need to be given to the nursing aspect, particularly on the agency supply through Thornbury noting HUTH spending £90k on agency against NLAG £2.5m. Shaun Stacey agreed it was a useful piece of work but would also need to look at activity and performance numbers to tell the full story.

10.6 BAF Risk Review – SO3.1

10.7 BAF Risk Review – SO3.2b

The above two items were deferred to the May meeting.

Item 11 04/22 **F&P Committee Governance Documents**

11.1 Update due in May

11.2 Review of F&P Committee Terms of Reference

The current TOR had been provided although it was understood that some changes had been made by the Corporate Director's Office but had not been provided in time for the meeting. A brief discussion took place on some further changes that were required including:

- Estates & Facilities to read *Estates, Facilities & Sustainability*
- 5.1.5 – Referred to crossover with Q&S Committee which would now need to include others including Strategic Development Committee (SDC)
- Digital Strategy, Performance & Development – to be removed as now reported to SDC
- 7.5.2 – Deputies to be listed
- 7.6.5 – To add a further bullet to add that Richard Peasgood would be the Senior Administrative Support to the meeting. **Action**: Shaun Stacey / Lee Bond / Jug Johal / Gill Ponder to discuss further on the detail on how the role would work.

Gill Ponder commented that Alison Hurley would be updating the TOR including the additional amendments above.

Item 12 04/22 **Items for Information**

12.1 Performance Letters to Divisions following PRIMs meetings

The letters from March 2022 had been provided for information and were noted.

Item 13 04/22 **Any Other Urgent Business**

There were no matters raised

Item 14 04/22 **Matters to highlight to other Trust Board Sub-Committees**

There were no items raised that required highlighting to other Trust Board Sub-Committees.

Item 15 04/22 **Matters for Escalation to the Trust Board**

The following items were noted:

- A&E long term model of care
- Planned Care
- Finance – challenge of temporary staffing and plan for 2022/23

Richard Peasgood to pull together the highlight report for the Trust Board and circulate to members of the Committee for agreement.

Action: Richard Peasgood

Item 16 04/22 **Review of Meeting**

Fiona Osborne asked for feedback on her first Chairing of the F&P Committee. The Committee agreed it had been a good meeting.

Item 17 04/22 **Date and Time of next meeting**

The next meeting was due to take place on 25 May 2022 – 1.30pm-4.30pm via Teams

Attendance Record 2022/23

Name	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Gill Ponder	✓											
Linda Jackson	-											
Fiona Osborne	✓											
Michael Whitworth	-											
Maneesh Singh	✓											
Lee Bond	Apols											
Peter Reading	-											
Shaun Stacey	✓											
Jug Johal	✓											
Helen Harris	Apols											
Brian Shipley	✓											
Simon Tighe	-											
Ab Abdi	-											
Chris Evans	-											
Richard Peasgood	✓											
Ian Reekie	✓											
TOTAL ATTENDEES	8											

MINUTES

MEETING:	**Finance & Performance Committee**	
DATE:	**25 May 2022 – via Teams Meeting**	
PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P Committee
	Fiona Osborne	Associate Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Jug Johal	Director of Estates & Facilities
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
IN ATTENDANCE:	Jennifer Moverley	Head of Compliance and Assurance (For item 6.1)
	Richard Peasgood	Executive Assistant – Operations Directorate
	Matt Overton	Associate Director – Central Operations (For Item 7.3)
	Edd James	Director of Procurement (For Item 8.8)
	Vince Tennison	Head of Safety & Statutory Compliance (For item 9.1)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 1 05/22 There were no apologies for absence to note.

Item 2 05/22 **Quoracy**

There were enough of both Executive Directors and Non-Executive Directors in attendance for the meeting to be quorate.

Item 3 05/22 **Declarations of Interest**

Gill Ponder noted that no declarations had been received prior to the meeting. There were no new declarations of interest made.

Item 4 05/22 **To approve the minutes from the previous meeting held on 20 April 2022**

The minutes from the meeting held on 20 April 2022 were reviewed and the following amendments highlighted.

- Maneesh Singh noted his job title should read “Associate Non-Executive Director”
- 6.1 CQC progress report - Amber actions nearing closure – It was noted that levelling up had nothing to do with actions being downgraded and to remove the sentence.
- Reference to UCS and outcome (page 7) to read … *Gill Ponder noted that the UCS had delivered a very good outcome, so continuation of funding for that service would be beneficial to those patients who were within the scope of the UCS, even though that would not result in an improvement in the overall A&E 4hr standard, or in ambulance handover times.*
- 7.1 (Action Log) – trajectory not updated. Peter Reading suggested that having a trajectory would not add value to the report. Gill Ponder stated that from the Committee’s perspective improvement in the overall 4-hour wait could not be seen and therefore needed to find a way to show improvement by way of step change. (Post Meeting Note: It was agreed at a meeting on 10 June that Urgent Care would be added to the agenda bi-monthly; this would ease the worries from the Committee).

- Page 8 - … Non-recurrent CIP delivery in 21/23 – should read 21/22.

Following review, and subject to the above amendments the minutes were approved.

Item 5 05/22 **Matters Arising**

5.1 Action Log

The action log was reviewed.

7.1 (18 02 22) – IPR – Trajectory not updated. Shaun Stacey advised that dates had been included when actions were expected to be completed, noting that not all elements had been covered. The planning cycle had only just been concluded with a further iteration to be submitted and until then it was not possible to put an expected completion date in the IPR.

Fiona Osborne was still not clear from the document whether any of the actions constituted process redesign. Shaun Stacey referred to the information from the analysts and with the rapid turnaround required for the IPR this was not getting picked up by the Divisions. Shaun and Richard Peasgood were working on sorting out those issues. Gill Ponder acknowledged that improvements would continue to be made and proposed closing the action, which was agreed. **Item Closed**.

7.5 (18 02 22) – Cancer – delays in the PTL caused by paper-based system. Gill Ponder had heard back from Chris Evans who had confirmed that better use of electronic systems was being explored. **Item Closed**

9.4 (18 02 22) – CDIP – Final report to be signed-off by F&P. Gill Ponder noted that this was Digital Services which now reported to the Strategic Development Committee and would be picked up by them. **Item Closed**

10 (18 02 22) – BAF Risk – Estates Strategy. This was included within the F&P workplan and continued to report on cleaning standards to Q&S Committee. **Item Closed**.

7.2 (23 03 22) – Financial & Operational Plan – Cancer Target. This had been included in the slide pack provided at the last meeting. **Item Closed.**

14 (23 03 22) – Workforce impact on the delivery of operational and financial plans. Gill Ponder had raised with Michael Whitworth. **Item Closed.**

6.1 (24 04 22) – CQC Progress Report – Amber actions to include target delivery dates within the notes. This had been actioned and therefore **Item Closed**.
8.1 (24 04 22) – Highlights and lowlights to include timescales. Actioned therefore **Item Closed.**
8.1 (24 04 22) – Urgent Care should have outcome rather than an action. Actioned therefore **Item Closed**.
8.1 (24 04 22) – Lowlights action to be included for current month. Actioned therefore **Item Closed.**

8.1 (24 04 22) – Ambulance handover delays and 4 hr waiting time not explicit in the report. Shaun Stacey advised this was reflected in the report therefore **Item Closed.**

Following review, the Action Log was noted.

5.2 F&P Workplan V6

The workplan would be reviewed in detail at the next meeting.

Item 6 05/22 **Presentations for Assurance**

6.1 CQC Progress Report

Jennifer Moverley presented the paper and highlighted changes since the last report with the current position of 82% of 145 actions rated as blue or green.

There were 27 actions aligned to F&P Committee and Jennifer Moverley briefly highlighted the seven amber actions as listed in the summary document.

Lee Bond referred to waiting lists contained within the report and noted the previous target of 18 weeks and asked if this could be aspirational and if the CQC were still holding on that target. Peter Reading stated that waiting lists was the biggest single issue in the CQC report of 2015 in certain areas and therefore important that it should be measured given the historical interest from CQC. Unless the CQC acknowledge the shift across the Country they would expect the Trust to follow-up from previous reports so should wait to see what happens once they had arrived.

Peter Reading noted the deterioration with diagnostics and asked if this was a one-off or something more structural to be concerned about. Shaun Stacey advised that it was too soon to tell. Ongoing issues with Ultrasound due to being contracted out but not able to deliver level of activity, which could indicate that the mobile unit was turned off too quickly. He did not think the DM01 position was an issue.

There were no further questions raised and Jennifer Moverley left the meeting.

Item 7 05/22 **Review of Monthly Performance and Activity Delivery (IPR)**

7.1 Unplanned Care

Shaun Stacey highlighted issues to note including the number of patients seen through urgent care with a slight improvement to ambulance handover. There was an ongoing challenge due to the increased number of patients over 12 hrs from Decision to Admit to Admission and included within the report were actions taken to make a difference.

Delays in 7-14 and 21-day discharges due to difficulties with availability of beds outside of the Acute setting and working with Local authority, Commissioning Group, and Lincolnshire Partnership to improve the exit blocks.

Fiona Osborne noted the actions for the number of patients waiting over 12 hours was still showing in the IPR the same as in previous months and the flow of patients being dependent on activity outside of the organisation and asked if Shaun Stacey was seeing any movement to free the access up. Shaun Stacey explained that it was not just about outside the organisation but also trying to ensure two reviews were being carried out per day but the amount of leave now being taken back was making it difficult. The actions therefore remained as they were in the IPR until they were sustained. There were problems in M01 with flow due to Covid and the difficulty of bed availability in the community. Work was ongoing to adopt a different model to not use residential care unless necessary and encourage to go home with a wraparound service of care in place. This had taken four weeks as had to remodel community services as new money was not available. Also working with Lincolnshire and East Riding to try and influence them to

adopt similar practices but this could take time and therefore may only see small improvements.

Lee Bond commented that there were too many beds and asked if it was worse at one site; if the new ED would be ready for opening from a staffing and operational perspective; and if the Quality & Safety Committee were seeing an increase in patient harm against the increase in 12 hours and given the improvement in SHMI if that could deteriorate because of the ongoing pressures.

Shaun Stacey advised that the pressure was equal at both sites although SGH suffered more because of a slightly distorted catchment area and poor environmental conditions. He did not believe however, that more harm was occurring. The challenge was the number of people coming into the two sites and would benefit from an alternative route of care, primarily community managing long term conditions in a different way. Some people came into the hospital because there was no appropriate support for them outside. People were being moved back home as much as possible as a first option and the data was telling a success story although not on the 4hr standard. There was an average of 21 patients requiring admission but 60% of those patients could be cared for at home if wrap around support was in place and until that was more readily available still need the bed provision.

Lee Bond asked if Local Authority funding for domiciliary care should be considered. Shaun Stacey explained that it was anticipated that improvements would be seen in flow from June/July onwards in SGH but in NEL could only influence Care Plus to adopt similar model, but this would not help for Lincolnshire or East Riding patients.

Post Meeting Note: *Shaun Stacey advised at the June F&P meeting that improvements to flow would be seen in September 2022.*

Fiona Osborne commented that if the process of producing the IPR, discussed the previous month, was addressed it would save the number of questions raised in the meeting.

Maneesh Singh commented that recurrent conversations were held where A&E dominated and asked what assurance the Committee could get i.e. assured that the hospital was doing everything it could but not assured that would hit the target for quite some time.

Shaun Stacey acknowledged that 4hr emergency standard was going through a national review with the likelihood that the target would be changed given that it was a national struggle to hit the 4hr target. Patients were being cared for appropriately, with minor cases passing through the department within 4hrs; for those who required admission everything was being done to ensure beds were available. The report, therefore, was advising that patients were being cared for and coming to no harm either psychologically or physiologically but had a higher level of resourcing, with some staffing costs affected with the continuing virus.

Jug Johal advised that preparation was being done for the new ED with a Matron working on a transition plan. Shaun Stacey advised that staff would be recruited once the money was agreed noting it was currently behind where it should be. The recruitment plan was very robust although there could be vacancies when ED opened but there should not be any impact on performance other than ambulances which should see improvement as there would be more cubicles available. The difficulty would be those patients that need to be admitted if there continued to be insufficient bed numbers available each day.

7.2 Planned Care

Shaun Stacey referred to the three highlights and three lowlights in the report, noting specifically the improvement in outpatient DNA rate and in the lowlights the cancer waiting times for 62-day GP referrals which was an unvalidated figure of 55.1%.

Shaun Stacey advised that M01 position was not as expected with some anomalies being picked up as coding and recoding was undertaken. Some Divisions had lower activity than predicted as well as some sickness and unexpected loss of locums had resulted in turning off cases in Upper GI. It was anticipated that a recovery plan would be in place by the end of that week.

Maneesh Singh queried the reason for not getting ERF funding and asked if weekends could be used. Shaun Stacey explained that weekends were being used as much as possible and running waiting list initiatives within the current financial envelope. The productivity problem was not expected, and the sickness absence was not foreseen.

Maneesh Singh referred to sickness not being related to Covid but stress which was worrying in theatres and costing money with stress and never events recurring and asked what the plans were to look at that. Shaun Stacey explained that there were challenges in theatres particularly to recruit staff of a high calibre, but there was a recruitment programme in place to manage that.

Gill Ponder referred to patients added to a PIFU pathway continued to be under trajectory, but the report did not say what action was to be taken. Shaun Stacey explained that work was ongoing with all clinicians to encourage its use, with some lack of confidence in its use and some would not use it so some challenges to overcome. There was a national drive as well as GIRFT promoting its use, so it was hoped that it would improve as work was done through the Specialties. Gill Ponder asked if there were any success stories from outside that could be used. Shaun Stacey advised that there was nothing in Humber or York which was why GIRFT was being used.

Gill Ponder also noted the Cancer 62-day performance remained a concern and Shaun Stacey advised that work was in progress to encourage use of pathways efficiently, but it relied on clinical behaviour.

Gill Ponder noted that some of the narrative in the report was cut and pasted on several pages and similar to previous months so likely work to do on that.

7.3 Business Continuity including EPRR

Matt Overton presented the paper and highlighted the current increase in risks due to the Russia/Ukraine situation as well as attempted cyber-attacks and highlighted specifically an attempted cyber-attack to Humberside Fire & Rescue Service the previous day. He also highlighted the global shortage of goods and resources caused by the pandemic including supply chain issues.

Matt Overton highlighted the Business Continuity Strategy which included 157 service level business continuity plans across the Organisation that were tested through multi agency exercises. The Trust participated each year in the annual NHSE core standards for EPRR process and had gained substantial compliance since 2013. There was an open strategic risk (SO1.6) linked to business continuity rated 16 (high).

Fiona Osborne commented that it was a comprehensive paper but was struggling to understand how the threats related to service level plans. Matt Overton explained that the plans were reviewed annually as risk changes or new threats identified and then added specific updates.

Jug Johal highlighted the use of a table-top exercise for a terrorist attack and asked if there was anything planned over the next 12-months. Matt Overton advised that sitting alongside EPPR work programme were routine test unless have an incident, otherwise every three-years but could bring forward if required.

Matt Overton explained that a review was always undertaken after any exercise which had a post action report and action plan and it was monitored through the EPRR steering group. The organisation was a leader in the region as well as identifying areas of best practice
14.50pm and supported other Trusts.

Matt Overton was thanked for the report and he left the meeting.

7.4 Monthly Deep Dive – Diagnostics

Shaun Stacey presented the report with particular focus on DM01 performance which had progressively improved but had started to deteriorate since April. There was continued struggle to access laboratories and working through Cardiac Network across the Humber patch to improve that. Other areas of concern included non-obstetric ultrasound which continued to cause pressure despite some improvement.

Fiona Osborne commented that whilst working with CCG on additional capacity, the volume of referrals had the biggest impact on waiting times and asked if communication with GPs was in place. Shaun Stacey confirmed that working with GPs to reduce the number of referrals for diagnostics where not required was key.

Gill Ponder referred to the spike in the number of referrals and Shaun Stacey stated that there was limited diagnostic availability and as caught up with Elective work resulted in a 6-7-month delay so repeat tests would be required. He added that they were also trying to return to pre Covid levels of referrals.

7.5 BAF Risk Review – SO1.2

Shaun Stacey referred to the main BAF document to see what changes had been made to that area, noting the latest changes were highlighted in blue for ease of reference, specifically noting a new System-wide Ambulance Handover Improvement Group replacing the internal ED Performance and Ambulance Handover Group.

Lee Bond referred to the additional gap in control that had been added to the BAF i.e. validation of RTT clock stops in high risk area specialities only due to ongoing capacity pressure as a result of Covid. He suggested that the Trust should use current availability rather than citing lack of capacity and asked if that could be related to productivity.

Gaps in assurance and not meeting targets of RTT and DM01 and whether cancer should be included - Gill Ponder suggested the wording could read *not meeting constitutional standards* rather than naming them individually.

Gill Ponder noted the current risk score of 20 with the aim to reduce to 15 by 2023 and further reduction longer term and asked if the Committee members were content with the current risk score, which was confirmed.

Item 10 05/22 **Finance Update**

10.1 Finance Report M01

Brian Shipley presented the finance report for M01 and highlighted key areas to note:

- The Trust reported a £0.11m deficit for the month of April which was £0.51m worse than plan.
- Income was £0.16m overall worse than plan in month. ERF income was £0.5m below plan due to 75% of the ERF being deferred in case of potential clawback from the ICS.
- Pay was £0.62m overspent in month with Medical Staffing being £0.69m adverse to plan being the main driver. Non delivery of CIP savings in Medicine due to loss of several doctors in month. The pipeline savings looked healthy but need converting to recurrent savings.
- Slippage on investment programme of nursing expansion but masking that were pressures from escalation beds. The key challenge was recruiting to posts.
- Other pay was £0.05m overspent including over delivery in CIP within Corporate functions and overspent due to unfunded developments within Transfer Teams of £0.4m).
- Non-pay was £0.36m underspent in month mainly due to outsourcing being lower than plan.
- Staff absences, isolation and current risk assessment criteria resulted in increased cost pressures and impacting on use of temporary staffing, which was increasing year-on-year.
- Had delivered a balanced position against plan but propped up by corporate areas with pressures in medical staffing workforce schemes with the plan not sufficiently phased but spend increased which was why non-compliance. ERF not achieved plan but have spent money on activity and now needed to improve core capacity.
- Delays with EDs and Ward 25 were driving variances.

Lee Bond commented on the salient facts including incorrectly classifying Covid but when business as usual resumes that would be corrected. Key drivers were far more transparent and evident, including additional pay costs, escalation beds open all the time which was not in line with plan and causing additional pressure. Conversation with Special Measures team this was a major problem. Independent sector, spending money on follow-ups but hopefully the level of spend will decrease as follow-up waiting lists brought under control to some degree.

No issues from cash position but in-month run rate had to come under control.

Fiona Osborne referred to the Medical Agency Compliance (Page 9) which was showing that unsocial hours had significantly increased and asked if there were any early indications of why. Lee Bond explained that Richard Winter from NHSE/I reviews and discussed the graphs each month and highlighted that a piece of work the previous year with NHSI/E on nursing and agencies which saw some very slight improvement but nothing more had been done in Medicine. More information would be available the following month.

Fiona Osborne referred to the CIP savings programme (page 12) which explained the core programme and the targets for Divisions / Directorates. Lee Bond explained that the recruitment pipeline scheme would be more effective if the retention issue was resolved, noting the number of nurses from overseas was off-set by the number of leavers and asked if conversations were being held to deal with retention. Peter Reading pointed out that this was a matter for Workforce Committee but highlighted that he had done the appraisal and objective setting with Christine Brereton which included work around leadership development where retention focused heavily. Peter Reading suggested referring to Michael Whitworth for assurance that this was progressing.

Gill Ponder stated that she had previously dropped a note to Michael Whitworth and specifically referred to recruitment.

Peter Reading highlighted recent portfolio changes of Associate Directors of People which had brought fresh eyes and explained that Nico Betinica was undertaking a root and branch exercise of recruitment practices due to economic pressures needed to get slicker on practices as the labour market would be difficult on Trusts.

8.2 Financial & Operational Plans 2022/23

Lee Bond referred to the last update which highlighted a £60m deficit for the ICS, since that time £26m additional funding had been made available to ICS plus a small pot of money for non-recurrent. This equated to a net improvement of £20m for ICS so there was a requirement to get from £25m down to zero to access that funding. This had been discussed and agreed with the Exec team where a couple of assumptions had to be made including slippage on EDs and an expectation of using reserves if not achieved 2019/20 activity as a minimum from core capacity. Conversations were taking place, but this could put some organisations in surplus and some in deficit with a rebalancing undertaken to ensure all in same position.

Lee Bond explained that changes to the plan did not require increased efficiency asks from Divisions and it was hoped that a balanced plan would be agreed over the following few days to be able to focus on delivery. Shaun Stacey explained that he was aware that ICS had reviewed the planning submission in respect of data, links to the national picture for M01 and also the recovery position for Humber and North Yorkshire in terms of long waiters which were not quite delivering the central ask.

8.3 Recovery Support Programme for finance (RSPf) – Letter for Information

The latest letter had been provided and Lee Bond explained that Kate Wood had attended the last meeting to talk about the approach to GIRFT and what it meant to the organisation and how it tied into financial plans. It had been quite a positive conversation which was reflected in the letter and the requirement for activity plans dovetailing and complementing whatever was being done in terms of GIRFT with a focus on locum and agencies; the 2022/23 plan was also raised. He added that Workforce Committee and Finance & Performance Committee were tied together in terms of actions to deliver the plan.

8.4 Capital Investment Board Minutes

The Capital Investment Board minutes had been provided for information and were noted.

8.5 Cost Efficiency and Reference Cost Process

A paper had been provided explaining a summary of the approach for producing NLAG's mandatory cost submission to NHSE/I.

Brian Shipley presented the paper and explained the usual approach taken for the benefit of new members of the Committee. He explained that a Costing Steering Group was in place to address some of the known areas with recommendations to support a planned approach and linked to the standard of reporting activity. The IPR document does not, however, tick the box from a costing perspective so maybe need to include the activity numbers appended to the IPR.

There were three recommendations which required approval and support from the Committee i.e. The costing team's method used; the request for an activity report to show clinical activity delivered, which would enable the team to reconcile/verify the activity data for the NCC submission and possibly support the Trust in monitoring it's elective recovery performance; and support the continued and future programmes of work for the Costing Steering Group. The Committee supported and agreed the three recommendations.

8.6 BAF Risk Review – SO3.1

Lee Bond stated that the current risk score was 5 but for 2022/23 increased to 20 which was reflective of the difficult start of the year with the probability of the risk requiring to be higher.

8.7 BAF Risk Review – SO3.2b

Lee Bond referred to the risk to the strategic capital spend and stated that the role of Finance was to monitor and gain assurance on spend and whether on track and delivering. He noted that the particular risk score would need to be updated in conjunction with Ivan McConnell.

8.8 Procurement Improvement Plan

Edd James, The Director of Procurement across three organisations i.e. NLAG, Hull & York & Scarborough Trusts, gave a brief background history and explained that his role was to coordinate the three procurement teams to create a single procurement function to help drive efficiencies; this was linked to NHSE Procurement Target Operating Model. Edd James explained about a Draft Strategy, which looked to deliver ten aims and objectives taken from the three Acute Trusts as well as the ICS and their current individual strategies. Different systems were in place across the three organisations for data and technology.

Edd James highlighted that a skill shortage had been identified as well as a gap around senior grade staff whereas they were heavy in Bands 2/3 so currently going through succession planning to identify those gaps.

Strategic procurement included the need to have more engagement with the customer, simplify the processes and work with clinical and non-clinical teams to implement value-based procurement to deliver tangible, measurable financial benefit to the health system.

NHS Supply Chain were supporting a 6-week review of all Trust supply chain management activities and Edd James explained that he was currently process mapping across the three sites how it operated, improvements that could be made and where could roll out better materials management and hoped that initial output should be known within the next few weeks. Following which a Business Case would be produced to take to the respective Trusts, probably around October 2022.

Procurement needed to align and deliver the ICS sustainability strategy as well as the NHSE/I sustainability milestones.

Edd James concluded in highlighting that one of the key concerns was the resource required to deliver the big agenda and reap the benefits as quickly as possible.

Fiona Osborne queried the structure that Edd James was aiming for and whether it was for development of the current skill set or a restructure. Edd James confirmed that it would

probably mean restructure noting some Band 2/3 may be ready for more and NHSE/I looking at Band 8b/c levels but there was a gap at the middle grades.

Lee Bond stated that materials management would improve and a change of model to use procurement business partners in areas where there would be influence on the cost base. The Strategy would supersede NLAG's current procurement strategy, but it was just the start of the journey.

Edd James highlighted that he was currently working with ICS on the Sustainability Strategy and how it linked to the Trust's Green Plans. Lee Bond noted that an environmental assessment was built into tenders but not sure there was much more that could be done.

Gill Ponder queried where contract management would fit in and Edd James stated that it was not done in procurement but left to the individual business.

Fiona Osborne queried policies and procedures (slide 5) and the concerns on compliance following review of the SFIs of the three Trusts and asked if a temporary or permanent resource was required to address the issues raised. Edd James explained that in the business case there was an option for a temporary resource. He added that he links in with Lee Bond and Andy Bertram through a Procurement Board.

Gill Ponder stated the Committee would be keen to hear initial thoughts and findings and noted that Edd James was due back to the committee in November to provide an update on how things were progressing.

Following the discussion Edd James was thanked for attending and he left the meeting.

Item 9 05/22 **Estates & Facilities**

9.1 BAF Risk Review – BLM and Premises Assurance Model (PAM)

Vince Tennison joined the meeting to present the report and highlighted areas to note including the BLM programme (page 5) which was a smaller programme in 2022/23.

Gill Ponder asked if plans for 2022/23 would encompass the requirements from the water infringement notices. Jug Johal advised that the Critical Infrastructure Risk funding would be utilised to discharge the water improvement notices. A costed action plan was in place and triangulated with the six-facet survey.

Vince Tennison referred to the end of year dashboard (Table 3) which showed a consistent picture over the previous four years in stability and established knowledge which was evident through auditing, and areas of good practice. A key challenge was with Estates as it had been identified that they did not have sufficient resource.

The key areas for improvements were highlighted including Water for both staffing and maintenance; Ventilation in relation to DPOW theatre emergency/business resilience as the majority had passed their life span; and the Estates maintenance of equipment and physical infrastructure which required moderate improvement.

Vince Tennison referred to the recommendations, approved by the Estates Governance Group and the progress being made.

There were no further questions from the Committee as it was a very comprehensive report with a helpful dashboard and costed action plans included. Gill Ponder thanked Vince Tennison for attending and he left the meeting.

Item 11 05/22 **F&P Committee Governance Documents**

10.1 Board Assurance Framework (BAF) – Q4

Gill Ponder asked if there was anything not already discussed in the meeting. Fiona Osborne queried if more was required on strategic threats noting the estates and engineering equipment specifically in relation to inflation and capital spend to meet the strategic objective. Inflation was still increasing and suggested it should be documented. Peter Reading agreed as it was not just about cost but also supply.

Action: Jug Johal

11.2 Review of F&P Committee Terms of Reference

Gill Ponder noted that the focus in the TOR was more on Finance and Estates and suggested adding more on performance as a list of items noting it would not be an exhaustive list. Gill Ponder agreed to add to the TOR and circulate to agree off-line before taking to Trust Board for final ratification.

Peter Reading had reviewed the TOR and had proposed a £25m cap under Capital and Other Investment Programmes and Decisions (5.3.2). Following a discussion between Peter Reading and Lee Bond it was agreed to reduce to £15m which would be changed.

Action: Gill Ponder

Peter Reading referred to the F&P workplan and stated he was surprised that Business Continuity was discussed at the Committee as he thought EPPR should go to ARG Committee as it was a risk issue. Gill Ponder stated that it had been discussed previously and it was on the F&P workplan as it was part of Shaun Stacey's portfolio but was happy to remove it from the workplan and the TOR if that was agreed to be the right way forward as part of a possible wider review of Committee responsibilities. The current workload of ARG was also noted and there was nothing in national guidelines as to where it should feature other than Trust Board have sight of it.

Action: Gill Ponder

10.3 Annual Effectiveness Review of the Committee Results

Gill Ponder noted that an action plan was required from the results of the review of the Committee and proposed having a sub-set of NEDs to look at an action plan as a starter for ten and then ask Executives for their comments. It was agreed that Richard Peasgood could support.

Action: Gill Ponder / Richard Peasgood

Item 11 05/22 **Items for Information**

11.1 Performance Letters to Divisions following PRIMs meetings

The letters from April 2022 had been provided for information and were noted.

11.2 Linen & Laundry Briefing

Peter Reading advised that this had been discussed at TMB and suggested it should be sighted by the Committee as it was a concern. The proposal to explore other options was supported.

Fiona Osborne queried the SLA with Synergy and asked if there were any financial penalties or just an escalation route. Lee Bond was not sure of the financial ramifications and agreed to check.

Action: Lee Bond

Item 12 05/22 **Any Other Urgent Business**

There were no matters raised

Item 14 05/22 **Matters to highlight to other Trust Board Sub-Committees**

- Ongoing issue with workforce concerns noted

Item 15 05/22 **Matters for Escalation to the Trust Board**

The following items were noted:

- Performance of both finances and constitutional standards
- Key points from Estates.

Richard Peasgood to pull together the highlight report for the Trust Board and circulate to members of the Committee for agreement.

Action: Richard Peasgood

Item 16 05/22 **Review of Meeting**

Gill Ponder stated that the deep dives into the BAF did not feel right and maybe needed to reflect further on how this could be achieved as it felt hard work today. She requested any suggestions off-line on how this could be done differently.

Shaun Stacey commented that the changes to the BAF were incredibly small each month. Gill Ponder stated that the detailed conversation around ED was of more benefit and a good debate. She highlighted the original reason for adding the deep dives each month was because it had been proposed to discuss the full BAF each quarter, but this did not give enough time for each risk aligned to the Committee.

Lee Bond noted that the strategic risks did not change, and each risk was updated every month and that discussions within planned/unplanned care and finance included risks.

Gill Ponder asked for the Committee to think about how this could be done differently.

Item 17 05/22 **Date and Time of next meeting**

The next meeting was due to take place on 22 June 2022 – 1.30pm-4.30pm via Teams

Attendance Record 2022/23

Name	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Gill Ponder	✓	✓										
Linda Jackson	-	-										
Fiona Osborne	✓	✓										
Michael Whitworth	-	-										
Maneesh Singh	✓	✓										
Lee Bond	Apols	✓										
Peter Reading	-	✓										
Shaun Stacey	✓	✓										
Jug Johal	✓	✓										
Helen Harris	Apols	Apols										
Brian Shipley	✓	✓										
Simon Tighe	-	-										
Ab Abdi	-	-										
Richard Peasgood	✓	✓										
Ian Reekie	✓	✓										
TOTAL ATTENDEES	**8**	**10**										

NLG(22)141

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	2 August 2022	
Director Lead	Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse Mike Proctor, Non-Executive Director	
Contact Officer/Author	Mike Proctor, Chair of Quality & Safety Committee	
Title of the Report	Quality and Safety Committee (QSC) minutes from May and June 2022 meetings	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meeting for May and June.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 24th May 2022 from 1.30pm to 4pm
Via MS Teams

Present:

Mike Proctor	Non-Executive Director**(Chair of the meeting)**
Maneesh Singh	Associate Non-Executive Director
Fiona Osborne	Associate Non-Executive Director

In attendance:

Dr Kate Wood	Medical Director
Dr Peter Reading	Chief Executive Officer
Abdi Abolfazi	Deputy Chief Operating Officer
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Hannah Burn	CQC observer
Jan Haxby	Director of Nursing, NE Lincs CCG
Mr Kishore Sasapu (item 112&113/22)	Deputy Medical Director
Sarah-Jayne Thompson (item 113/22)	General Manager
Alison Hurley (item 126/22)	Deputy Director of Governance
Jennifer Moverley (item 119/22)	Head of Compliance
Antony Rosevear (item 118/22)	Associate Director for Community
Rachel Greenbeck (item 118/22)	Head of Nursing for Community
Laura Coo	PA to the Medical Director **(for the minutes)**

111/22 Welcome and Apologies for Absence

Apologies for absence were received from: Sean Lyons, *Shaun Stacey (Abdi Abolfazi to represent),*

Matters Arising

112/22 Clinical Harm & Risk Stratification (minute 090/22 refers)

Kishore Sasapu referred to the presentation distributed which was taken as read and highlighted the key points.

Due to the pandemic the waiting lists increased, therefore creating a risk of harm to those waiting. Work was undertaken to understand how to risk stratify those people and provide treatment to those who needed it most urgently. Previous papers had been presented to this Committee to show the risk stratification process and it was now more or less at a monitoring level which was why it was felt it would be better to show how we avoid harm and to look at whether there were enough pathways and processes in place to be able to categorise the risks and consider how those in the lower risk category were affected by waiting a longer length of time. Currently if anybody is identified as coming to harm at their clinic appointment, the clinician responsible for that patient raises it through the incident reporting system, and to date Kishore was reassured that we had not come across anybody who had come to serious harm.

Kishore could not say 100% that all clinicians were reporting incidents but he did reiterate the message through the various clinical groups he was working with to identify a process, including the possibility of inviting patients to contact the Trust if symptoms were worsening.

Kishore invited any comments or questions.

Kate Wood thanked Kishore for the update and reiterated that this was business as usual and although challenging and difficult it was about good patient care and noted the Trust had just had significant assurance from internal audit which was great. Kate went on to clarify that when Kishore was discussing assurance, he was looking into the possibility of digging deeper to provide more assurance and how we could monitor the risk within the 'low risk' category of patients which is a huge step from where we were two years ago. Kate wanted to thank Kishore, Jackie France and the operational teams to get us to this point but thought the assurance Kishore had provided today was helpful.

Fiona Osborne commented that at the last meeting the Committee were really supportive of the Risk Stratification process but Fiona thought it had been suggested for this Committee to have some examples from patients and it would be useful if we could look at their targeted experiences too.

Maneesh Singh asked about the clarity of the process for referral to treatment referencing one of the themes that would be picked up later in the meeting in the CLIP report was the delay to treat and Maneesh asked if that would be picked up in this process.

Kishore explained that the process of risk stratification was undertaken by clinicians and prioritised The data for clinical harm was captured by ensuring that if anybody had come to harm it was brought up through the incident reporting system and the good news was that we were not seeing any serious harm incidents. Whether there was something more that could be targeted was a bigger piece of work, looking at gall bladder for example, unless there was a proper audit of the whole group it would not work. Fiona Osborne commented that what the Committee needed was to see examples where they were already taking key learning forward not an extra piece of work.

Jan Haxby had noticed a huge journey the Trusts had been on and agreed with Kate that a few years ago it was a very different conversation. If any external

CCGs, etc were seeing anything in the process that was being missed they would flag it and they were not seeing anything. HUTH were under significant pressure with this at the moment and CCG had suggested for them to contact NLaG to learn lessons from us as thought it would be helpful for them to see the wider picture of the journey to get to this process.

Mike Proctor thanked Kishore for the update and echoed what Kate had said that we are in a different position to when this originally started being discussed at this Committee in September 2020. Ultimately the Committee was keen to learn about the patient's journey but questions would be asked as we go along to give us greater level of assurance.

113/22 Colorectal Cancer Update

Mike Proctor explained that the cancer deep dives were a new approach for this Committee and hoped they would enable the Committee to understand the issues and be assured.

Kishore Sasapu and Sarah-Jayne Thompson referred to the paper distributed which was taken as read. Cancer treatment covered a huge stream of patients but the administration streams were those being referred through the 2ww and Primary Care pathway if it was thought they needed to be fast tracked and on top of those there was a route for that. The question was how to move to a point where those processes were faster. They were hoping once they get to the to the 62 day target to then get to the 28 target and to achieve that by tightening up the pathway to see the nurse and then the rest of the pathway.

There were six patients waiting over 104 days, one was a complex pathway but the oncology process delayed it as well as the patient not coming in for investigations. Another was a very rare complex melanoma and the patient did not want immediate treatment therefore there was a delay.

Another patient had a Colonoscopy under Anaesthetic but it had not been conclusive. The patient then had Covid and had to wait seven weeks before a repeat which had caused a delay.

Kishore went on to say that where a Colonoscopy was unsuccessful, the system needed to be improved but the decision making from a senior clinician was something that would make a difference.

Fiona Osborne queried the problem outlined in the first paragraph in the paper "referrers in this locality tend to refer more patients with suspicion of cancer which are not diagnosed as cancer" as looking through the report, Fiona could not find where solutions were proposed. Kishore replied that when it came to Primary Care there was a constant engagement but there were inconsistencies in the use of the FIT test in primary care prior to referral to screen those who needed an invasive test. This led to larger numbers being referred to Endoscopy than was clinically necessary.

Maneesh Singh asked how the Trust compared to the national standard in outcomes. Kishore responded that when it came to Colorectal outcomes the Trust was well within the range and NLaG was one of the best in the country but there

was a problem with permanent stomas, where the Trust was an outlier, therefore we had asked for an external audit to investigate that. Kate Wood clarified that the cancer outcomes were tracked and Colorectal was not an issue but that took us to the quality of life aspect and NLaG were an outlier for reversing stomas.

Kate suggested that where the report mentioned that incidents would be escalated through the governance process that it would be better to have some numbers /examples as it would help to see the detail.

Maneesh commented that it was good to see the transparency and collaborative working.

Mike Proctor did not understand the figures and asked how many surgeons we had for cancer work and did they have enough cancer work to keep up their skills.

Kishore responded that there were approximately. 250 cancer operations in colorectal every year with three Colorectal surgeons on each site. The requirement to keep up to date was for each surgeon to do 20 surgeries every year so the Trust was well above that.

Mike thanked Kishore and Sarah for the update and thought the paper was good but could perhaps focus on outcomes in future papers too.

Kishore and Sarah-Jayne left the meeting at 2.08pm

115/22 Declaration of Interests

The Quality and Safety Committee was quorate and there were no declarations of interest.

116/22 To Approve the Minutes of the Previous Meeting held on 26 April 2022

The presentation of the ergonomist report had been delayed to June.

Page 6, second to last paragraph to replace '*those themes were so high*' with '*the ward continued to appear in the top 10 sickness levels*'

Page 7, second to last paragraph should say '*physical changes with key learnings and processes'*

Page 8, third line typo should say '*external stakeholders'*

Page 9, last paragraph, first sentence, to be changed to '*Fiona was not aware that the lowlights were limited specifically to three and agreed that this should be flexed if appropriate for the circumstances.'*

Page 10, to say '*Angie Legge confirmed there was a poor outcome*

Taking into account the above amendments the minutes were otherwise agreed as a true and accurate reflection of the previous meeting.

117/22 Review of action log

The report from the ergonomist had been deferred to the June meeting and all other actions were up to date.

Regular Reports

118/22 Community Update (including EoL)

Antony Rosevear and Rachel Greenbeck joined the meeting at 2.10pm

Ant referred to the update distributed which was taken as read and highlighted the key points. The paper gave information on the five key focuses in Community Services. The context around this was following the community services block contract review the Division were very appreciative of the extra funding as it would allow them to go on and do some of the work described in the paper.

Fiona Osborne asked about the last days of lives document, the report said it was underutilised and asked if re-writing it would help. Rachel added that this was being reviewed and rolled out with training and support but they were linking in with Chief Nurse colleagues to ensure there was no duplication with other documents.

Kate Wood noted that the Respect training information seemed to imply that there needed to be a bit of a push in the Divisions to make sure colleagues knew about the documentation and asked what progress had been made with those conversations and if any support was needed. Rachel noted that this was being picked up at the EoL Group which Divisions attended but the additional medical support offered by Kate would be greatly appreciated.

Kate felt there needed to be more explanation about pain control and the assurance mechanisms in place for patients on EoL. Rachel and Ant were not sighted on it but Kate thought there needed to be assurance from somebody other than Kate, it needed the additional piece of work to close the loop for the documentation which was why they asked for the QI support. There was some good assurance in place right now and Kate urged strongly for a report to brought back to this Committee.

Action: Report on pain control in End of Life to be brought to Quality & Safety Committee.

Ant advised that OPAT was working which was great news and it continued to be live capacity wise. They had three to four virtual beds but the pathway was implemented with minimal funding and within the plans that had gone forward OPAT was on the priority list with Homecare. One of the methods of delivery was looking at home care providers, the Podiatry team were looking at pathways to increase opportunities to OPAT. Jan Haxby had emailed Ant to discuss further as this was originally set up as a pilot if it continued the healthcare economy needed to look at how to sustain this in the longer term.

Ellie Monkhouse backed up what Kate had said about the pain management work, there were a lot of mechanisms embedded in the stop and check processes i.e. 1pm staff huddle checking pain relief medication and it was included in the 15 steps process. The issue was there were various pain assessment charts and they amalgamated various tools. It would be across the organisation similar to medicines management and they had already identified some wards. Ellie was worried about the Spirituality Task and Finish Group as the Chaplain, Harry sat within the Chief

Nurse Directorate. Ellie asked if Harry was linked into this and where it fitted into the governance processes.

Action: Rachel Greenbeck and Ellie Monkhouse to discuss outside of this meeting.

Mike Proctor knew that out of hospital care was important and a massive issue particularly given the number of escalation beds in secondary care and that went beyond community care it was also multi-agency and wondered if the board needed to understand that process.

Mike thanked Rachel and Ant for attending the meeting and for providing the update.

119/22 CQC Improvement plan

Jennifer Moverley referred to the report distributed which was taken as read and gave a summary of the actions:
Two actions had moved from green to blue, including the provision of the mental health room. Three actions had moved from amber to green.

82% of the actions were either green or blue, there were no red actions for this committee and five amber actions. The staffing action had moved from red to amber and would continue to be monitored.

In terms of EoL clinical care and treatment – there had been some delays with the delivery of the Respect project and the roll out. The Bluebell principles were now on 13 wards.

Two actions for Medicine and ED were related to oxygen prescription – the division were working through a QI approach to address this.
In respect of RCNs in ED – standards were not feasible for a multi-site district general like NLAG, but there was robust mitigation in place to maintain safety.

Fiona Osborne asked about No. 11, ED and No.16 for Medicine both about the oxygen prescriptions, Fiona appreciated that Medicine was under increased pressure but this was flagged as having limited assurance in the CLIP report (to be discussed later). There was a bit more detail in the report than the actions taken within the Divisions. Jennifer assured Fiona that they did have plans in place to meet with them and plans were in place to hopefully move to forward.

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Kate Wood added that one of the important things to do was to identify a problem and follow it through. It was a fair challenge from Fiona and they had tried a number of different interventions but now had to move on to look at what next and needed to let the teamwork it through.

Ellie commented that this was also discussed at PRIMS hence where the QI intervention came from, it was still quite a new concept for the oxygen prescriptions and they were trying to make things as easy as possible and would hopefully move forward with QI intervention.

Jennifer Moverley left the meeting at 2.38pm

120/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and highlighted the key points.

There was good news in relation to IPC where they had seen a 29% reduction in C-diff and should celebrate that.

They were seeing some impact around the escalation beds put in place for operational pressures. The team were exploring the turnover rate for our non-qualified staff. There was some work around pressure ulcers in terms of them doing the same in community and looking at whether deferred visits had increased the amount of time taken to identify pressure ulcers. Ellie would bring that information back within this report next month.

PRIMS picked up on the vulnerabilities work round the amount of time it had taken for PEG tubes and it was being addressed by the DMDs and Ellie would provide assurance via her report at the next meeting.

Fiona Osborne asked if there was any early indication as to what was happening at the SGH site with the non-qualified vacancy rates. Ellie thought it was more about people not wanting to work in health care now but that was just speculation and she did not know the reasons for sure.

Mike Proctor knew there had to be a balance with the shifts that were good shifts and those that were difficult and Mike was concerned about where that balance was and asked if there was any hope that was going to get any better. Ellie wished she could answer that and was absolutely determined not to normalise this but wanted to keep the report transparent. Ellie continued to highlight where she had concerns and what was been done together to try to tackle those concerns, the level of detail Ellie had included in the report should provide some assurance. Ellie was spending a lot of the time in the detail and in fundamentals. Mike thought the fact that it was not getting any better was the issue. It was worth noting that despite all of this we were not doing bad we could provide a lot of assurance, were responsive, the level of detail that we had and there were quite robust processes in place. They used Opel levels for staffing daily for example and the QI work was helping as was creating a better mindset with the staff.

121/22 IPR

Kate Wood referred to the IPR report distributed which was taken as read.

Kate now had confidence in the VTE data and was conscious that work was now required to evidence that improvement. Kate drew members attention to the comment about out of hospital SHMI as of June 2021 as there was a bit of a dip in our depth of coding. Our coding team had now merged with another organisation did not have such a good record for mortality and Kate was a little nervous this could impact on our coding. Kate needed to work this through with Shauna McMahon. Kate did not know whether this was cause for concern but wanted to make members aware of the situation.

122/22 Annual Clinical Audit Programme

Angie Legge referred to the report distributed which was taken as read. The programme was developed every year and there was a prioritisation in place, the team used this to ensure the most essential projects were undertaken, although they did try to complete everything. Angie asked for approval of the programme but requested for the Committee to support that some of the documentation audits may be postponed due to the impact from CQUINS. There were also some conversations with the Informatics team which would have an impact for the first quarter.

Kate Wood added that we were very fortune to obtain funding for two colleagues to support CQUINS. Kate would be nervous about not doing the documentation audits and would prefer to shift them for when there was capacity as documentation needed to have a continual process and suggested maybe the Divisions could do it themselves. Angie agreed it would help with the ownership of that documentation and was a conversation Angie was having with the team and was the way forward.

Fiona Osborne commented that what did not come out of the paper was what the risks would be in choosing not to do those audits but Kate had answered that this was in the prioritisation, which categorised the risk. Fiona was comfortable with that.

The Committee approved the Annual Audit Programme

123/22 Key SI Update including Maternity

Angie Legge referred to the document distributed which was taken as read. There had been no further maternity or key serious incidents declared in the month. None had been closed this month but the Never Event reports were nearly there. Angie had asked for a bit more depth in the analysis before they were concluded so these would likely appear as completed in the next report. For additional assurance Kate Wood added that Angie vetted every serious incident (SI) reported followed by Kishore Sasapu on Kate's behalf.

124/22 CLIP report & Annual SI Report

Angie Legge referred to the report distributed which was taken as read. The CLIP report pulled together several key themes and from listening to the discussions at today's meeting Angie was delighted that members had clearly read the report. The team always tried to get feedback in terms of the key themes and to feed that into the report. They were also hoping to get something on the hub to widen the accessibility of learning, appreciating that different people learn through different ways so was going to get the training in the hub too.

Fiona Osborne thought the report was incredibly clear and thorough but there were several items marked as limited assurance and asked if they dealt with through the PRIMS process or was it a different route.

Kate Wood explained there was not an escalation out of the CLIP report it was the other way around, this report was the culmination of the Governance Team providing the whole picture for us but agreed it needed something added to the report to say where it was being managed and dealt with. In terms of limited assurance Angie Legge would work with the teams to provide that detail.

Maneesh Singh asked if NLaG was an outlier for litigation and what support was there for staff who undergo complaints. Angie responded that the Trust was not an outlier for litigation, and support was provided for staff involved in inquests or litigation.

Mike Proctor noticed there was a large increase in PALs but thought that was most likely going back to pre-covid levels probably because relatives were more involved in care again.

125/22 Potential Deviations from National Documentation

None

126/22 Board Assurance Framework (BAF)

Alison Hurley referred to the BAF report distributed which was taken as read. From Kate Wood's perspective one of the challenges that they always faced was that the risk rating sat at fifteen but our target was ten, perhaps we had to accept that what we aspired to was not what we achieved in this year. Angie Legge explained that fifteen was a marker as to the position we find ourselves in it was not just about workforce but the challenges coming through our door, ambulance waiting times, recovery, mutual aid, etc and although what we had heard today was that we have challenges we were sighted on our challenges and were looking ahead i.e. through vulnerabilities walk rounds the nutrition was picked up. Kate mentioned coding what they were trying to articulate was that we were challenging on the risks as they were coming through. Kate was not pushing for us to change the risk rating right now but was looking at it through a different view to Ellie Monkhouse.
Ellie agreed with Kate and found it quite hard to score what we were facing in the last two years as it was shifting all the time and difficult to reflect or represent the situation within a score. All we could do is show what process and mitigations were in place. Mike Proctor would articulate the fact that there were concerns within his highlight report to the Board.

Alison would be working to update the quarter one and there would be the opportunity for the Directors to comment/ contribute to the BAF.

Alison Hurley left the meeting at 3.17pm

Highlight reports

127/22 Quality Governance Group (QGG) & ToR

Angie Legge referred to the highlight report and Terms of Reference distributed which were taken as read.

The Terms of reference were ratified.

Fiona noted that unacknowledged results were discussed at the digital strategy board yesterday specifically to do with the backlog and she was concerned the digital strategy board was not the correct place for discussion and was assured it had gone through the QGG and this board but could not see any reference to the backlog.

Angie responded that it was discussed at the QGG but they were seeking further information and one of the things they were looking at was the level of harm. The work was ongoing and would be referenced in the next highlight report. (section 4.3 on the QGG minutes referred)

With regards to the electronic results Kate Wood explained that originally through a number of SI's it was determined that there needed to be an electronic way for all tests to be acknowledge/determined through WebV. This was discussed at a number of forums and the roll out was done however it was not always that straight forward. For example, when Kate looked at blood results she could not acknowledge them on that screen and would not have time to then go into another screen to acknowledge them so the results were being accessed but the system was not registering that. This issue had been raised by several clinicians.

For abnormal blood results the labs still phoned the wards and there was a sense check so concerns would be immediately escalated so a robust system was in place. For X-ray reports, red flags were escalated directly to the Clinician and for Endoscopy the results were flagged straight through to Clinicians.

Kate was worried that a system had been implemented that did not do what we wanted and if we needed to work through the backlog, that would be an academic process. Fiona Osborne thanked Kate for that assurance.

Mike Proctor asked that the highlight reports were written with the reader in mind as not all made sense.

The Committee approved the Quality Governance Group (QGG) Terms of Reference.

128/22 Mortality Improvement Group (MIG)

Read to note

129/22 Patient Safety Champions

Read to note

Items for information

130/22 Quality Governance Group (QGG) minutes

131/22 Mortality Improvement Group (MIG) minutes

132/22 Patient Safety Champions minutes

133/22 Any Other Business

Nothing raised

134/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

- To be agreed outside of the meeting

135/22 Meeting review

Not discussed

136/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 21 June 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 3.27pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022
Michael Proctor		✓	✓	✓		✓	✓	✓				
Michael Whitworth	✓	✓										
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓				
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓				
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓				
Ellie Monkhouse	✓	✓			✓	✓	✓	✓				
Dr Peter Reading	✓	✓	✓	✓	✓	✓		✓				
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓				
Helen Harris		✓										
Jan Haxby	✓				✓	✓	✓	✓				
Shaun Stacey			✓				✓					

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 21 June 2022 from 1.30pm to 4pm
Via MS Teams

Present:	
Mike Proctor	Non-Executive Director**(Chair of the meeting)**
Maneesh Singh	Associate Non-Executive Director
Fiona Osborne	Associate Non-Executive Director
In attendance:	
Dr Kate Wood	Medical Director
Dr Peter Reading	Chief Executive
Abdi Abolfazi	Deputy Chief Operating Officer
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Donna Smith	Associate Chief Nurse, Community & Therapies
Dr Joseph Maung	ENT Clinical Lead
Kirsty Harris	Assistant General Manager, Surgery & Critical Care
Sara Wood	Lead Nurse for Patient safety
Mel Sharp	Deputy Chief Nurse
Jane Warner	Associate Chief Nurse, Midwifery
Laura Coo	PA to the Medical Director **(for the minutes)**

137/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Jan Haxby*, *Shaun Stacey (Abdi Abolfazi to represent), Jennifer Moverley,*

138/22 Opening remarks

Mike Proctor advised there had been some late changes to the agenda, item 5.2 , Pain relief in end of life and 7.2 the Medicine Divisional update would be deferred, item 7.4 the National In-patient survey had not been considered elsewhere at other managerial gatherings so would be brought back to this Committee at a later date. Item 7.8 the DoLS and Safeguarding report was not submitted in time due to work pressures so had been deferred to the July meeting

139/22 Declaration of Interests

The Quality and Safety Committee was quorate and there were no declarations of interest related to any agenda item.

140/22 To Approve the Minutes of the Previous Meeting held on 24 May 2022

The minutes were approved as an accurate reflection of the previous meeting however Ellie Monkhouse noted that the attendance table was not correct as Ellie had only missed the December meeting.

Action: Laura Coo to update the attendance table

Matters Arising

141/22 Ergonomist report

Angie Legge referred to the ergonomist report distributed which was taken as read. Angie explained that an ergonomist looked at how people worked with reference to human behaviours. They were asked to look at the accountable items process in Theatres (for counting instruments, swabs and other items in and out during surgery). The report contained a number of recommendations and Angie would like to gain pace with the changes that needed to be made.

Angie invited any comments or questions.

Fiona Osborne felt that the report contradicted itself in some areas where it talked about processes and behaviours and noted there was only one action they said could happen relating to training and Fiona thought the action plan should be bigger and include compulsory actions with clear elements required, rather than training in relation to changing those behaviours.

In terms of behaviours Angie recognised why the ergonomist said we were safe as there were not many errors and it was a safe process but took on board Fiona's comments. Angie would discuss with Paul Bunyan to make sure it was in line with the cultural work he was leading. Fiona commented that it would also be useful to have a list of bullet points for understanding what the training would involve.

Kate Wood interjected that the report was commissioned on the back of the Never events in Theatres and it only came here for information as people wanted to have sight of it however it was going through QGG and the Division and that level of detail would be covered by them and Kate would ensure this Committee was updated when necessary.

Kate also commented that all the recommendations from an external group who had observed approx. ten lists seemed to have been accepted and asked if a working group had been set up to go through the recommendations. Angie noted that the responses to the recommendations were collated and feedback to the report authors . The recommendations were based on interviews with staff as well as observations but there was not an official working group set up although Angie agreed it was a good idea.

Maneesh Singh commented that the report talked about an NLaG policy but all hospitals seemed to have their own policies and asked if there was any way that could be standardised. Angie noted that all Trusts had policies based on national guidance, and the key was to standardise across the hospitals within NLAG.

Kate thanked Angie for negotiating with NHSE/I to get this external review/report as there were a number of SI reports where this could help to drive things forward.

It was agreed that progress should be reported to the QSC via the QGG and to QSC by exception.

142/22 Pain Relief in End of Life

Item deferred

143/22 Review of action log

086/22 of 26 April 2022, Ergonomist report - the committee discussed today under matters arising. Action closed

All actions were up to date.

Regular Reports

144/22 Head & Neck Cancer Update

Mike Proctor welcomed Joe Maung, ENT Clinical Lead and explained that this committee wanted an update looking at the patient experience point of view rather than just looking at performance metric which would hopefully make it easier for Joe focus his update going forward.
Jo referred to the report distributed which was taken as read.

Jo outlined that any patient seen in Primary Care who had suspected cancer would be referred to 2ww and triaged straight away. Normally all patients were seen within 2wks to keep in line with the 31/62 day target. Within 62 days of the GP referral they had to have start the referral for treatment, the earlier the patients were seen the quicker the treatment could be started. The current range was approx. ten days which meant there was less time to see the patient to plan the scans, biopsies etc so they were requesting all of the investigations at once which had speeded up the process and cleared those who were not. Things were slowly improving but the bottom line outcome was the one that reduced the anxiety for the patient so they could then focus on the diagnosis element. The experience was a lot better and Joe was very pleased to inform the Committee that our performance numbers were improving compared to this time last year. 97% of patients were seen within 14 days of the GP referrals. Unfortunately, our figures could not be matched or compared with national figures as national figures were intertwined with other cancers.

Mike asked about the outcome measures related to this and how successful surgeries were compared to other areas, Mike imagined it was a very small group and asked where Joe got his support from. Joe worked in collaboration with Hull and had a lot of support, at DPoW only deal with diagnostic Head and Neck but there was a lot of support from Hull. The Head and Neck lead from Hull had been to NLaG to help and did clinics at Goole and another clinician from Hull also came to NLaG to help.

Mike asked if NLaG patients had a good outcome when compared to Leeds etc. but Joe could not answer that as the paper did not contain the national outcome measure however our patients were monitored for five years and so far there were no serious incidents, major complaints or delays of treatment arising from the Head and Neck cancer side which was reassuring. There had been a few complaints about delay in treatment from the Hull side.

Maneesh Singh asked about monitoring of harm, given that the Trust currently only 20% of patients seen by day 62 and wondered how they were classed as no harm and how that was defined.

In response Joe explained his interpretation of that was that the delay could lead to a further delay in treatment of cancer i.e. delay in small procedures that could then progress to something bigger. In NLaG there was no significant difference, there were a few mortalities but they were because of the size of the tumours when the patient arrived.

Following on from what Maneesh had said, Fiona Osborne referred to a statement on page two talking about patients given a cancer diagnosis being 13% below the standard but that sounded more than slightly below the target. Joe thought it was difficult to measure but the delay depended on whoever managed the patient to start with. This was the area Joe was working on and had to consider the mindset and anxiety of the patient and involved multiple steps.

Fiona asked about Joe's statement about this being a learning process noting Mike had asked for the patient experience element of this pathway beyond waiting times. Fiona was interested in what the changes meant i.e. streamlining the pathways with HUTH what did that mean but acknowledged it was work in process.

Kirsty Harris informed the committee that a cancer improvement plan was being worked on and they would have a solid plan on paper shortly which linked into what Joe had said about requesting all the investigations at once as it speeded up the process. They were working closely with HUTH and would share the action plan with this Committee once it had been developed.

Mike appreciated the open and honest update from Joe and Kirsty and the questions had helped to tease out what this Committee wanted to focus and to gain assurance on.

Kate Wood reminded members that ENT was part of the Humber Acute Services work and this was a good example of a collaboration process.

Mike thanked Kirsty and Joe for attending and providing the update.

Joe Maung and Kirsty Harris left the meeting at 2.09pm

145/22 Medicine Divisional Update

Item deferred

146/22 Family Services and CNST update

Jane Warner and Preeti Gandhi joined the meeting at 2.05pm

Jane advised that there had been a new SI following a baby born by forcep delivery who was found to have a fractured skull and unfortunately this was the third baby to have a fractured skull in the last six months. There was a very robust process in place and it was being reviewed externally but there had not been any trends or themes identified. They had reached out to NHSE/I for support in this matter and Jane noted that the Trust no longer used Kielland's forceps for forcep deliveries.

Jane referred to the report distributed which was taken as read and highlighted the key points.

Jane Warner referred to the Family Services update distributed which was taken as read. The report was included a Paediatric and Neonates update and Debbie Bray would be attending the July meeting to provide a Paediatric update.

Page two showed the 15 steps visits which highlighted the wards which had been identified as outstanding. Fiona Osborne was involved in the Antenatal Clinic visit and commented that the Antenatal Ward Manager was outstanding and the way she had turned the ward communication around in the area was phenomenal. Overall, this was a well embedded process which they would continue with.

Page four mentioned electronic prescribing (EPMA) and Jane reminded members that the decision was made with agreement from Pharmacy to suspend EPMA in Maternity for a period of time due to Maternity patients being classed as both inpatients and outpatients. The department would be following A&Es lead setting up a virtual ward on the system.

There had been a lot of scrutiny from Health Education England in relation to antenatal and new-born screening but there were only a couple of actions outstanding.

Midwifery staffing continued to be a concern, but vacancies were reviewed regularly and international recruitment was in progress for four new Midwives who would hopefully be starting later this year. Establishment reviews had been undertaken by Ellie Monkhouse in each of the areas.

Baby tagging had been a challenge but was now established on both sites. There was a mixture of management of baby tagging amongst staff plus there had been some system issues which they were working through. The team recently conducted an abduction simulation which went well and was a good learning experience for the staff.

The new CNST date was 5th January. There were some concerns around safety action 3 – term admissions to the neonatal unit, but the detail was in the action plan embedded in the document distributed

Saving babies lives – the concern was around the electronic system and having to manually pull data from the system.

Safety action 8 MDT action training including PROMPT had been unpicked and Jane was hoping they would become compliant with that.

Ockenden – there were 19 actions outstanding from the initial report and they were around evidence gathering and it was specifically highlighted that our website needed to be improved and they were working hard with that.

In terms of Breast services, page nine and ten highlighted the collaborative working with HUTH and that was going forward.

Jane added that the report was not more detailed than usual to cover all the areas within Family Services and included some performance data.

Ellie Monkhouse thanked Jane for her comprehensive report but wanted to understand the process for this report better. There were some requirements for CNST and the Committee needed an overview of Family Services as was the case for every Division and there was the Paediatric element too and Ellie was concerned everything was not being covered and did not think this way of reporting worked well.

In terms of the Divisional report Mike Proctor agreed it was then same as the other Division , but with regards to Ockenden and CNST Mike would be led by Jane and Ellie however the Divisional aspect needed to be covered the same as with the other Divisions but with the support of somebody from Paediatrics to give the update. Ellie agreed with that approach and felt some of the detail had been missed reporting this way, the main concern was the CNST element and that the Committee was not seeing the detail.

Maneesh Singh asked with regards to for perinatal mortality in the summary it said there were six and asked what they were as we had a slightly higher than average still birth rate. Jane would need to have a look at the stats and commented that there was a glaring obvious error in the perinatal mortality rates within the report. There had been an increase in the mortality rates but NLaG were not an outlier but there had been interest in that these were they related to Covid. Preeti Gandhi added that some reviews of still births were carried out and they would be quite happy to bring those findings back here as it would be interesting to see how the Pandemic and Covid had affected things, there were still some studies being conducted.

Fiona Osborne found Jane's verbal update very useful but felt the report was not so easy to follow in terms of practicalities and suggested a simpler format would be better for the Committee to review. Mike agreed the more bespoke the report could be the better and was happy with a briefer more focussed highlight report for future meetings.

Kate Wood added that she had thought today's report should be the Family Services update not CNST, Ockenden etc but appreciated the Committee needed to know about them too. The regular Family Services update needed to come to this Committee in the same frequency as the other Divisions and CNST and Ockenden every other month. Mike suggested having an addition to the workplan for CNST and Ockenden to say as required.

It was agreed that the revisions to the workplan would be made and brought to the next meeting

Mike thanked Jane and Preeti for joining the meeting today.

Jane and Preeti left the meeting at 2.37pm

147/22 Patient Experience

Mel Sharp referred to the patient experience quarterly report distributed which was taken as read and highlighted the key points. The patient priorities for 2021/22 had been included in the report.

- The Friends and Family test remained a challenge and members of the team had done a full site walk round to try to understand the issues.
- Complaints had a learning workshop planned to look at the learning lessons and what we get out of those but it was fair to say our complaints were all extremely complex
- There were some themes coming out of the "I want great care", families said they were not updated, there were bed moves at night and treatment plans were not always as the patients expected.
- Patient Experience continued to have a focus on the A&E departments but the Family Liaison Roles would stop at the end of June.
- The team had continued with the patient helpline and the calls had significantly reduced since the visiting times had changed.

The complete Picker report would be shared at the next QSC. They picked up one flag which was that the family situation was not considered at discharge but Mel noted that NLaG's internal process was ranked at first in the country whereas we were ranked at 65 last year. Some positives were the food was good, and patients felt they were receiving enough food and drink, staff helped with pain control and the patients knew what happened next and felt very comfortable to give their views and opinions.

Ellie Monkhouse added that in 2019 we were an outlier with CQC for the results n our survey but NLaG had shot up approx. 35 places and Ellie was keen to get the messages out to our teams.

148/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read. Ellie had asked Mel Sharp and Sarah Wood to attend to give updates on specific areas as themes had been picked up around nutrition and hydration and ulcers (included as an appendices).

Nutrition and Hydration

Mel Sharp referred to appendix two of the nursing report which was taken as read. Mel chaired the Nutrition group and one of the focusses was around the PEG pathways and to look at the cross site provisions and pathways, and whether we could meet the demands, looking at the whole referral process. Towards the end of April, a complaint was raised about a patient with mental health needs which identified some support issues. Support was required for patients with learning difficulties and they realised that some reviews should be undertaken in key areas. Our vulnerable adults safeguarding team identified a number of patients who needed to be reviewed but noted that no harm had occurred. Themes picked up

were around training on the fundamentals of care, safeguarding awareness, early referrals, having best interest meetings for more focus. They now had a stop and check process on every ward at around 1pm time to review the vulnerable patients and Mel was confident that was working very well. They had also started short snappy training sessions for key areas and there would be a real focus at the next training day about how we support our patients around nutrition.

Peter Reading commented that NLaG's PLACE score for food in 2018 was one of the worst in England and wanted to thank MS for the work she had done to improve that to where we are now.

Sara Wood joined the meeting at 2.45pm

Pressure Ulcers

Sara Wood referred to appendix three of the Nursing report, which was taken as read, noting the information was split into acute and community acquired.

Acute

70 incidents were included for review and one of the key points was that the majority of pressure ulcers were reported in the first three days of admission. One of the key themes picked up was that patients were waiting for a length of time in ECC so the outcome was there needed to be some focus work there and to look at skin damage and focussed support with ECCs for the staff for those patients who were in their care for much longer than they would normally be due to extended waiting periods. The findings would also be shared with the pressure ulcer group.

Community

There were not any themes to note in community, and no higher numbers from any one care home but as a result in the increase in the intermediate care beds they were now in multiple numbers of care homes which had led to the teams being spread more thinly. The only other action to note was that community was going to be undertaking a full review of all the pressure ulcers in the last 12 months.

Fiona asked about the vacancy rates for midwives at DPoW last month as the Committee had talked about the continuity of carer teams to keep the staffing levels safe. Ellie advised that the method at DPoW was different to that at SGH and they would not need to pause Continuity of Carer at the DPoW site.

Fiona noted a contradiction between the shift fill rates and the red flags and asked if it that was a pattern. Ellie advised that one of the priorities was to embed the red flag system more but it could be more down to individual interpretation and it was taking time to embed. They were not taken just as read they were reviewed to make sure there was not a risk.

Mike Proctor thought it was useful to have deep dive into those specific areas and thanked Sara and Mel for the updates.

Sara and Mel left the meeting at 3pm

149/22 IPR

Kate Wood and Ellie Monkhouse referred to the report distributed which was taken as read.

Kate highlighted some of the lowlights structured judgement reviews (SJR) completion and screening for sepsis.

SJR completion was becoming a bit of a struggle mainly due to time constraints and would be highlighted over the next few months. Areas were extremely busy and the organisation had moved from a paper completion of SJRs to electronic SJRs which had been rolled out by the NHSE/I team called 'better tomorrow'. Individuals needed to have training on the new system.

The reason for SJRs was to understand the patients care prior to their death and the reviews were identifying that although not a contributing factor, sepsis was not always identified.

Several structures were in place for mortality, the Trust had a Bereavement Team/Office in place, the Medical Examiner's Office and the SI process.

Mike Proctor found that very helpful as the Committee did not want to be focused just on numbers and thought it was a perfectly legitimate and reasonable approach so would take that on board when watching the figures. Kate would continue to update at this Committee.

For the sepsis screening there were concerns around reporting when a patient had a raised NEWs score, in that people were not escalating this. The QI team were involved and a review was being carried out. NHSE/I were also involved but there were opportunities to tighten the care up for assurance, so long as the teams were able to provide regular updates that they were leading change through QGG and MIG where they would gain that better depth of detail that would then feed into this Committee. Kate apologised that she could not give assurance at this stage.

Ellie Monkhouse updated that on the back of our performance for Infection Control trajectories, the *C.Diff* trajectories for this year was 21 and were already at six but we were in a unique position coming out of a pandemic and wanted all to be on their guard.

There was an increase in the number of complaints and PALs but Ellie did not think that was a reflection on us but was more the situation, had complex cases and was more to do with DTA.

There was a slight dip in performance but this continued prolonged pressure from the pandemic was having quite a significant impact.

Mike wanted to acknowledge the record breaking SHMI.

A final point from Ellie was regarding the mixed sex accommodation (MSA) this was area that when a patient was in Critical Care that they were deemed medically fit to go back to a ward and moved within four hours but EM could not see anything changing in the near future. There was a robust process that went into reviewing those breaches and our Commissioners were informed of those breaches.

150/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read and highlighted the key points.

One incident had been closed. The SI related to the twin pregnancy was discussed, it transpired the guidance used was not in line with the most recent NICE guidance. The division were now using the document control checklist to ensure all reviewed guidance was checked against the latest NICE guidance.
There were delays in some investigations being signed off partly due to the workload as we use clinicians for investigations and the Trust had been under significant operational pressure.

151/22 Potential Deviations from National Documentation

None

152/22 CQC Improvement plan

Angie Legge referred to the report distributed which was taken as read and highlighted the key points.

The final two red actions had been improved from red to amber so there were no reds remaining.

83% of 145 actions were now rated as blue and green and there would be some work on moving those greens to blue to evidence those actions were embedded.

There had been some delays with the delivery and roll out of the Respect training – and Angie wanted to see more assessments on the process.

Kate Wood mentioned the Community and Therapies EoL action and the issues of continued roll out and embedding EPACS. This was not an NLaG specific problem, we had employed one person for Respect training and the fact that they had managed to get the levels of trained to where they are was impressive but there was still a quarter of our staff to be trained. Whilst the online training was very good when it comes to training, Kate noted that Respect was a new approach requiring an adjustment in mindset which is often easier in a classroom environment.

153/22 Review of workplan

Angie Legge referred to the workplan distributed which was taken as read.

Mike Proctor had already acknowledged it needed to be revised, Ellie Monkhouse would forward her suggestions to Angie and Mike to take to the Trust Board in August.

Kate Wood flagged that the register of external visits should be Jennifer Moverley not Hayli Garrod.

Highlight reports

154/22 Quality Governance Group (QGG)

155/22 Mortality Improvement Group (MIG)

156/22 Patient Safety Champions

Items for information

157/22 Quality Governance Group (QGG) minutes

158/22 Mortality Improvement Group (MIG) minutes

159/22 Patient Safety Champions minutes

160/22 Any Other Business

Mike Proctor commented that he expected the next agenda would be very full so asked if we could have Community and EoL added back in. Ellie Monkhouse asked if the report could be specific around EoL rather than the process Ellie had in place.

Mike noted the July meeting would be on a Monday and that the change of date had been advised of a couple of months ago. Some members thought the date of the July meeting could be a problem and would let Laura Coo know so that if necessary this could be looked at again.

161/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

- Maternity SI

162/22 Meeting review

163/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: Monday 25 July 2022
Time: 10.30am – 1pm
Venue: Via MS Teams

The meeting closed at 3.35pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022
Michael Proctor		✓	✓	✓	x	✓	✓	✓	✓			
Michael Whitworth	✓	✓										
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Ellie Monkhouse	✓	✓	x	✓	✓	✓	✓	✓	✓			
Dr Peter Reading	✓	✓	✓	✓	✓	✓	x	✓	✓			
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Helen Harris	x	✓	x	x	x	x	x	x	x			
Jan Haxby	✓	x	x	x	✓	✓	✓	✓	x			
Shaun Stacey	x	x	✓	x	x	x	✓	x	x			

NLG(22)142

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	02 August 2022	
Director Lead	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee	
Contact Officer/Author	Michael Whitworth, Non-Executive Director and Chair of Workforce Committee	
Title of the Report	**Workforce Committee Minutes - May 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday 31 May 2022, and approved at its meeting on Tuesday 19 July 2022, are for information.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 31 May 2022 at 14:00 hours via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Nico Batinica	Associate Director for Workforce Systems and Recruitment
Christine Brereton	Director of People
Alison Dubbins	Associate Director of Leadership, Culture and OD
Fiona Osborne	Associate Non-Executive Director
Robert Pickersgill	Governor, Membership Office
Michael Proctor	Non-Executive Director and Deputy Chair
Peter Reading	Chief Executive
Shaun Stacey	Chief Operating Officer

In Attendance:

Diane Hughes	Associate Director, Special Projects
Sean Lyons	Trust Chair (first hour only)
Cate Neal	Health and Wellbeing OD Business Partner (agenda item 6)
Liz Houchin	Freedom To Speak Up (FTSU) Guardian (agenda item 8)
Jennifer Moverley	Head of Compliance and Assurance (agenda item 9)
Claire Hansen	Programme Director, Humber Acute Services (agenda item 12)
Ivan McConnell	Programme Director, Humber Acute Services (agenda item 12)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Apologies for absence

Apologies were received from Paul Bunyan, Helen Harris, Linda Jackson, Ellie Monkhouse, Kate Wood and Jenny Hinchcliffe

2 Declarations of Interest

The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

3 Minutes of the previous public meeting held on Tuesday, 29 March 2022

Page 1, under present, line 4 should read: Fiona Osborne.

Page 8, second to last paragraph, last line should read: Fiona Osborne added that she appreciated that work is ongoing with targets but without connecting it to the statement that process redesign was needed it was undermining the good work being achieved.

With the above amendments the minutes from the previous meeting held on Tuesday, 29 March 2022 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

Further to discussions at the last meeting regarding the culture transformation work Christine Brereton reported that a launch event is being organised that will formally launch the Cultural Transformation Programme. This will also include the formal Clever Together an interactive online staff engagement platform tool. Funding for that has been secured from NHSE/I. The Terms of Reference for the Culture Transformation Board and Culture Working Group have been signed off at Trust Management Board (TMB).

Robert Pickersgill stated that the Leadership Strategy is a long-term programme, and any culture shift will take a minimum of three to five years and ten years to get to any form of ideal. Robert enquired if there could be anymore urgency behind that. Christine reiterated that work on cultural transformation had already commenced with the roll out of Just and Learning and the design and development of the leadership strategy presented to this Committee. This would be rolled out in 22/23 and beyond.

The Chair noted the progress that had been made to date, and that it was the role of the committee to monitor progress.

4.1 Review of action log

Action 96 - Add 'Update on Progress Made' to the agenda for the May meeting

Kate Wood had sent apologies for today's meeting and the Chair was happy to defer this item to next month.
Action: Kate Wood

5 People Strategy - End of Year Review 2021/2022

Christine Brereton presented the end of year review 21/22 against the year 1 implementation plan for the People Strategy. She reported that a total of 22 objectives have been fully achieved and 8 are ongoing, near completion, or included in the next plan for 2022/2023 which gives the foundation for transformational change to be able to move forward.

Fiona Osborne was interested in objective 8, and she asked if that was discreet and not an ongoing action, and has the trust completed its work around working relationships with the ICS. Christine Brereton replied that the trust will continue to work with the ICB as it becomes embedded, it will have a statutory form from July and that is a continued objective. Fiona went on to ask, with that objective did the trust achieve what it expected to, discreetly in year. Christine replied there had been progress developing relationships and work around health and wellbeing (HWB).

The Chair celebrated the achievement around recruitment. He enquired around the facility time for trade union representatives and whether that had been resolved. Christine Brereton replied that temporary facility arrangements have been put in place to increase time for the RCN, Chair and

Secretary roles. Paul Bunyan is working on a paper that is being submitted to TMB in June to review those arrangements for 22/23. The Chair felt that was positive.

Peter Reading added that Christine and her team have delivered very well last year and are getting the basics right. They have a people team that feels solid and a good performance against capacity stretching objectives, he thanked everyone involved.

People Strategy - Annual Delivery Plan 2022/2023 Sign Off

Christine Brereton reported a draft plan of objectives for the People Directorate for 22/23. This plan has been designed to support delivery of the NHS People Plan and People promise, NLAG's People Strategy and the Trust's priorities – Priority 1 – Our People. The plan needs to be finalised and will then be submitted to a future workforce committee and TMG. Quarterly reports will continue to come to this committee to monitor progress and delivery.

Fiona Osborne asked if the metrics being developed had got measurable outcomes assigned to individual outcomes, may be a three-tier structure. Turnover is a measure of recruitment and a combination of different things and for that to be valuable it needs to be exclusive as a driver for that KPI. Nico Batinica agreed, and reported that work is in progress. He explained that there will be a number of key metrics that will report against objectives individually and overall. The metrics will feed into the PRIMs and the IPR and be the basis when providing information to other committees.

Fiona Osborne stated that she supported the plan overall. She discussed the link with the Finance and Performance Committee and the need to reduce bank and agency costs and is aware that the trust has a tight margin of error for this year. Nursing recruitment has been good with 120 nurses from overseas and since October to March vacancies have gone up indicating that retention is an issue. Fiona asked with long term sustainable plans is the trust going to be able to shift fast enough to help support turnover to plug the retention gap.

Christine Brereton stated they did a deep dive into retention to understand some of the reasons why people are leaving, and from what areas and this would feed into the cultural transformation work. Christine also reported that the nursing establishment had increased which would impact on overall vacancy numbers. In the short term, where the trust has hotspot areas identified through the deep dive then focused attention from HR/OD would be put into place.

Alison Dubbins stated that an example of that was specific work with the nursing team to reduce isolation and exclusion issues and disconnect with the national and international community. They are working on core skills to have a base line from which to manage challenge and behaviours and are focusing on tension to take that into specific areas. This will result in a number of workshops with staff.

The Chair stated after Finance and Performance and the letter back from Region, Lee Bond is committed to strengthen the linkage between the Workforce Committee and Finance Committee to have the same plan, timelines, and profile as finance. The Chair asked is the trust on track as an organisation, perhaps either Christine or himself should join Finance and Performance or ask Lee Bond and Gillian Ponder to join this committee to understand and give that assurance. Nico Batinica added that with the ICS/ICB they have worked hand in hand with finance to make sure everyone is using the same data for the planning submissions. They continue to work monthly and should be able to measure as nurses increase and agency spend is reduced. Christine stated that this is a key objective in the plan for 2/23.

Michael Proctor was encouraged hearing about retention but the reality in nursing terms is there are lots of jobs available and some of them are more pleasant and easier than some of the front-line roles. The reality is it will take some time before the trust gets on top of that and people enjoy what they are doing daily. Alison Dubbins felt some of this may be addressed in the HWB update. There is a robust plan in process this year with OD and EDI and they have had over 87 online conversations. They inject a lot of resource and emotional intelligence time to have those conversations to connect and listen to staff and more often it is about being heard and seen. They are getting a real traction with nursing staff to pull OD and EDI into their business areas and that is heavily supported by trade union colleagues. Schwartz rounds and counselling in the short term is critical to hold onto people who are struggling right now. The Chair added this can be seen with the emergency development in Grimsby, staff have been part of the design and are really excited about the build.

Peter Reding recognised the negative aspects and financial consequences; the trust never wants people to leave because they are unhappy. Nationally, there is a shortage of staff and huge opportunities for people to move. Trusts also need to be careful, if there is not enough turnover the weakness would be that too many people will have only ever worked at the trust. In remote trusts it is about building career opportunities because some people do want to stay in an area.

Diane Hughes stated the amount of work around wellbeing and sign posting to resources does make a big difference bringing people in with other ideas and opportunities for our staff for career development. The trust has increased its establishment and that will improve morale on wards and staff will feel they have been listened to. Peter Reading highlighted the trust has some fabulous nurses who have worked at the trust for a while and that does give some balance.

6 People Strategy Deep Dive – Health and Wellbeing including submission of 2-year HWB Plan

Alison Dubbins reported that his forms part of trust priority 1, to continue to raise awareness of and expand access to HWB services for staff and to improve staff culture and engagement. She reported that the North Lincs Council has recently recognised NLaG for the Health Workplace Gold Award. This is a mark of the work that Cate Neal, EDI, and the team have done, supported significantly by the HRBPs.

Cate Neal reported the plan links to trust priorities and the NHSI/E trailblazer programme for HWB. NLaG was the first to test on the seven HWB areas and carry out a diagnostic across the trust. The results show current strengths and areas for improvement. The rag ratings scored green in personal HWB, fulfilment at work, environment, data insights development and professional wellbeing support. Amber ratings were achieved for relationships and managers and leaders and there were no areas of excellence or where staff where at significant harm. There are 38 actions and sub-actions in the action plan, it is a live document and priority has been given to areas where they scored poorly ow where staff would be at risk if actions were not put in place.

Schwartz rounds are taking place in the Autumn with facilitators and the HWB Steering Group already in place. Wellbeing hubs will offer a safe space and the trust is also looking at broader HWB support for things like the cost of living, legal and financial packages and to extend green spaces. The engagement strategy is being worked out and a twitter account has been launched. Comms are being put onto social media and screen savers to show what is being offered for staff. Wards have been visited to inform staff about HWB plans and provide wellbeing packages. A further thirty-eight requests have been received and more themed staff engagement events, such as PRIDE, are being arranged. The HWB plan is now moving at pace into delivery.

Michael Proctor stated that he liked Schwartz rounds, and he felt they work better when senior staff are involved and talk about their own emotions. Cate Neal agreed, it is absolutely important for senior staff to be involved.

Fiona Osborne reported that she has been involved in 15 steps and knows that mental health support is being publicised but when talking to staff they feel there is a personal stigma attached when contacting mental health services. Cate Neal confirmed that is being covered by the teams giving the message that services are completely independent, confidential, and not reported to people's line managers and are already in place with Remploy specialist advisors. Sometimes people want to approach their line managers to make adjustments and Remploy will contact managers.

Christine Brereton stated that the two-year plan is a strategic overview, and it is clear, through the plan, the areas the Trust needs to improve on and that it is important to make those offers come alive for staff.

Robert Pickersgill felt that the trust needs to place value on establishing the route cause of the difficulties that come out of the Schwartz rounds. Alison Dubbins added that HR and OD have gone back to basic first principles to develop a more diagnostic tool to take a diagnostic approach with line managers to understand core concerns and reasons Robert Pickersgill added that there is lots of anxiety because members of staff want to give a good service. Cate Neal further added that wellbeing support services do gather anonymous information on themes.

The Chair is the HWB Guardian for the trust and attends regional training sessions. He stated there isn't a blueprint, people are doing things differently, it is about developing things, communication and lessons learnt.

7 NHS People Plan - Progress Report

Regular updates on the 2021/2022 plan were presented to the committee. That has now evolved and is embedded into the 22/23 people plan. Christine agreed to provide a short update on progress outside of the Committee.
Action: Christine Brereton

8 Freedom to Speak Up (FTSU) Guardian Update - Quarter 4 and Annual Report

Liz Houchin reported there was a total of 157 concerns raised for the year, and only 4 were raised anonymously, which is lower than the national average. Main themes include 72 having an element of behaviour and that will form part of the cultural transformation work that is ongoing. Liz Houchin reassured the committee that inappropriate behaviour is experienced across all organisations and going forward she must report that on a separate category to bullying and harassment.

The staff survey showed a reduction in bullying and harassment that was below the national average. There was an increase in staff feeling able to raise concerns about unsafe clinical concerns, a decrease in staff speaking up about any other issues and a decrease in confidence of staff feeling able to raise any concerns. Given the change of questions in the 2021 staff survey, the NGO will not be producing a FTSU Index in the future. There is a new question in the survey 'we each have a voice that counts - raising concerns', the trust reached 6.1% which is below the national average of 6.4%.

Liz Houchin will produce a review against the FTSU strategy, now two years in. The NGO highlighted the launch of the e-learning package for Executives, with the follow up module being circulated. The Board development sessions and work over the last eighteen months has provided learning and understanding of the FTSU Guardian role in the trust.

Regarding page 10, staff survey results, Fiona Osborne stated there was an anomaly in questions 17b and 21e, a reduction in confidence that the trust would address concerns and a reduction in the number of people feeling safe to speak to the FTSU office about their concerns, she asked what is causing that anomaly. Liz Houchin replied it is whether people take it a step further, and how they feel to speak to anybody, or whether it is around the Guardian. Fiona Osborne went on to ask what more the trust can do to resolve that problem, the strategy is very clear, and people are formally aware of the FTSU Guardian in the organisation. Liz Houchin stated that continuing with communications, network groups and getting the message out there and the leadership development work will improve people's perception to speak up to any leader.

The Chair felt that some examples in the report are powerful and he asked if they are shared anywhere. Liz Houchin replied that on the Hub page there is 'you said, we listened, and we did', making sure that the loop is closed, and feedback is provided to demonstrate to other staff that it was worth speaking up.

Christine Brereton added that only 38% of staff completed the staff survey, that may be the disconnect. It is important that FTSU is part of the cultural transformational work and everywhere in the trust is a safe space to speak up. The trust needs to encourage people to speak up through line managers and other forums.

Diane Hughes asked of those that spoke up was it to their line manager or Chief Nurse in the first instance. Liz Houchin confirmed it was a combination and some people had spoken up to their line manager and nothing had happened. Some people feel they cannot go to their line manager and go to the FTSU Guardian who's first question is 'have you spoken to your line manager to support and try and solve the problem'.

The Chair confirmed that the committee approved the Freedom to Speak Up (FTSU) Q4 and Annual report.

9 BAF 2021-22 Quarter 4 Report

Christine Brereton reported an update on Q4 BAF for 2 and 5.

Michael Proctor reported that linked in with discussions at the Quality and Safety Committee around strategic objective 1.1 and whether due to ongoing workforce issues does the trust need to increase the risk score from 15 to 20. Michael was concerned about the long-term impact of continuing pressures in the clinical setting and his worry was that might be normalised. The likelihood of an issue from possible to likely was considered and the Quality and Safety Committee had not made that decision. Peter Reading felt Michael was right to raise the concern, it is about burn out of staff, health and wellbeing and morale. The trust is in a slightly worse position in terms of geography, and it would be honest to accept that the risk has increased, and Peter supported increasing that risk. Christine Brereton added that Helen Harris and herself were going to try and influence the BAF for 2022/23 because everything is wrapped up in the one risk and they had discussed trying to break that down.

Michael Proctor highlighted that he was specifically talking about increasing objective 1.1 quality of care, rather than staffing, although it is linked to workforce. Peter Reading confirmed he was

happy to work with Christine Brereton to look at strategic risk and make a recommendation to Trust Board.

10 CQC Update

Jennifer Moverley highlighted things are progressing as detailed in the report available on SharePoint. The Chair referred to maternity emergency mandatory training and anaesthetic staff on the obstetric rota and asked for any highlights from amber ratings. Jennifer reported that the amber is just under target and very consistent. The appraisals in the emergency department in February got to 85%, have now slightly dropped off, but are still consistent.

11 Workforce Performance Report - Trust and Directorate

Nico Batinica reported that IPR targets have been reflected with increased rigor around workforce.

11.1 Vacancy Position

March's data has seen an increase in establishment, so looks slightly worse. A total of 120 international nurses, 80 NQNs and 70 local nurses are due to start at the trust.

Unregistered vacancies continue to increase because of a more competitive market. A rapid workshop in being held in July to increase the pace of recruitment.

11.2 Turnover

Regarding turnover on page 10, Robert Pickersgill asked if Nico's team correlates the data as the trend goes back to June last year. Nico confirmed he had looked at that and it is a national issue that came back when the country was starting to come out of the pandemic, particularly for registered qualified staff. The trust needs to try and fill vacancies to be able to affect turnover.

11.3 Retention

Nothing discussed.

11.4 Sickness Absence

Robert Pickersgill commented that the sickness rate has increased. This was reported as in the main sickness for covid.

11.5 Mandatory/Statutory Training Completion

Nothing discussed.

11.6 PADR Completion

Nothing discussed.

11.7 HR Cases

Nothing discussed. The Chair commented for ease of reading, in some narrative the term above and below plan is used and he wondered if it also needs to say if better or worse than plan.

11.8 Recruitment Metrics

Nico Batinica presented the NLaG Recruitment Performance Report. This was well received by the Committee. The dashboard would be circulated to the committee following the meeting.
Action: Wendy Stokes

A total of 1,600 applications were received in April and recruitment remains very busy. There is some correlation around the time to hire for certain staff groups and the team is working with divisional managers to give them protected time for shortlisting. Time to hire links with time taken to shortlist and capacity in nursing staff groups because of the number of vacancies. The team can focus its attention on some interventions to work through the barriers, and remove as many as possible, and that will also link back into retention and turnover.

Christine Brereton stated going forward the team will try and get a plan on one page to show a headline and see any gaps, rather than just detail. Nico highlighted that there is a KPI of two days for managers to inform recruitment of their decision.

Peter Reading left the meeting at 15:43 hours

12 HASR Review Update

Claire Hansen reported that they had looked at the whole workforce across the Humber and that allowed them to conclude where they want to be. There has been some good work done with Christine Brereton and Nico Batinicia building and developing a review on issues around deliverability. They have looked at travelling access, workforce, new skills, building out of hospital and digital space. They have options ready for a pre-consultation business case to be submitted by the end of June and an NHS Gateway review by the end of July in readiness for a public consultation the second week of September.

Step 2 is the evaluation approach, and they are nearing the final bit looking at travel, access, and workforce and will be looking at capital and revenue affordability. An update will be given in July at the joint session.

Claire Hansen reminded everyone that there are fifteen potential configuration options that need evaluating. In essence there are three main configurations:

- Acute/Local Emergency Hospital Model - one site acute with everything there and one local emergency hospital at a lower level without general medical and care of elderly patients, obstetric led unit and midwifery led unit
- The overarching model is Acute/Elective Model - acute hospital on one site and one site for elective surgery
- They have brought back a central site configuration - to be determined

They want to make sure they have given due consideration to all models put forward by clinical teams and when finished should have four options.

From December 2021, they began the creation of the 9-step workforce planning methodology. From that they worked with medical staffing and Clinical Leads looking at different requirements. They had Chief Nurse Directorate support and looked at AHP, maternity, neonatal and paediatrics with Clinical Leads and Heads of Midwifery/Children's Nursing. Work is now underway in steps 5 - Stakeholder confirm and challenge, 6 - Compare and contrast, 7 - Feasibility Assessment and

8 - Financial costing. The P2 PCBC workforce plan will be completed by end of June.

Workforce geomapping gives an overview of the observations of the travelling for staff. NLaG staff live round the area particularly medical staff, estates and facilities, general admin and registered nurses and health professionals. Consideration must be given around potential models and the cost impact of travelling for the workforce, perhaps staff will retire earlier, and 25% of all staff do not use a vehicle. With workforce maps you can breakdown the detail showing where people are living, and a lot are living close to their place of work. You can see how they are travelling and any change to working location may have an impact on their ability, and opportunities and mitigations that can be put in. If care is to be provided closer to home the workforce will need to move closer to home.

They are looking at partnership working with universities and some opportunities with Lincoln. They are also looking at new roles, summer camps for school age children and a practical placement summer camp to push end emphasise available opportunities. At universities there is a split of 70% females and 30% males going into doctor training.

Michael Proctor stated there will also be financial implications and a huge amount of work to be done, once in public consultation there will be lots of people involved and it may become difficult.

Robert Pickersgill asked about the availability of medical staff, funding the Medical Council and BMA and the restriction of supply. Claire Hansen felt it important to influence people coming up by looking at 5, 10 and 15 year olds. There is also a need to look at new roles for ACPs once qualified, where is their career progression, that opportunity needs to be developed. There is a need to create space for current medical staff to devote to training so when students come in, both medical and nursing, that will encourage them to come back. The suggestion of having dualled academic clinic roles will help to drive that important message of training and how it is received and delivered.

13 Trust Board Highlight Report

- Approved FTSU Q4 Report and Annual Report
- Health and Wellbeing
- Linkages with Finance and Performance Committee around retention
- BAF risk in terms of Christine Brereton going to work with Peter Reading to make a recommendation to Trust Board

14 Self-Assessment - Annual Review of Committee

The link with other committees had briefly been discussed and the Chair suggested a regular conversation with NED Chairs to link in referrals. The Chair also agreed to discuss membership with other committees and perhaps reflect on that and discuss it further at Trust Board. Christine Brereton stated she had discussed that with executive colleagues, and Finance and Performance Committee and Quality and Safety Committee already involved the executive director in the first instance.

15 Items for information (not for printing)

15.1 Minutes of Health and Wellbeing Steering Group meeting held on 30 March 2022

Noted, nothing discussed.

16 Any Other Urgent Business:

Nothing discussed.

17 Date, time, and venue of next meeting:

Tuesday, 19 July 2021 at 14:00 hours via Microsoft Teams

The meeting closed at 16.26 hours

Cumulative Record of Workforce Committee Attendance (2022/2023)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Michael Whitworth	1	1	Christine Brereton	1	1
Michael Proctor	1	1	Helen Harris	1	0
Fiona Osborne	1	1	Robert Pickersgill	1	1
Sean Lyons	1	1	Tim Mawson	1	0
Peter Reading	1	1			

NLG(22)143

Name of the Meeting	**Trust Board of Directors – Public Board**
Date of the Meeting	2 August 2022
Director Lead	Dr Kate Wood, Medical Director
Contact Officer/Author	Rachael Norfolk – Revalidation Assistant Jane Heaton – Associate Director, Strategic Medical Workforce
Title of the Report	**Annual Revalidation Report**
Purpose of the Report and Executive Summary (to include recommendations)	This report is an essential requirement done on an annual basis summarising the appraisal position for doctors connected to NLAG as their Designated Body. The purpose of this paper is to provide the board with information about processes in place at NLaG for medical appraisals, revalidation recommendations to the GMC, and medical governance arrangements. The report will therefore help NLaG in its pursuit of quality improvement, provide the necessary assurance to the higher-level responsible officer and can act as evidence for CQC inspections. Furthermore, the purpose of this paper is to provide assurance to the board that the organisation continues to implement and comply with the Responsible Officer Regulations and legislation; Medical Profession (Responsible Officers) (Amendment) Regulations 2013. The Board, through the Chief Executive Officer, are required to sign the 'Statement of compliance' at the end of the report confirming that the organisation is compliant with the RO regulations. The approved annual report and signed statement of compliance will be submitted to NHSEI by the Responsible Officer's office.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

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

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

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

Annual Revalidation Report 2022

Contents

1. Background to appraisal and revalidation

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system. It was also launched to enable a proactive system of ensuring doctors are fit to practice in the UK. Prior to the introduction of revalidation there was no consistent mechanisms of ensuring doctors are fit to practice and if there was concerns around fitness to practice, a patient had already come to some form of harm.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctor
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

All doctors are allocated to a designated body (DB) through the GMC. NLaG is the designated body for all our non-training grade doctors such as Consultants, Specialty Doctors, International Training Initiative doctors and Trust Grade doctors. Dr Kate Wood is the Responsible Officer (RO) and Mr Ajay Chawla is the Appraisal Clinical Leader for the Trust.

Doctors in training are connected to the deanery (Health Education England – Yorkshire and Humber) and locum agency doctors are connected to the HOLT medical agency for purposes of appraisal and revalidation and therefore are not included in this report.

2. General Information

2.1 Medical appraisal and Revalidation process during COVID-19 Pandemic 2021-2022

In December 2021, the GMC, in collaboration with NHS England and Improvement, contacted all UK designated bodies for revalidation outlining the GMC's and NHSEI's approach to revalidation. The GMC advised designated bodies that the GMC and NHSE&I would continue their flexible approach to revalidation and appraisal that had commenced during the 2020 pandemic.
Flexible approach include;

- If a doctor misses an appraisal due to reasons relating to the pandemic, then this will not stop a doctor revalidating providing all the supporting information is available to make a recommendation of revalidation (for example 360 multi-source feedback, reflection on significant events, CPD)

- Postponing appraisals and/or deferring revalidation at the doctors' request for more time to collect supporting information. This can alleviate pressures to meet revalidation requirements.
- Doctors who were still required to have appraisal between the months December-January could postpone their appraisal to a later date.

All the approaches as described above where adopted to ensure that doctors could focus on patient activity, as well as own personal wellbeing, during the ongoing pandemic.

2.2 Annual Organisational Audit report (AOA)

The Annual Organisational Audit report is an element of the Framework of Quality Assurance (FQA) and this is a standardised reporting mechanism for all Responsible Officers (RO) to complete and return to their higher-level RO.

Owing to the continued pandemic, NHS England and Improvement advised NHS healthcare organisations in England in December 2021 that submission of the AOA will not be required for the 2021-2022 appraisal year. However, organisations were encouraged to submit AOA results for the annual report.

AOA Reference	Item	Number of prescribed connections	Completed appraisals (1)	Optional completed appraisals (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	Consultants	201	193	0	8	0	**201**
2.1.2	Staff grade, associate specialist, specialty doctor	135	106	0	29	0	**135**
2.1.3	Doctors on Performers Lists	0	0	0	0	0	**0**
2.1.4	Doctors with practising privileges	0	0	0	0	0	**0**
2.1.5	Temporary or short term contract holders	109	54	0	55	0	**109**
2.1.6	Other doctors with a prescribed connection	0	0	0	0	0	**0**
2.1.7	**Total of 2.1.1 - 2.1.6**	**445**	**353**	**0**	**92**	**0**	**445**

There are no measure 3 doctors for 2021-2022 owing to the flexible approach adopted towards medical appraisal and revalidation.

A breakdown of Measure 2 is as follows:

- 83 doctors were new arrivals to the UK and the NHS and obtained their primary medical qualification outside the UK.
  New doctors to the UK and NHS do have a delay to their first appraisal which range from 6 months up to 12 months from their start date. The reason for this is because a doctor has to bring a significant amount of supporting information and evidence which matches their scope of work, demonstrates that they are safe, demonstrates engagement with professional standards, demonstrates continued improvement within their service area (e.g. participating in audits) and ultimately the supporting information and the discussions around it will contribute to lifelong professional development.

Furthermore, appraisal has a focus on reflective practice, and this is usually a new skill that doctors must learn in preparation for appraisal, for example reflecting on audit results or significant events. This gathering of information, particularly for new doctors to UK and NHS, can take time as supporting information/evidence that has been accrued abroad cannot usually be applied to UK practice and therefore be included in the appraisal.

In addition, the Trust has recently adopted an approach whereby doctors will not be scheduled appraisals during the months of January, February, or March. The doctors that are cited in the above data started with the organisation from August 2021 which means that their scheduled appraisal will be April 2022 onwards.

In the meanwhile, these doctors are engaged by the Revalidation Assistant personally to have a 1:1 medical appraisal support session which aims to induct the doctors into the medical appraisal process and therefore are able to begin work on their portfolio which constitutes as process engagement.

- 5 doctors had long term sickness during their appraisal period

- 4 doctors whose appraisal was postponed on GMC/NHSEI advise but these doctors are engaging, and appraisal paperwork is awaiting appraiser sign off.

2.3 Responsible Officer Role

Dr Kate Wood, Medical Director, is the nominated RO for this Trust. The RO has received RO training and is a licensed medical practitioner. Therefore, NLaG is compliant with Regulation 5 of The Medical Profession (Responsible Officers) Regulations 2010.

The RO also attends the NHS England and NHS Improvement quarterly RO network meetings and best practice is shared with the Clinical Lead for Appraisal and the Revalidation Assistant.

2.4 Funds, capacity, and resources

To date the organisation has been compliant with Regulation 14 of The Medical Profession (Responsible Officers) Regulations 2010, which states that each designated body must provide the appointed/nominated RO with sufficient funds and other resources necessary to enable the RO to discharge their responsibilities.

2.5 Records of NLaG licensed medical practitioners

The Revalidation Assistant is the Trust-wide coordinator who maintains records of NLaG licensed medical practitioners. This includes;

- GMC Connect: A database of Medical Practitioners who have a prescribed connection to NLaG

- L2P Appraisal software system. All Medical Practitioners who are on the NLaG GMC connect database will have an L2P account.

To ensure that these lists are accurately maintained, the Revalidation Assistant runs ESR starter and leaver reports at least every 2 weeks and adjust the lists above accordingly.

2.6 NLaG Medical Appraisal Procedure policy document

This procedure will be due for review again in February 2023.

2.7 Short-term placement and locum doctors

Short term contract holders, such as NHS locum Consultants, fixed terms speciality doctors and Trust Grade doctors, are supported in their continuing professional development (CPD), revalidation and governance in coherence with substantive medical staff, i.e., they are not considered or managed differently to permanent medical staff.

Short term contract holders are expected to maintain their CPD through the appropriate Trust processes, such as Study leave, participating in mandatory training, attending medical teaching sessions, to name a few.
They are also expected to engage with medical appraisal and revalidation.
Upon appointment short term contract holders are incorporated into the local appraisal software system, L2P, are duly welcomed by the RO via email, advised of medical appraisal help sessions, signposted to the revalidation assistant and the GMC are informed that the doctor in question has a prescribed connection to NLaG.

In terms of governance all new short-term contract holders are initially made aware of governance procedures, such as incident reporting, through the Trust's induction Policy as are all new starters to the Trust.

3. Ensuring Effective Appraisal

3.1 The Medical Appraisal

Doctors who have prescribed connection to NLaG use the L2P software system. Each doctor has an individual L2P account which is linked to their NHS e-mail. The doctors are required to fill their appraisal form via the L2P system and there are 3 basic elements to the appraisal.

1. Appraisal Inputs – doctor fills in each section of the L2P form and uploading supporting information/evidence which covers their scope of practice. Once completed the doctor submits form to appraiser via the L2P system.

2. Appraisal meeting – meeting between doctor and assigned appraiser.

3. Appraisal outputs – Doctor and appraiser agree a PDP for the year going forward and the appraiser writes up a summary on how the doctor meets the 4 domains of Good Medical Practice with the supporting evidence provided. The appraiser and doctor both sign off the appraisal. The appraiser then submits to the RO office for RO review and sign off.

Appraisal inputs vary among doctors however the appraisal outputs are somewhat more structured. The appraiser must confirm in the final sign off statements that:

- An appraisal has taken place that reflects the whole of a doctor's scope work and addresses the principles and values set out in Good Medical Practice

- Appropriate supporting information has been presented in accordance with the Good Medical Practice Framework for Appraisal and Revalidation and this reflects the nature and scope of the doctor's work

- A review that demonstrates appropriate progress against last year's personal development plan has taken place

- An agreement has been reached with the doctor about a new personal development plan and any associated actions for the coming year

- No information has been presented or discussed in the appraisal that raises a concern about the doctor's fitness to practise

The appraiser is not automatically obliged to confirm all the statements mentioned if they feel that one or more is not reflected in the appraisal.

All doctors at NLaG are reminded that their annual appraisal must cover their entire scope of practice, which may include charity work, private work etc. and the doctor must provide evidence that they are fit to practice every single role they carry out whether this be clinical, managerial or educational because every single role a doctor carries out in their practice, does have an impact on patient care.

Supporting information to demonstrate fitness to practice against a scope of work varies however the Trust, via the revalidation assistant, does provide clinical governance information to all doctors. This includes;

- Incidents that they have been named in the past 12 months; if a doctor is named in a significant event or incident, they must summarise the event and demonstrate reflective practice. Any doctors that are informed of significant events and/or incidents by the Revalidation Team, but upon RO review the information is not included in appraisals, the appraisal will be referred back to the doctor to rectify. This is because it is a GMC requirement that a doctor must comply with.

- Complaints that they have been named in the past 12 months.

- Claims that that have been named in the past 12 months

- Clinical activity data (upon request)

Doctors are also encouraged to upload or provide evidence of medical indemnity/insurance. Where this is omitted, doctors are required to confirm that they understand the legal obligations on having medical indemnity/insurance for their role(s).

In relation to mandatory training, it is not a mandatory requirement for appraisal and or revalidation however the revalidation team do inform doctors that mandatory training courses do attract Continuing Professional Development points (CPD) and therefore doctors do upload their mandatory training matrix as part of the support information portfolio.

GMC guidance states that consistent failure to engage with mandatory training can be a GMC referable matter and may impact on revalidation. "*Failure to meet local appraisal or contractual requirements may be discussed at your appraisal but should not influence the revalidation recommendation made about you … However; in exceptional circumstances your responsible officer may decide that significant failure to meet local requirements will impact on their recommendation. They would need to be satisfied (and satisfy us) that failure to meet local requirements means you are not*

engaging with revalidation and therefore failing to meet our requirements. They would need to specify which of our requirements you have not met.'

Doctors are also required to undergo 360 feedback at least once in a 5 year cycle. The RO office also actively recommends and ensures doctors complete the 360 feedback element in year 3 of their revalidation cycle which is approximately 2 years before a doctor is due to revalidate their license.

All supporting information which is presented by the doctor must be fully reflected on how they meet the 4 domains of Good Medical Practice. Reflective practice also drives quality improvements as well as professional and personal development.

All doctors are contractually and professionally obliged to engage with appraisal. Doctors are sent reminders via the L2P system and the RO office that they are due for appraisal. Doctors who are late with appraisal are then supported by the RO office and the Divisional medical directors.

Consistent non-engagement with appraisal results in the RO discussing the doctor's individual case with the GMC Employment Liaison Advisor and potentially, a subsequent referral to the GMC for non –engagement. Prior to all formal non-engagement referrals, the RO requests that the GMC contact the doctor with an early warning letter. If the doctor is also eligible for pay progression this is deferred by a year.

No submissions of non-engagement have been made during 2021-2022.

3.2 Medical Appraisers

Between April 2021 and March 2022, NLaG had 48 approved medical appraisers who were conducting appraisals. 47 are currently active with one appraiser being on extended leave. The Trust also has 5 senior appraisers, one of which is the Clinical Lead for Appraisal. Each appraiser has undertaken medical appraiser training which is provided internally by the Trust.

In June 2022, the budget for medical appraiser (the medical appraiser role attracts 0.25 PA per week) was transferred to the Medical Director's Office from the operational divisions. The budget allows for up to 55 appraisers to be assigned at the organisation and therefore there are currently 6 vacancies which will be advertised for.

Each Medical appraiser undergoes quality reviews. This consists of two parts; Firstly, a report which collates appraisee's feedback via the post-appraisal questionnaire (PAQ). An example of PAQ can be referred to in section 4.2.2.

Secondly, a quality assurance report on the medical outputs that the appraisers have produced. The revalidation team also uses the quality assurance reviews to identify and implement improvement to local process which is then picked up in the annual training sessions.

The quality assurance of medical outputs is usually conducted by the revalidation office however due to an upcoming external quality assurance visit, MIAD Healthcare will be conducting the EXCELLENCE review for the organisation in August 2022.

3.2.1 Quality Assurance of Medical Appraisal Outputs using EXCELLENCE tool

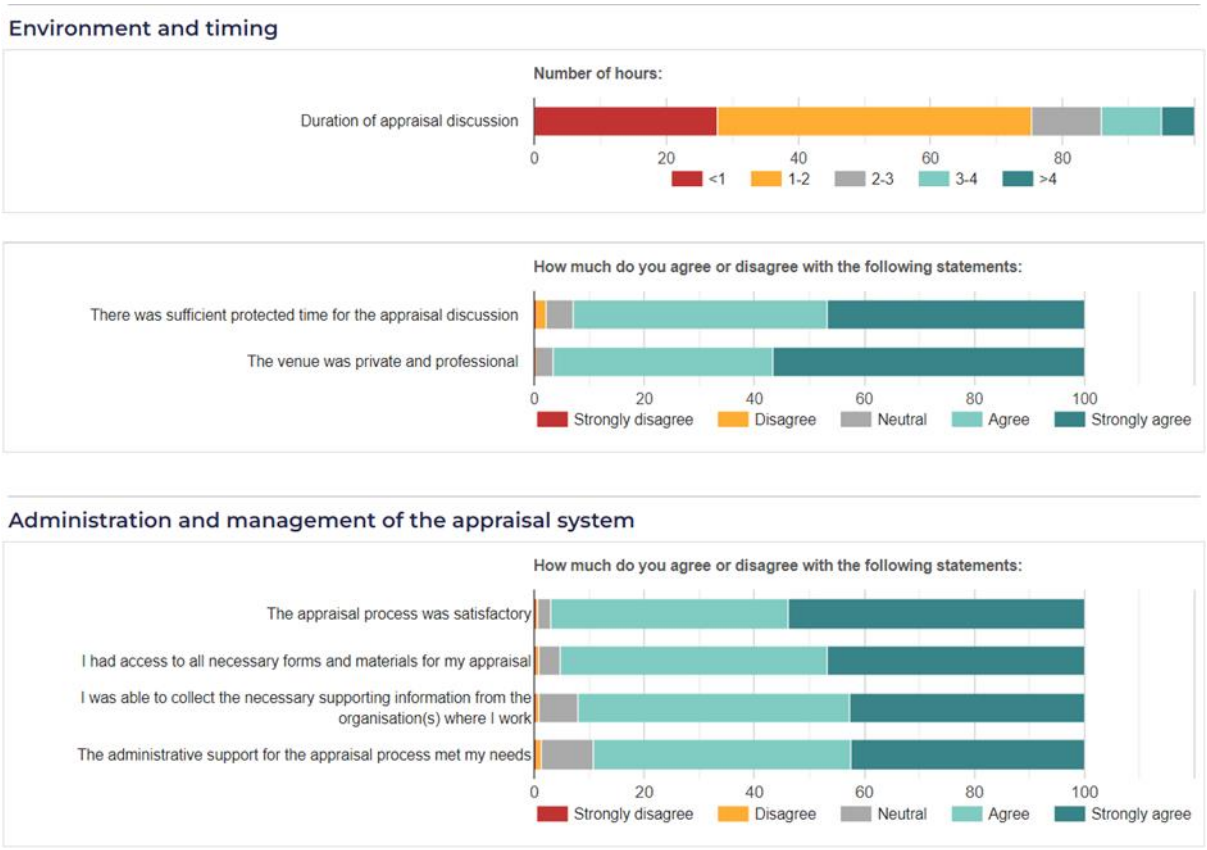
Due to the upcoming external review, which is to be conducted by MIAD Healthcare, the external reviewers will carry out an independent quality assurance exercise on medical appraisal outputs using the EXCELLENCE TOOL.

Results of this quality assurance exercised, whereby there are improvement actions, will be addressed by the Revalidation Team.

The report is expected in November 2022 and an update will be provided in the 2023 Annual Revalidation Report.

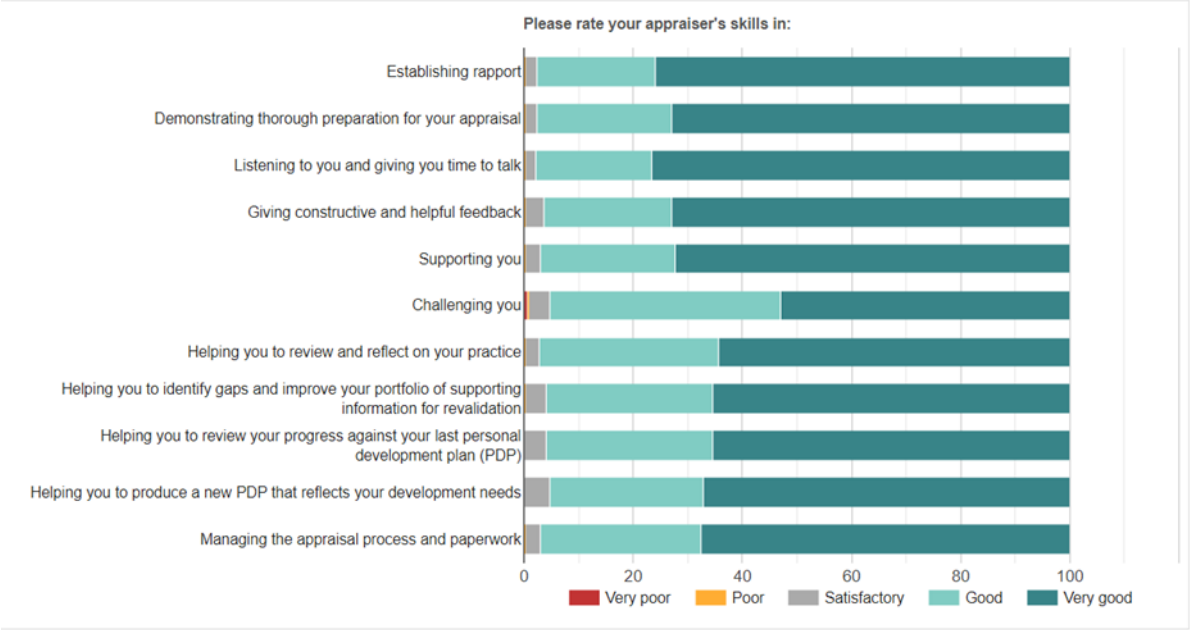
3.2.2 Medical Appraisal Post Appraisal Questionnaire (PAQ) result

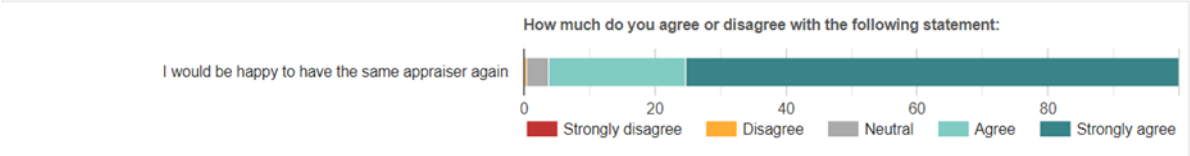
Process Overview



The headline result for 'Process Overview' is that appraisal meetings can typically last up 2 hours however emphasis is on ensuring that meetings are meaningful regardless of length. 92% of doctors agreed that they had protected sufficient time to complete their appraisal despite the pressures of the pandemic.
In terms of administrative and management support for medical appraisal, doctors agreed that they were supported and were able to collect the necessary support information from the Trust.

Appraiser Overview



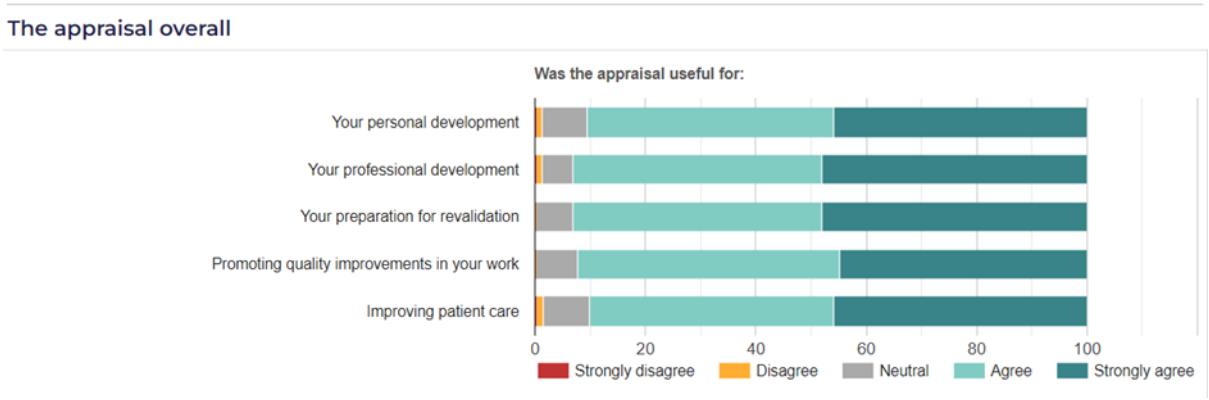


Doctors indicated that they would be happy to have the same appraiser again which is a reflection on the quality of appraisers the Trust has. At least 95% of doctors reported the following;

- That they were able to establish a good rapport
- That their appraiser had clearly prepared for the appraisal meetings
- That they were listened to
- Received helpful feedback
- Felt challenged and supported
- Were able to review and reflect on their practice
- Were able to identify gaps in their appraisal portfolio
- Were able to review progression again their last PDP
- Develop a new PDP for their development needs
- That their appraiser had a good handle on the appraisal paperwork

All of the above is an excellent and positive reflection of the skill, knowledge and experience of the Trust's appraisers and that continued investment in the appraiser role is clearly in the Trust's best interest, whether through off site training or the 0.25 PA allocation, but it is clearly returning its investment through high quality appraisals and a medical workforce that feels supported through the appraisal process.

Appraisal Overall



Not only are the doctors benefiting on an individual/personal basis, but the benefits have the potential to impact on the organisation, for example 85% doctors agreed that their appraisal was useful for improving patient care and promoting quality improvement. No doctor disagreed with any of the above statements.

3.3 L2P appraisal software

The Trust re-procured L2P in November 2021. All medical appraisal documentation is stored electronically on the system and only the Revalidation Assistant has full administration rights whilst the RO has full viewing rights for appraisals.

Access and use of data adhere to the requirements of the Data Protection Act (1998). L2P is registered with the Information Commissioner's Office: Registration number. z2384214

If external individuals require a doctor's appraisal, then the requester is required to approach the doctor concerned in writing. The request must be reasonable and clearly stated. On rare occasions this may not be possible particularly in police, legal or GMC matters whereby appraisal information can be released without consent depending on the severity of the issue and what level of patient harm has occurred. These cases should they arise are judged case by case in relation to releasing appraisal information and in line with internal Trust polices.

There are clear guidelines regarding access arrangements for medical appraisal documentation for medical staff in the Medical Appraisal Procedure.

With regards to maintaining patient confidentiality, doctors are notified that supporting information that has patient identifiable data must be removed or redacted before uploading documents to the L2P form. They are required to tick a confirmation every time they upload evidence.

For the Board's information there have been no breaches of patient data to date in relation to medical appraisal during 2021-2022.

L2P also has several reporting mechanisms. This includes;

- NHS England quarterly compliance
- NHS England annual compliance
- Past appraisal performance by grade
- Past appraisal performance by department
- Resource forecast by month

- Resource forecast by department
- Late appraisals by department
- Late appraisals by month
- Appraiser activity
- Appraisals with appraiser
- Appraisal completion by department
- Agreed PDP learning/development needs
- Medical educators
- Medical educators CPD
- Medical Leadership

The contract with L2P is due to expire in November 2026.

3.4 Quality Assurance measures

Current quality assurance measures, as well as planned measures which are included in the action plan, are outlined below:

- Appraisee feedback on the overall process and their appraiser.
- EXCELLENCE quality assurance tool. Every appraiser has 2 appraisals quality assured per appraisal year. This equates to approximately 100 appraisals being quality assured per year.
- Monthly revalidation meetings between the revalidation assistant and the Responsible Officer
- Responsible Officer occasionally facilitates at the RO network meetings, in partnership with NHSE/I and the GMC. This ensures sharing of best practice and new process development.
- Annual Training events for medical appraisers and all medical staff who wish to learn more about local process
- Medical Appraisal Induction sessions for all medical new starters to NLaG although primarily aimed at new starters from abroad.
- Annual Audit to NHS England and Improvement
- Annual revalidation report
- Statement of compliance signed by the CEO, which is then submitted to NHSE/I
- Revalidation team and RO attends the NHS England appraisal networking events
- Quality visits from NHS England and NHS Improvement
- External audit which will begin in August 2022 by MIAD Healthcare
- Fortnightly meetings between Clinical lead for appraisal and revalidation assistant.

3.5 Compliance Reporting

As of 1st July 2022, the revalidation assistant will submit monthly data to the NLaG workforce BI working group dashboard via POWER BI.

The revalidation assistant also submits the same data to the HR Business partners for the PRIMS meetings.

3.6 NHS England Quality visits

There have been no visits from NHS England & Improvement since July 2019.

4. Recommendations of Revalidation to the GMC

4.1 Revalidation submission data

Select the time period you wish to view data for:

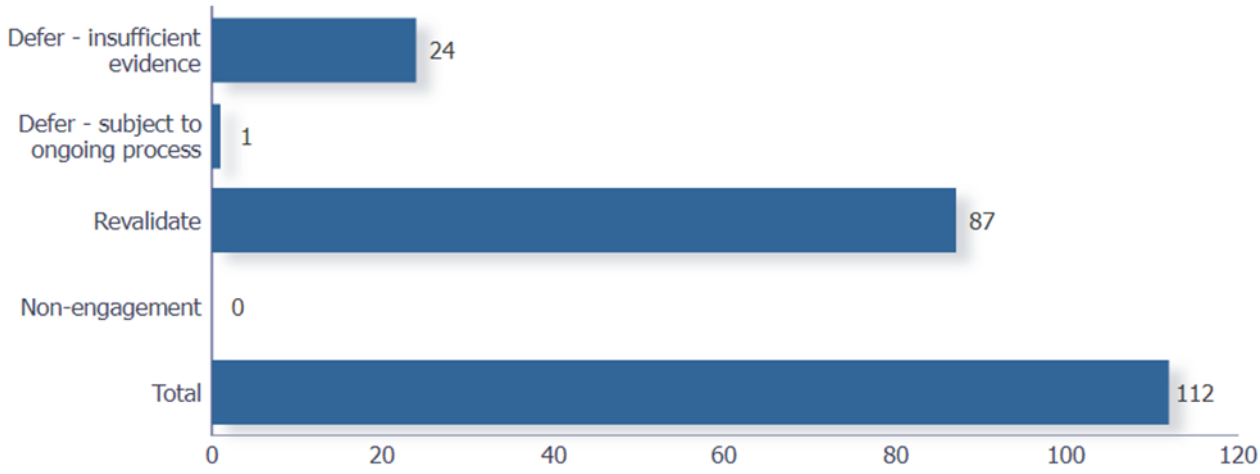
Between 01/04/2021 and 31/03/2022

What would you like to view? (•) My selected organisation ( ) Average for my organisation type

Recommendations

By type

Showing data for your selected organisation



Between April 2021 and March 2022, 87 doctors were revalidated. A doctor revalidates once every 5 years. There were no non -engagement submissions made to the GMC by NLaG.

As mentioned earlier in the report, the Trust had continued to adopt a flexible approach which has begun during the 2020 pandemic and therefore the Trust supports deferrals for doctors whereby they need to bring additional information for their appraisal. Where a doctor is deferred, they are reassured that this is a neutral act and that they will receive as much support as possible, if required, by the RO office.

1 doctor was deferred due to ongoing process (Maintaining High Professional Standards process) however this doctor has since revalidated.

6 Medical Governance

6.1 Local Medical Governance arrangements for medical appraisal

The revalidation assistant provides timely governance information to all doctors for their appraisal which includes; Datix incidents and serious events, complaints and

claims that occurred in the previous 12 months from date of requesting the information from the appropriate teams; Ulysses team and Complaints Handling team.

Currently we inform every doctor if they have been named in any of the above, whether this is in a managerial capacity, direct clinical input or part of a wider team, and if so that they must summarise and demonstrate reflective practice which encourages quality improvement ideas.

Although the doctor is directly provided with clinical governance data, it still maintains the doctor responsibility to upload to the L2P form and reflect. If it has been found that a doctor has not included this information, despite being named, then the revalidation assistant will refer the appraisal back and outline the omission.

In line with GMC requirements, doctors must include all incidents and SIs that they have been named in by their employer(s) in their appraisal for purposes of reflective practice.

If a doctor consistently omits incidents or SIs despite repeated assistance and support from the revalidation team, then this could be considered as a probity issue which opens the possibility for the doctor to be referred to the GMC for non-engagement with appraisal and revalidation processes and consideration of internal MHPS procedure being undertaken. To date there have been no incidents of probity issues relating to clinical governance data.

6.2 Monitoring conduct and performance

Medical staff performance and conduct is managed through regular supervision, through annual appraisal and participating in regular audits, case reviews, SJRs, all but to name a few, as part of quality improvements processes which are captured via the appraisal and revalidation process.

During appraisal discussions the doctor is encouraged to discuss aspirations and challenges and to review the progress of PDP objectives. The doctor is also required to reflect meaningfully on when things have gone wrong and demonstrate how changes and learning needs have been identified and actioned.
We also train appraisers to challenge doctors in relation to participating in quality improvement activities, especially if there is a lack of.

The “Doctor’s in Difficulty” (DiD) group has been operational since April 2018. The purpose of DiD is to ensure those required to attend are sighted on issues and concerns in relation to “Doctors in Difficulty”. Doctors are classified as being in difficulty if they meet one or more of the criteria below;

- Known through internal referrals to/from the General Medical Council and NHS Resolution and/or have restrictions on clinical practice
- Going through an MHPS investigations
- On or recently returned from long term sickness absence
- Recent sickness absence relating to stress, anxiety and/or other mental health issues
- Have had 4+ sickness episodes in over 12 months (rolling)
- Involved in a confirmed serious incident
- Training issues

- "Other" – this covers a range of issues that would not sit in the above categories, for example, employment tribunals.

The attendees of the group, which has senior HR representation, gives an opportunity to check whether the doctors mentioned above are receiving the required support from the operational divisions and the HRBPs, and challenge where there is a deficiency in pastoral support and/or general support altogether (such as return to work).

Other processes of note include the local Maintaining High Professional Standards policy and procedure, ensuring private practice is declared in the appraisal form and that doctors provide evidence of adequate and appropriate insurance and/or indemnity cover, whilst further ensuring that NHS and private practice do not conflict, and job planning.

6.3 Responding to Concerns

The Trust has a specific Maintaining High Professional Standards Policy/Procedure (MHPS) which supports in dealing with responding to concerns. In addition the Doctors in Difficulty Group ensure those required are sighted on issues and concerns known through recruitment of doctors with restrictions on their practice, internal referrals to/from the General Medical Council and NHS Resolution or those that have previously or are due to commence employment at Northern Lincolnshire and Goole NHS Foundation Trust

.

Our Trust Board is sighted on all cases going through the formal MHPS process, for example the number of suspensions and this is provided by our People and Organisational Effectiveness Directorate.

6.4 Transfer of Information between ROs

When a doctor joins NLaG and has come from another UK healthcare organisation whether this is another NHS Trust, Locum agency or training, then the Revalidation Assistant invokes the Medical Practice Information Transfer process (MPIT).

The revalidation assistant will formally contact the doctor's previous designated body with a MPIT form, which is prepopulated with the doctor's name, GMC number and NLaG's RO details, and requests that the designated body and its RO, or authorised delegate, fills in the form.

The MPIT form requests the following information;

- Date when Doctor left previous organisation
- Date of last ARCP/appraisal
- To inform the new RO any of additional information or concerns relating to the doctor's practice

7. Employment checks

Systems to ensure that appropriate pre-employment background checks are undertaken to confirm doctors who are starting with the Trust, have qualifications and are suitably skilled and knowledgably to under their professional duties, are covered by the Recruitment and Selection Policy and the "Recruitment and Selection – A Best Practice Guide".

For Agency Locum doctors who are identified as potential candidates to fill a shift which is live on the Locum Management System, the CV of potential candidate is sent to the Clinical Leads to review that the qualification, skills and training competencies of the candidate are suitable for the shift.

8. Conclusion

8.1 Review of actions from last year's annual revalidation report

- To continue and enhance the support for new doctors from abroad

All new starters are personally supported by the Revalidation Office upon commencement of employment. They are inducted into the appraisal process and are given an in-depth overview of the L2P system
The revalidation office offers further support with any other issues the doctor may have with their new employment and are guided as such to the relevant teams.

- continue to work with GMC in terms of workshops being hosted at NLaG

Workshops were hosted virtually during 2021 and more workshops are set up for October-November 2022. The revalidation assistant has a good working relationship with the GMC'S Regional Liaison Adviser who delivers workshops.

- Ensure that Mandatory Training is reviewed in a supportive way at medical appraisal

Doctors are reminded and encouraged to upload their mandatory training record to their appraisal and are advised that they can claim internal CPD for completing Mandatory Training.

- Trust to continue to work towards the 4 principles of effective medical governance

Within the previous annual report, the Trust committed to continuing to work towards the 4 principles of effective medical governance. Those four principles were:

1. Organisations create an environment which delivers effective clinical governance for doctors.
2. Clinical governance processes for doctors are managed and monitored with a view to continuous improvement.
3. Safeguards are in place to make sure clinical governance processes for doctors are fair and free from discrimination and bias.
4. Organisations deliver processes required to support medical revalidation and the evaluation of doctors' fitness to practice.

Contained within each of the four principles were clear outcome criteria that the Trust can map against to identify improvements and gaps.

The Trust undertook a self-assessment to benchmark against the above and to understand where the organisation could continually improve and identify any gaps to ensure this is a continual process of quality improvement. This is a continuing working document.

- Continue to train and retrain medical appraisers

Training event was done in November 2021 which was attended by 42 senior medical staff.

- Ensure NHS locum consultants who are doing CESR are including this in their appraisal and PDP

  Appraisers are reminded to ensure when scope of work is discussed, that CESR is brought up as part of the appraisal discussion.

- To ensure appraisal of paediatric work for medical staff who primarily see and treat adults. This would include Surgeons, Anaesthetists and Emergency Medicine medical staff.

  As part of the medical appraisal checklist which needs to be confirmed by doctors before submitting appraisal, doctors are prompted to confirm that they have undertaken CPD which relates to treatment of children.

8.2 Current issues and new actions

- To support the new reporting dashboard using POWER Bi for medical appraisal reporting
- To review the Medical Appraisal Procedure document which is due for review in February 2023.
- Continue to work with GMC in terms of workshops being hosted at NLaG
- Assist the Medical Leadership programme by ensuring that all new leaders and doctors who undertake the programme complete the medical leadership module on L2P.
- Continue to train and retrain medical appraisers. The budget to pay medical appraisers has since transferred from the operational groups to the Medical Director's Office. Within this budget, there is capacity for 55 appraisers and therefore there are currently 7 vacancies.
- From April 2023, no doctor will have a scheduled appraisal during the months of January, February and March. This will require step-by-step implementation to ensure doctors are given notice of their new appraisal month. There is a project plan in place as well as a communication strategy to ensure smooth operation. The Medical Director's Senior Management Team are regularly kept updated regarding this.
- MIAD Healthcare external review for quality assurance purposes of the revalidation service at NLaG.

8.3 Action from the Board

To ask the Board to accept the report noting it will be shared with the higher-level RO at NHS England and Improvement.

The Board, through the Chief Executive, are required to sign the 'Statement of compliance' at the end of the report confirming that the organisation is compliant with the RO regulations.

The approved annual report and signed statement of compliance will be submitted to NHSEI by the Responsible Officer's office.

Feedback and recommendations from the Board are also welcomed.

8.4 Statement of compliance

The Board of Northern Lincolnshire and Goole NHS Foundation Trust have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Chief Executive

Official name of designated body: Northern Lincolnshire and Goole NHS Foundation Trust

Name: Signed:

Role:

Date:

NLG(22)144

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	02 August 2022	
Director Lead	Christine Brereton – Director of People	
Contact Officer/Author	Liz Houchin – Freedom To Speak Up (FTSU) Guardian	
Title of the Report	**FTSU Q1 Report 2022-23**	
Purpose of the Report and Executive Summary (to include recommendations)	Report is the Q1 report and gives an update from last board, an overview of number of concerns raised, national and regional updates, the proactive work undertaken by the Trust's FTSU Guardian, and future plans for FTSU. It is for approval and assurance	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q1– April – June 2022

Liz Houchin
7th July 2022

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q1 2022-23 (which covers the period April –June 2022). Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

This paper satisfies the Trust Strategic Objective of 'Being a good employer', and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

3. Introduction / Background

3.1 The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement. The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

4. Assessment of FTSU Concerns Raised

4.1 In Q1 2022-23 the number of concerns received were 35.

- 3 concerns were raised anonymously in Q1.
- 53 concerns involved an element of patient safety (12 month rolling average). This puts the Trust in the mid- quartile nationally, the peer figure being 57 and the national median 49 (figures according to Model Hospital data)
- 17 concerns involved an element of bullying and harassment (12 month rolling average) which puts the Trust in the lowest quartile nationally, the peer figure being 31 and the national median being 36.

4.2 The Q1 figure of 35 is slightly higher than Q1 in 2021-22

4.3 The main themes raised were around behaviours, patient safety and process.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority of concerns were managed and

closed within 10 weeks. Any outstanding concerns are discussed monthly with the DOP /CEO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data ie HR information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified and interventions put in place where needed.

Q4. 2021-22 (January-March 2022)			**Q1. 2022-2023 (April – June 2022)**
Concerns	**38**		**35**
Themes	Behaviour / relationships	12	13
	Bullying & Harassment	7	7
	Culture	2	0
	Leadership	1	1
	Patient Safety	6	10
	Process/Systems	16	10
	Personal Grievance	0	0
	Worker Safety	5	9
	Staff Safety	0	Now reported in Worker Safety
How Raised	Openly	11	15
	Confidentially	27	17
	Anonymously	0	3
Perceived detriment		0	0

NB. Please note some concerns may have more than 1 element.

Report Breakdown by Division and Role.

Q4. 2021-2022 (January – March 2022)			Q1. 2022-2023 (April – June 2023)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor/ Dentist	3 x C&T 3 x Med 1 x S&CC 1 x Med Director	8	Doctor	1 x Medicine 2 x S&CC	3
Nurse	7 x Med 1 x W&C 2 x S&CC 1 x C&T 1 x CSS 1 x Chief Nurse	13	Nurse	1 x Medicine 1 x W&C 5 X S&CC 1 x C&T	8
HCA	3 x Med 1 x W&C 1 x People	5	HCA	2 x Medicine 1 x Bank	3
Midwife		0	Midwife		0
Admin	2 x CSS 1 x C&T 1 x Corporate 3 x S&CC	7	Admin	3 x COO 1 x Corporate 2 x S&CC 1 x Digital	7
AHP		0	AHP	3 x C&T 1 x Medicine 2 x S&CC	6

Other	2 x CSS 3 X C&T	5	Other	1 x E&F 2 x C&T 3 x COO	6

4.6 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback has been provided by staff that have spoken up and has been predominantly positive.

Quarter 2022-23	Feedback received	Would you speak up again? Yes
Q1	7	7
Q2		
Q3		
Q4		

Within the feedback received, the following are extracts of qualitative feedback received:

Liz, it has been a pleasure to have you involved with our concerns and help us see a way forward by opening the required dialogue with managers. Thank you again.

I thank you for listening and taking my concerns forward to the person that I thought should know.

Thank you for your efforts, really appreciated your input

4.7 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

FTSUG received an anonymous text message from a staff member stating that a member of their team had accessed a colleague's personal information on WEBV, FTSUG passed information onto Data Protection Officer, who investigated incident. Appropriate action was taken followed by discussion at SLC asking managers to remind colleagues about inappropriate access to clinical systems and potential consequences for staff and the Trust if this happens.

5. Regional and National Information and Data

5.1.1 National update

The National Guardian's Office reported 20,362 cases were brought to Guardians in 2021-22 (on a par with previous year)

All FTSU Guardians will have to take an annual competency test (new Guardians will also have a mentor). Trust FTSU Guardian has passed the test and has been accepted to become a mentor.

Q1 data for 2022-23 will be submitted to the NGO by the Guardian when the data collection period opens.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included the Ockenden report, the new Guardian training and how the NGO supports Guardians.

6. Proactive work of the FTSUG during Q1

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Health & Wellbeing Steering Group
- Attendance at Overseas Nurses Induction
- Walk Rounds at SGH with NED for FTSU and at DPOW with Trust Chair
- Walk rounds with Chaplaincy team at DPOW and SGH

Future Plans

- Work to define the future work of combined Champions to include Pride and Respect, FTSU and Health and Wellbeing is ongoing by the People Directorate
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian
- Attendance at all network meetings

7. Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

The Trust Board is asked to:

a) Note the report for assurance
b) Approve the report

Compiled By: Liz Houchin,
Date: 7th July 2022

Name of the Meeting	**Trust Board of Directors – Public Board**	
Date of the Meeting	2 August 2022	
Director Lead	Dr Kate Wood, Medical Director	
Contact Officer/Author	Dr Liz Evans – Guardian of Safe Working Jane Heaton – Associate Director, Strategic Medical Workforce	
Title of the Report	**Guardian of Safe Working Quarterly Report – Quarter 1**	
Purpose of the Report and Executive Summary (to include recommendations)	To note the quarterly report - for information	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: JDF
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
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Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Dr Liz Evans
Guardian of Safe Working
1st July 2022

1. Executive Summary

Exception reports for the quarter 1st April 2022 to 30th June 2022 saw a decrease from 89 to 43 exception reports in this quarter.

The majority of the exception reports submitted were in connection with working hours, with a small number also submitted around service support, educational opportunities and work patterns which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant Divisions/Directorates.

There is still on-going work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

Exception Reports

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	240.10
Number of Doctors/Dentists in Training (WTE)	198.03
Number of Less than full time (LTFT) Trainees (Headcount)	26
Number of Training post vacancies (WTE)	41.27

Source Finance data

During the period of this quarterly report (1st April 2022 to 30th June 2022) there have been a total of 43 exception reports submitted through the allocate exception report system.

This showed a decrease of 46 exception reports from the last quarter (1st January 2022 to 31st March 2022).

Of the 43 exception reports submitted, 35 of these were linked to hours. This showed a decrease of 42 report from the previous quarter.

The exception reports for this quarter relating to hours had been agreed by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL).

All of these exception reports have now been closed on the system as they have been actioned appropriately.

The below table is a breakdown of the exception reports over the last quarter (April 2022 – June 2022)

Exception Reports Open (ER) between 1st April 2022 – 30th June 2022	
Total number of exception reports received	43
Number relating to hours of work	35
Number relating to pattern of work	2
Number relating to educational opportunities	2
Number relating to service support available to the Doctor	4
Number initially relating to immediate patient safety concerns	0

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an immediate safety concerns (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st April 2022 and 30th June 2022	
Total number of exception reports resolved as at 30/06/2022*	50
Total number of exception reports unresolved as at 30/06/2022*	1
Total number of exception reports where TOIL was granted	29
Total number of exception reports where overtime was paid	12
Total number of exception reports resulting in a work schedule review	2
Total number of exception reports resulting in no further action	9
Total number of exception reports resulting in fines	0

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

2. Immediate Safety Concerns

During this quarter there were no exception reports submitted where the Doctors raised an immediate safety concern in addition to either a concern around working hours or clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

3. Work Schedule Reviews

During this quarter there were 2 work schedule reviews required. Both of these have been closed pending a further meeting with the heads of the departments involved to discuss ways of improving support to the doctors in training.

4. Trend in Exception Reporting

There has been a decrease in exception reports received this quarter. This is likely to reflect a lack of engagement from the doctors, rather than a lack of issues, and has been seen in previous years. This quarter showed, as the previous ¼ report had, exception reports relating to educational opportunities were again due to service delivery, for example doctors have reported difficulties in gaining assessments in clinics owing to a lack of consultant presence. This has been discussed with the head of PGME who is addressing the issue.

5. Fines Levied against Departments this quarter

During this quarter there were 0 fines levied against Departments.

6. Communication and Engagement

Work continues to look at the communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for a year, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF has been changed to lunchtime following consultation with some of the juniors at induction, which has had a positive impact on attendance. This is likely to change in the next few months, to improve the attendance from PGME.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. In addition, there is a regular quarterly newsletter which is circulated via e-mail. Information around the guardian office is available on the HUB.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, who commenced in this role in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated a decrease in comparison with the previous quarter. This is possibly due to a lack of engagement from the junior doctors. We will be ensuring that information is given during induction to ensure that people are aware of the reporting system.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise.

In summary, we appear to be in a positive position going forward.

Engagement of the Educational Supervisors remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned. Once engagement is improved it is likely we will see a rise in the exception reporting rate, which hopefully will reduce over time.

Dr Liz Evans - Guardian of Safe Working

Date: 1st July 2022

NLG(22)146

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	2 August 2022	
Director Lead	Simon Parkes, NED / Chair of Audit, Risk & Governance Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Audit, Risk & Governance Committee Minutes from 21 April 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 21 April and approved at its meeting on 10 June 2022	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: ARG Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Oversight of entire BAF process, completion and achievement.
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**21 April 2022** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Michael Whitworth	Vice Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Alison Hurley	Assistant Director of Corporate Services
	Mike Norman	External Audit – Auditor (Mazars)
	Helen Higgs	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Chris Boyne	Deputy Director / Internal Audit Manager (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Nicki Foley	Local Counter Fraud Specialist
	Nicola Parker	Assistant Director of Finance – Planning & Control (Item 5.2)
	Jug Johal	Director of Estates & Facilities (For Item 12.1)
	Bill Parkinson	Associate Director of Safety and Statutory Compliance (For Items 11.1 & 12.1)
	Sue Meakin	Data Protection Officer (Item 12.3)
	Ivan Pannell	Head of Procurement (Items 12.4 & 12.5)
	Rob Pickersgill	Governor Representative
	Anne Sprason	Directorate Admin Manager / PA to CFO (Minutes)

Item 1 04/22 **Apologies for Absence:**

Apologies received from Mark Surridge (Mazars) and Helen Harris (Alison Hurley deputising).

Item 2 04/22 **Declarations of Interests**

Simon Parkes asked if there were any additional declarations of interest not otherwise disclosed on the Trust Declaration system. None were advised.

Item 3 04/22 **Minutes of Previous Meetings**

3.1 The minutes from the meeting held on 24 February 2022 were agreed as an accurate record.

3.2 The Highlight Report from 24 February 2022 had been provided and noted. Simon Parkes advised that the Trust Board shared the Committee's concern of online abuse directed at payroll staff via NLAG staff Facebook group, as reported in the Highlight Report.

Item 5 04/22 **Matters Arising/Review of Action Log**

7.1 (22 07 21) – LCFS Induction Video – Michael Whitworth advised that this issue had been raised with the Executive Team and the Workforce Committee. It had been agreed that it would become part of the induction video but at this stage could not be tracked for compliance. Nicki Foley confirmed that she was involved in the working group but was unclear if it would be part of mandatory training. Michael Whitworth understood that it was to be mandatory and asked Nicki Foley to clarify and advise him if not. Close on Action Log.

Action: Nicki Foley

8.1 (21 10 21) – Offer of Support to LCFS – Links to item 7.1 above. Close on Action Log.

12.4 (21 10 21) – Document Control Report (People Directorate) - Simon Parkes advised that there was now some reduction in the number of outstanding documents and had heard from Christine Brereton, Director of People that these were being addressed. Close on Action Log.

6.2 (24 02 22) – External Audit Resource – updated position advised. Close on Action Log.

7.2 (24 02 22) – Internal Audit Follow-Up Report – Simon Parkes had written to Christine Brereton and the issues were being addressed. Close on Action Log.

9 (24 02 22) – Board Assurance Framework – Issue of High-Level Risk Register being brought to the ARG Committee. Concern had been expressed by Angie Legge (in Helen Harris' absence) that the Committee would review each risk to determine if appropriate action was being taken. Simon Parkes assured colleagues that the reason for the Committee's request was to ensure that risks were adequately managed across the organisation not the individual risks. This was accepted and once Helen Harris returned to work, Angie Legge would bring the TMB Highlight Report from the Risk Management Group to the Committee so that it can see the full risk register and the process on high level risks in terms of escalation.

10 (24 02 22) – Losses and Compensation Report – Issue of lost patients' property and impact on patient dignity. Lee Bond had raised the issue with the Executive Team who acknowledged that this could happen on busy wards. It had been agreed to include a review of PPM procedures and application at ward level within the Internal Audit plan for 2022/23. Lee Bond stated that it may not remove all instances but would keep it on the radar. Simon Parkes had also raised the concern at the Trust Board and Governors Assurance Group. Close on Action Log.

11.3 (24 02 22) – Salary Overpayment – Recovery Policy and Procedure – Simon Parkes had written to Christine Brereton on the removal of reference to disciplinary action for repeated non-compliance of actioning pay changes which the Committee had agreed should remain in place. A response was awaited and Simon Parkes will update at the next Committee meeting.

12.7 – Laundry Contract – Lee Bond advised that a one-year extension with Synergy had been signed in order to consider options in the meantime. There had been concerns about re-tendering following the first tender exercise. Harrogate had indicated they might be interested in a joint contract and consideration was also given to being included in the Hull contract which was due for renewal at the end of 2022; however, this would break contract rules. Hull and other organisations had been in

receipt of letters from Synergy concerning their inability to contain their costs given global pressures. Lee Bond stated that it was unclear how that could help with more conversations but would explore further with Edd James as necessary. Close on Action Log.

All other items were either included on the agenda or considered closed and following review, the action log was noted.

Item 5 04/22 **Annual Governance Issues**

5.1 Going Concern Report 2021/22

Nicola Parker presented the report which provided evidence regarding the Trust's status as a going concern. Simon Parkes stated that it looked uncontroversial. Lee Bond referred to section 5 which listed three basic scenarios for consideration suggesting that (iii) that the organisation was not a going concern could be excluded. He suggested that scenario (ii) raised questions *'uncertainties regarding future issues which should be disclosed in the accounts'…* in that there would always be uncertainties and would need to determine if those uncertainties were more or less than previously considered. Lee Bond added that the winding up of CCGs and the introduction of ICS's would mean more focus on system accountability and questioned if that meant more uncertainty. Lee Bond stated that scenario (i) "*The body is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis"* was therefore appropriate, Lee Bond asked the Committee if there was anything which they felt merited further disclosure in the accounts.

Gill Ponder agreed with Lee Bond adding that the organisation would still need to continue to serve the population over the next year. Lee Bond added that the Trust was absolutely a going concern, and that his questions was not about that but about whether there was a need to say anything further in the accounts to give context, adding that his view was that there was not but that he was interested in the view of the Committee.

Michael Whitworth did not think that there was anything material to disclose. Gill Ponder asked if the Annual Governance Statement gave sufficient context but did not think that any more disclosures were necessary, which the Committee members agreed. Robert Pickersgill asked if the BAF covered the issue as a risk and asked if Covid, current developments with Russia and post-Brexit, due to their unprecedented nature, required a separate comment, suggesting they may be worthy of comment.

Simon Parkes summarised the discussion that the Annual Accounts should be prepared on a going concern basis with acknowledgement that there were significant challenges and some unprecedented risks but there was nothing to say that the organisation was not a going concern, and in terms of the accounts there was no material uncertainty to disclose, so option 1 was appropriate. Simon Parkes suggested referring in the Annual Governance Statement and in the CEO statement to Rob Pickersgill's points so that the reader has a reasonable view of the Trust.

The recommendation to the Trust Board, endorsed by the Committee, was that the annual accounts should be prepared on a going concern basis.

5.2 Draft Annual Accounts 2021/22

Nicola Parker presented the draft accounts and had provided for ease of reference, a summary at the beginning of the paper which listed key points contained within the accounts. Nicola Parker took the Committee through the highlights of the Annual Accounts.

Simon Parkes thanked Nicola Parker and congratulated her for getting the draft accounts ready for review in April which was extraordinary and a significant achievement.

Lee Bond commented that the Trust had achieved a significant milestone this year, in that turnover had just tipped over £500m which was important to note, and he also thanked Nicola Parker and the Finance team on a fabulous job producing the draft accounts..

Rob Pickersgill commented that the main statement was confusing as there used to be a separate statement of recognised gains and suggested the derivation of adjusted financial performance was potentially confusing and asked if there was some way of making it clearer i.e. Adjusted financial performance showed £86k surplus and then Adjusted financial performance for system achievement was £43k surplus. Lee Bond was unsure if there was any latitude to add anything to the template to reflect this more clearly. Nicola Parker explained that the system achievement figure did not need to be declared and it was noted that in the monitoring returns the figure of £43k was shown which was the ICS achievement. Mike Norman agreed with Nicola Parker. Lee Bond suggested for full completeness it would be better to show how the position changed from £86k to £43k.

Simon Parkes agreed that the first statement should be £43k which gave a fuller story of the accounts.

Gill Ponder commented that it was a remarkably clear set of accounts and could tie back all the numbers seen to discussions through the year and the addition of the notes explained further. She found it very clear and all questions she may have had were answered within the notes. Michael Whitworth agreed that the notes were a helpful addition.

Simon Parkes queried the SALIX capital and asked if appropriate disclosure of the current state of the project and funding should be made, given uncertainty over completing the work. Nicola Parker referred to the assets under construction (note 16) and explained that the value included assets under construction and the £48m included outstanding PSDS and ED AAU and Ward 25. Nicola Parker added that additional bids would be submitted but the capital programme for 2022/23 was yet to be finalised so in her view did not need to be disclosed.

Simon Parkes stated that getting a very good set of accounts done early said a lot about good financial management and thanked again Nicola Parker and the team.

5.3 Draft Annual Governance Statement 2021/22 (AGS)

Alison Hurley presented the draft AGS and explained that further information was to be added including the Auditors' comments; the Executive Directors would add their final comments once the detail had been confirmed.

Gill Ponder asked that the Finance & Performance Committee (page 5) was written in full given it was to be in the public domain. She also referred to the staff survey (page 9) which she did not feel gave a true reflection of the disappointing results and the position the Trust was in, adding that it needed looking at as it currently made it sound as though everything was ok. Alison Hurley agreed to feed this back.

Simon Parkes added that it was necessary to be honest and straightforward about some of the Trust's challenges and agreed with Gill's comments on the staff survey results and asked if this could be strengthened to be more explicit.

Simon Parkes also thanked Alison Hurley and noted that it was very helpful to have sight of the document early, as with the annual accounts.

Simon Parkes also noted the number of abbreviations and suggested, for consistency, removing all abbreviations completely and write out in full.

Action: Allison Hurley

Lee Bond commented that in terms of challenges with recruitment and retention, he could question whether it triangulated with the BAF and risk registers, and why it was not more explicit in those documents, also adding whether that was an inconsistency with the AGS. Simon Parkes commented that there were challenges in these areas and that it was a fair point. Gill Ponder agreed and suggested that the wording within the documents could be revisited, but also noted that there was lots of good work going on and therefore it was necessary to get the balance right. Alison Hurley advised that the BAF was currently being updated with Directors for Q4 and would be looking to ensure consistency throughout.

5.4 Draft Head of Internal Audit Opinion 2020/21

Helen Higgs presented the draft Head of Internal Audit Opinion which was based on the work completed to date and provided '*significant assurance that there was a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently*'.

It was noted there were still some outstanding audits to be completed and incorporated into the report. One report had limited assurance.

It was agreed it was a positive report, noting however that there were still some areas with audit recommendations not being actioned, acknowledging that progress was being made but not enough or fast enough.

Simon Parkes commented that overall, it was a fair reflection over the course of the year, however in terms of overdue recommendations it would have been helpful to have as many cleared before sign-off of the financial statements. There was an opportunity to reduce that number before the final audit opinion was produced and would better reflect the progress being made. Lee Bond stated that a third of recommendations were overdue, and this was poor considering that managers agreed the recommendations and timescales for implementation with Internal Audit. Simon Parkes suggested it should be highlighted to Trust Board and he would write to Executive colleagues to ask for progress with overdue recommendations over the next few weeks to clear more before the final Head of Internal Audit Opinion was issued.

Action: Simon Parkes

Item 6 04/22 **External Audit (Mazars)**

6.1 Progress Report

Mike Norman presented the report and highlighted issues to note, including that no significant matters had arisen from the planned interim audit work that needed to be highlighted to the Committee and that they expected to complete the audit as planned and report findings to the ARG Committee meeting in June, following the main audit of the accounts which would commence the following week.

The significant risks remained the same as those contained within the Audit Strategy Memorandum (ASM) presented to the Committee in February 2022 including land and buildings; the Trust were still waiting on the full valuation report from the District Valuer, although this was only a timing issue and sufficient information had been received to be able to prepare the accounts. Other significant risks included the change to the core financial accounting system in-year and Mazars IT colleagues had completed their audit work with a small number of observations regarding governance but there was nothing significant required to be raised with the Committee. There were no additional significant risks with VFM.

Mike Norman also referred to the national publications (pages 11onwards) and highlighted specifically item 12 (page 17) which the HFMA thought would be useful for Non-Executive Directors and lay members to consider when reviewing annual reports and accounts. Robert Pickersgill asked if a copy could be obtained and supplied to him. Mike Norman this was in the public domain on the HFMA website and Sally Stevenson agreed to circulate it.

Action: Sally Stevenson

Simon Parkes thanked Mike Norman for his update and asked if he was confident that sufficient resources were in place within the Mazars team to deliver their work by June. Mike Norman confirmed that he was confident that the audit programme would be delivered to the required timetable, adding that there was also continuity between last year's team and this.

Item 7 04/22 **Internal Audit (Audit Yorkshire)**

7.1 Internal Audit Progress Report

Chris Boyne, Deputy Director at Audit Yorkshire and Internal Audit Manager assigned to NLAG, introduced himself to the Committee and explained that he had taken over from Tom Watson and thanked Danielle Hodson, Assistant Internal Audit Manager (Audit Yorkshire) and Sally Stevenson for their support during the interim period.

Chris Boyne presented the report, advising that good progress had been made and highlighted that five audit reports had been finalised since the last meeting,. four with significant assurance ratings and one high assurance.

Lee Bond referred to the Core Financial Systems audit and noted the change over to the new ledger system during Month 9 and asked how the system was measuring up. Chris Boyne explained that the initial findings were positive and that it looked well controlled. One recommendation related to the procedures needing to be aligned to the new financial system and those were being addressed.

Simon Parkes referred to the payroll findings and discussions held at previous meetings of managers not taking prompt action in reporting payroll changes, which could clearly be seen in the audit report; specifically noting significant overpayments and three people not being paid in the month they commenced due to late information. He commented that this reinforced the discussion on not removing the possible use of disciplinary action if managers repeatedly failed to inform payroll of changes in a timely manner. It was agreed to highlight to the Trust Board.

Simon Parkes commented that other recommendations seemed broadly sensible and was pleased to note the new general ledger transition had gone well but would be interested to get final confirmation of that.

Gill Ponder stated that the Trust should be congratulated on the number of significant assurance ratings received over the year, which evidenced that the controls in place were effective and suggested this should be highlighted to the Trust Board. Governance arrangements and control mechanisms were clearly working well but, as discussed previously, overpayments and clearing of actions remained an issue.

Gill Ponder referred to the serious incident reporting audit and the change to the system and the significant assurance given with minor recommendations. Gill acknowledged that the definitions of a serious incident were nationally determined, and not within the Trust's gift to redefine, but would hope that any feedback given would be considered nationally.

Simon Parkes referred to the Mental Health Act Follow up recommendations audit and noted that all actions from the previous report had been completed and received a high opinion. Simon Parkes commented that those involved should be congratulated on completing those actions and it should be noted.

In respect of the BAF it was noted that some discussions had already taken place within the meeting and Gill Ponder queried if there were any organisations with exemplar BAF documents that the Committee could consider for any additional opportunities to improve the BAF. Chris Boyne confirmed he could facilitate sharing of work across the area. Alison Hurley suggested that such exemplar documents would form part of the BAF Board Development event scheduled for 5 July 2022.

Simon Parkes highlighted that he had discussed previously with Helen Harris the need for an up to date assurance map to identify and map assurance across the organisation and he would pick this up with Helen Harris on her return and bring back to the Committee for consideration. Simon Parkes added that this was a good thing to develop, in order to provide the Board with appropriate assurance.

Action: Simon Parkes / Helen Harris

Simon Parkes referred to a divergence of views between Executives and Non-Executives as to whether the BAF delivered its intended aims, stating that the Executives were more positive about it than the NED's and that this needed to be addressed

The request for the high-level risk register to be shared with the Committee was discussed. Lee Bond noted there had been some reluctance to share the risk register and asked where that reluctance was from. Simon Parkes explained that there was concern as to what the Committee were going to do with it and he had undertaken a meeting to resolve those concerns, and suggested speaking with Lee Bond outside of the meeting to discuss further.

Action: Simon Parkes / Lee Bond

Gill Ponder commented there seemed to be a discrepancy with some known risks not appearing on the BAF adding that long standing or high rated risks should be included and suggested there could still be gaps and that may be a reason to look at doing it differently in the future.

Rob Pickersgill stated that the Governors had asked to look at the BAF in more detail. They had also shown an interest in mitigation item; the timely notification of changes to Payroll, notwithstanding all the good work going on; and Medical staff job planning. These were areas where Governors were interested in seeking more assurance. In response Simon Parkes commented that the Committee will keep working on getting appropriate assurances.

7.2 Internal Audit Recommendations Follow-up – Status Report

Chris Boyne presented the report and highlighted the main issue related to 42 overdue recommendations; some of which were two years overdue. He acknowledged ongoing operational pressures and the impact of Covid but an action date for completion was agreed with managers so it was a concern, including regulatory interest, so would want to move those overdue recommendations along as soon as possible. Chris Boyne thanked the Committee for their support with this.

Helen Higgs suggested that as the overdue recommendations numbers were quite high there could be some that were no longer relevant or now out of date and suggested a separate piece of work to reflect on them. Simon Parkes agreed it would be sensible to determine if still relevant or valid but added that the deadlines were set and agreed by management and should be realistic and achievable.

Lee Bond also commented that when thinking about some of his Finance recommendations there were some that if taken to the letter were complete, but at the same time that may well not be in the spirit of the recommendation. Simon Parkes agreed with Lee Bond's comment that the actions should be done properly and in the spirit of the recommendation rather than the bare minimum to be able to sign them off. Lee Bond asked if the report could be sent to him in Word format for further review.

Action: Chris Boyne

7.3 Insight Technical Updates Report

The report was provided for information and noted.

7.4 Draft Internal Audit Plan 2022/23

Chris Boyne advised the Committee that planning had commenced on the IA plan for 2022/23 back in January through discussions with Trust Board members. A resulting long list had then been whittled down by the Executive Team resulting in the paper being presented.

Lee Bond explained that the draft plan had been reviewed by the Executive Team on 12 April and again on 19 April 2022 for further refinement, to come up with a risk based plan.

Chris Boyne highlighted that the report presented included those audits that were included within the 2022/23 audit programme and those that had been removed from the long list of original suggestions with suggestions of when they could possibly be done. There was some flexibility within the plan for any changes required throughout the programme, and Chris Boyne commented that some of the audit days assigned to

individual audits may need to be flexed accordingly, but would discuss with Lee Bond / ARG Committee as necessary if that proved to be the case.

Gill Ponder commented that something which was not in the IA plan but was a question that was often asked by CQC was around the integrity of the data that was included within reports, particularly in relation to performance and how the Trust knew its data was robust. Lee Bond agreed and suggested data quality should be included within the plan, and Simon Parkes agreed. It was agreed that Lee Bond would speak with Internal Audit outside of the meeting to see if a DQ audit could be included in the plan.

Action: Lee Bond / Internal Audit

Chris Boyne stated that Internal Audit do look generally at data quality during audits. Simon Parkes said it would be helpful to put a specific data quality area audit in the plan each year. Simon Parkes also suggested that there may be occasions where a formal audit review was not required but could be dealt with by an invite to the Audit, Risk & Governance Committee.

A discussion was held on the merit of having an annual data quality audit feature in the plan and rotate the areas for focus and Simon Parkes suggested that workforce metrics could be the first and then performance data as part of that rotation of areas. Gill Ponder commented that as the CQC were expected imminently it could be helpful to say there was a programme of focus in place, on a rotating basis and data quality was included within that. It was agreed that an annual data quality audit would feature going forward and the focus of areas would be rotated as necessary.

Following review, the report was noted.

Item 8 04/22 **Counter Fraud**

8.1 LCFS Progress Report

Nicki Foley presented the report and highlighted areas to note, including the National Fraud Initiative (NFI) exercise 2020/21 which had identified £7k of duplicate payments in three invoices; now being recovered.

An NFI payroll match report also identified four concerns of possible working elsewhere whilst off sick. Nicki Foley also explained off the back of another NFI report identifying possible secondary employment, subsequently established to have not been declared to the Trust, she had alerted the relevant managers to enable them to have the necessary conversations about secondary employment with those individuals. As a result of the exercise, contact with the LCFS had been made by two Consultants to discuss their secondary employment which had given the LCFS an opportunity to reiterate the reasons for the declarations needing to be made; both Consultants advised they would disseminate the information to their clinical colleagues.

Nicki Foley highlighted the newly developed counter fraud outcome based metrics, which due to the limitations of the previous national case management system resulted in not being able to record outcomes from other fraud activities e.g. value of fraud prevented or proactive exercises. This was also a requirement of the Counter Fraud Functional Standards to have outcome based metrics in place. Work had been ongoing in the CFP team to develop a set of metrics to collate and routinely report to the ARG Committee. The year-end position had been provided within the report at Appendix 2 as an initial view and would evolve and be adapted as necessary throughout the year.

Nicki Foley highlighted that there had been three new cases since the last meeting.

Simon Parkes raised the ongoing issue of employees working elsewhere whilst off sick. Nicki Foley explained that it was not unique to NLAG and was one of the biggest issues nationally and the CFP team were constantly raising awareness of this area, noting that including fraud awareness within mandatory training would be key to highlighting such issues to new members of staff.

Following review, the report was noted.

8.2 Counter Fraud Operational Plan 2022/23

The Counter Fraud Operational Plan, which came into effect on 1 April 2022, had been provided for information and Nicki Foley highlighted the key principles of counter fraud work including the ongoing piece of work around the fraud risk assessment. Each risk would be assigned an owner and be monitored and managed accordingly, and it was envisaged that this work would be completed over the coming year.

Simon Parkes was impressed with the level of proactive focus on fraud prevention and mitigating fraud risks and agreed that every risk should have an owner. Simon Parkes commented that there was a lot of good work that other organisations he had experience of, could learn from in terms of proactively managing fraud risks and he had not seen anything of this level anywhere else.

Simon Parkes thanked Nicki Foley for presenting the operational plan, and the report was duly noted.

8.3 Local Counter Fraud, Bribery and Corruption Policy and Response Plan

Nicki Foley presented the policy following its annual review which had resulted in only one minor change at section 8.11 regarding the title change from Fraud Champion to Counter Fraud Champion.

The ARG Committee approved the minor amendment.

Item 9 04/22 **Board Assurance Framework and Strategic Risk Register**

Simon Parkes noted that the risk register would be brought to the Committee in future to ensure an overview of the risks and sources of assurance to inform the work of the ARG Committee to advise the Trust Board accordingly. It was not intended to focus on the operational management of risks but to ensure comprehensive risk identification and appropriate documentation in place to support that from an oversight perspective, which the Committee agreed.

Item 10 04/22 **Losses and Compensations Report**

Lee Bond presented the 2021/22 report which included a summary of two financial years i.e. 19/20 and 20/21 and identified that losses, compensation, and special payments were higher than the two previous financial years. The main driver was bad debt write-offs relating to Overseas Visitors which totalled circa £270k for the year. Lee Bond asked Sally Stevenson to determine the method of admission to understand if elective or emergency admissions.

Action: Sally Stevenson

There was also an increase in the amount of personal properly claims, including loss of dentures which had been discussed at previous ARG meetings and it had been agreed to undertake an audit review. It was acknowledged that it had been difficult over the last couple of years with the number of ward moves, which may be offered as mitigation, but numbers had increased considerably compared to previous years.

Simon Parkes stated that he would be interested in feedback at the next meeting on the overseas visitors to understand it there were any issues around process or something that was not being done. The pharmacy waste due to a fridge door being left open was frustrating, but understandable as, depending on what was in the fridge, it could compromise patient safety.

Following review, the report was noted.

Item 11 04/22 **Management Reports for Assurance – Items for Approval**

The next two items were taken out of sequence.

11.2 Standards of Business Conduct Policy and Associated Documents

Alison Hurley presented the report which had been reviewed and amended with changes tracked for ease of reference. The policy had been streamlined following requests to make it more concise and the amendments also aligned with the new Electronic Declaration of Interest system. Also included within the document was clarification that three declarations (including nil returns) on appointment were required annually by employees if they were decision makers.

The Committee reviewed the document and approved the amendments.

11.1 Annual Health and Safety Policy Statement

Bill Parkinson attended the meeting to present the Annual Health & Safety Policy Statement and advised that only minor amendments had been made and were highlighted in yellow for ease of reference. The Committee approved for submission to the Trust Board.

Item 12 04/22 **Management Reports for Assurance**

12.1 HSE Investigation Update

Jug Johal attended the ARG Committee to present an update on the HSE Investigation which had been ongoing for seven years and gave brief background information for new members. Bill Parkinson had been the main point of contact for the investigation and he highlighted the six improvement notices issued for each site.

At this point Bill Parkinson lost MS Teams connectivity to the meeting and it was agreed to continue with the next item.

12.2 Quarterly Document Control Report

Alison Hurley presented the report and highlighted that no documents were out of date from before 2021, with a compliance rate now of 97.7%. Alison Hurley thanked the Divisions and Directorates for their continued support and advised that a regular review of documents was now business as usual.

The good progress made was noted as a big step forward by the Committee.

12.6 Salary Overpayments Report

Sally Stevenson presented the report and highlighted the significant decrease of £111k in the value of overpayments in Q4 of 2021/22. There was also a slight reduction on the annual figures.

Lee Bond stated that there were still some areas that were in direct control of Finance e.g. errors made by the Payroll team. He commented that if looked at the total value of salary payments made the overpayments were very small and the Payroll team should be congratulated but compared to the number of errors i.e. 41 that equated to almost one a week.

Sally Stevenson stated that the Payroll team should be congratulated as they were under enormous pressure with resource issues and the number of initiatives put on them to process at short notice and they were made to feel undervalued in the work they were doing but kept going and she was enormously proud of them. Sally Stevenson highlighted to the Committee the % of monthly salary payments made and the low error rate in that regard. The Trust was also not an outlier compared to other Trusts in the benchmarking data compiled by Audit Yorkshire (previously circulated to the Committee).Sally Stevenson also added that ESR manager self service did not help as digital does not necessarily make things better – managers who don't complete paper forms are not suddenly going to start completing the information electronically either.

Robert Pickersgill referred to page 5 of the report and the analysis and the cause seemed to be dominated by late notifications from managers but acknowledged the pressures within the Operational divisions. Lee Bond commented that the organisation still needed to follow proper process and in a timely manner to ensure that staff were paid correctly.

Gill Ponder suggested that the error rate was quite high and if other systems were not helping whether an action plan should be put together to raise the profile of timely management information. Sally Stevenson explained that regular monthly items featured in the Wednesday Weekly News from the Comms team, and Hub posts, and was working with the Comms Team to see if anything else could be done.

Simon Parkes acknowledged that it was enormously frustrating for staff when errors to their pay. Similarly, it was necessary to allow sufficient time to implement new pay initiatives properly otherwise if things were done too quickly then the error rate could increase as a result. It was suggested that it should be escalated to the Trust Board to stress the need for managers to take appropriate action promptly and also to consider if there was any more that could be done to reduce the risk of errors.

Bill Parkinson re-joined the meeting to continue presenting item 12.1.

12.1 (cont'd) Bill Parkinson advised the Committee of the six improvement notices that had been served for each site, noting the risk assessments for each site took approximately 3-4 months to complete. The improvement notices were signed off in 2016. There had been no further contact from the HSE since September 2020, but work continued with the water systems included as part of capital schemes. Bill Parkinson also explained the process involving the Coroner.

Gill Ponder asked if the Trust could be confident that everything had been done and the organisation was now compliant. Bill Parkinson stated yes and explained the work that had been undertaken which had seen very few positive legionella samples over the previous 5-years and now have one of the best systems around.

Rob Pickersgill noted that there were different systems for drinking water, showers etc. and Bill Parkinson explained that the drinking water from bore holes was monitored by the Council. In terms of the showers all shower heads were replaced every three months which had resulted in only a handful of positive samples; the Trust also had 92% compliance on water flushing. Jug Johal highlighted that over sampling was undertaken due to the age of the infrastructure and added that the shower heads were thrown away when replaced and not reused.

Simon Parkes commented that it was a balanced report and frustrating that it still dragged on and to let the Committee/Trust Board know if any help was needed. It was clear that the Trust was working hard to minimise the risks. Simon Parkes thanked Bill Parkinson for presenting the report.

12.3 IG Steering Group Highlight Report

Sue Meakin presented the report and highlighted the DSPT audit (Stage 1) was being undertaken by Internal Audit with a meeting with the Internal Auditors taking place the following week. Sue Meakin advised that it was very quiet on the ICO front at present and commented that there was a lot of work going on to integrate the IG teams across NLAG and HUTH. Work was commencing across the region with ICS and ICP. In terms of IG training this was currently around 90% but a final push to increase that figure to 95% was being undertaken by the teams.

Simon Parkes referred to the consistent level of 48-50 IG incidents and asked if there were any themes and Sue Meakin explained that this was the first report from the new ULYSEES system and trends were being considered with clinical records, noting that it was quite easy to click on the consent button and was trying to iron out those issues. A recent exercise had been undertaken and more detail would be included in the report next month.

Sue Meakin was thanked for the update and she left the meeting.

12.4 Waiving of Standing Orders Report

Ivan Pannell joined the meeting and advised that the waiver numbers were standard for the month noting there were some of high value, but the Trust had received significant capital funding on the digital front.

12.5 Contract Progress Report

Ivan Pannell highlighted that not as much progress had been made as he would have liked over the last couple of months, but they had been implementing the new e-Procurement system. Simon Parkes acknowledged the work on the new system and commented that he understood it was challenging but that it would be good to make further progress on the contracts in the coming months. Ivan Pannell explained that a Procurement Director, Edd James, had been appointed across the ICS who was looking at procurement functions across the three acute Trusts. He would be looking for opportunities for joint working where possible and higher value contracts which may lend themselves to working more closely with other Trusts, as well as the future model of how procurement had the potential to work centrally. Ivan Pannell stated that he was optimistic about potential future developments, and he believed that it would help NLAG.

Ivan Pannell was thanked for the updates and he left the meeting.

12.7 Hospitality and Sponsorship Declarations

Alison Hurley presented the report to highlight the progress on the electronic Register of Interests system and explained reconciliation with ESR data was ongoing with help from Digital Services, in order to establish a robust cohort of decision-making staff but it had been more difficult than originally anticipated in terms of identifying these staff.

Alison Hurley highlighted that only 30% of the decision-making staff cohort identified so far had completed the general DOI, when all should have completed this, as well as declaring any secondary employment or gifts if required. Alison Hurley informed the Committee that she had attended the JLNC, Divisional Board meetings and other meetings to discuss these requirements and provide support. Communications to staff via the Wednesday Weekly News, HUB updates and contacting individuals where there appeared to be a gap, were some of the approaches taken to address the gap in submissions.

Gill Ponder noted that she had declared an interest which appeared twice, which Alison Hurley agreed to review.

Action: Alison Hurley

Sally Stevenson noted that in the past the report included the value of sponsorship / gifts and questioned if it had been a conscious decision not to include that. Alison Hurley explained that the report was being developed and would add that information in.

It was agreed to add to the highlight report that a small proportion of the number of declared interests and to ask for a push from the Exec Directors to staff.

12.8 LSMS Annual Work Plan 2022/23 – for Information

The LSMS Annual Work Plan was provided for information and noted.

Item 13 04/22 **Action Logs and Highlight Reports from other sub-committees.**

Actions Logs and Highlight reports were provided from the following sub-committees:

13.1 – Finance & Performance Committee
13.2 – Quality & Safety Committee
13.3 – Workforce Committee
13.4 – Health Tree Foundation Committee
13.5 – RATS Committee
13.7 – Strategic Development Committee

There were no questions raised and the reports were noted.

13.6 – Ethics Committee – No meeting had taken place

Item 14 04/22 **Private Agenda Items**

There were no private items for discussion.

Item 15 04/22 **Any Other Business**

15.1 Any Other Urgent Business

There was no other urgent business raised.

15.2 ARG Committee Annual Workplan – Proposed Revisions

Gill Ponder noted that procurement had been added to the Finance & Performance Committee workplan to review progress of the service and did not want an overlap or duplication.

Sally Stevenson noted that the BAF was shown as being presented to this meeting but as it was only being updated for Q4 queried whether it should be presented at the June or July 2022 meeting. The Committee agreed the Q4 report should go to the June meeting and then Q1 to July.

12.25am *At this point the Internal and External Audit representatives left the meeting to allow for a private discussion on the next item.*

15.3 Results of IA Service Tender Exercise – for Approval

Sally Stevenson presented the paper, as Lee Bond had had to leave the meeting, which set out the analysis of the tender exercise which resulted in a recommendation for the contract to be awarded to Audit Yorkshire for a further three years with an option to extend. A comprehensive panel evaluation meeting took place to reach that conclusion.

Gill Ponder stated she was more than content to continue with Audit Yorkshire as they had done a good job; Michael Whitworth and Simon Parkes were also content with the decision and Simon Parkes thanked colleagues who contributed to the exercise.

Sally Stevenson explained that all bidders would be contacted the following day to advise of the outcome, a voluntary ten-day standstill period would commence, following which the contract would commence on 1 June 2022.

Item 16 04/22 **Matters for Escalation to the Trust Board**

The following items were agreed to be escalated to the Trust Board.

- Going Concern Report 2021/22
- Draft Annual Accounts 2021/22
- Draft Annual Governance Statement 2021/22
- Draft Head of Internal audit Opinion 2021/22
- Internal Audit Progress Report
- Annual Health and Safety Policy Statement
- Salary Overpayments Report
- Declarations of Interest
- Internal Audit Tender Outcome

Item 17 04/22 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues to highlight to other Trust Board Assurance Committees

Item 18 04/22 **Review of the Meeting.**

It was noted that having a scheduled break was helpful. It had been a big agenda and had managed to get through an incredible amount.

Item 20 04/22 **Date and Time of the next full meeting**

The next meeting was scheduled as follows:

Friday, 10 June 2022 – 12.30pm-2.00pm via Microsoft Teams. This meeting was to review the audited financial accounts and year end documents only.

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	2 August 2022
Director Lead	Simon Parkes, NED / Chair of Audit, Risk & Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Audit, Risk & Governance Committee Annual Report 2021/22**
Purpose of the Report and Executive Summary (to include recommendations)	The annual report summarises the key work of the Audit, Risk & Governance Committee during 2021/22. It contains details of membership and attendance at each meeting throughout the year, the principal areas of review undertaken by the Committee in terms of governance, risk management and internal control. Appendix 1 details attendees at meetings, either members, regular attendees or ad-hoc attendees. Appendix 2 is the committee's annual rolling work plan for 2022/23. The report is presented to both the Trust Board and the Council of Governors for information. The Trust Board is asked to note the annual report from the Audit, Risk & Governance Committee.
Background Information and/or Supporting Document(s) (if applicable)	HFMA Audit Committee Handbook 2018
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: June 2022 ARG Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Oversight of entire BAF process, completion and achievement
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable

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

Northern Lincolnshire and Goole NHS Foundation Trust

AUDIT, RISK AND GOVERNANCE COMMITTEE

ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2022

Simon Parkes – Non-Executive Director
Chair of Audit, Risk and Governance Committee

10 June 2022

1. Introduction and Purpose of the Report

The Audit, Risk and Governance Committee of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is established under Trust Board delegation with approved terms of reference that are aligned with the latest Audit Committee Handbook (2018), as published by the Healthcare Financial Management Association (HFMA) in association with the Department of Health and Social Care. The Audit, Risk and Governance Committee independently reviews, monitors and reports to the Board on the effectiveness of control systems and financial reporting processes.

This report sets out how the Committee has satisfied its terms of reference during 2021/22 and provides the Board with assurance to underpin its responsibilities for the Annual Governance Statement (AGS).

2. Terms of Reference

The Membership and Terms of Reference for the Committee are subject to regular review and revision as necessary, most recently in February 2022. The April 2022 Trust Board subsequently ratified the revised terms of reference for a further year. The terms of reference will be reviewed again during 2022/23 in line with the Committee's annual work plan to consider whether they remain fit for purpose. The Committee also revisited and re-approved adjustments to its rolling 2021/22 annual work plan during the year.

In terms of the impact of Covid-19 on the Committee's business, additions were made to the terms of reference of the Committee in April 2020 in order to: reduce physical attendance at meetings; make the frequency of meetings flexible and responsive; add to its responsibilities the oversight of the new temporary governance arrangements proposed for the Trust; manage the relationship with both the External and Internal Audit services appropriately; increase the emphasis on counter fraud and anti-theft preparedness; focus on the changing risks in the Board Assurance Framework; and undertake a risk-based review of the Committee's Work Plan. The additional provisions were included as an annex to the existing terms of reference and remain within the current document to enable them to be invoked with the explicit discretion of the Trust Board as necessary going forward.

As part of the Committee's regular review of its own governance arrangements, it undertook a self-assessment exercise in January 2022 using the latest HFMA NHS Audit Committee Handbook self-assessment checklist. This exercise did not identify any gaps in the Committee's processes or terms of reference. The results of this latest exercise were submitted to the Trust Board for information in April 2022.

3. Membership and Attendance

The Committee consists of three non-executive directors (NEDs), of which two must be present at a meeting of the Committee for it to be quorate. The Committee has been chaired by Simon Parkes, NED, since October 2021, having previously been chaired by Andrew Smith, NED, from February 2021 to July 2021. In the absence of Andrew Smith, the August 2021 meeting was Chaired by Michael Whitworth (Vice Chair / NED). NED members during the year were Michael Whitworth (Vice Chair), Gill Ponder and Neil Gammon (who ended his term at the April 2021 meeting). An Associate NED, Stuart Hall (Vice Chair at Hull University Teaching Hospitals NHS Trust), also attended the Committee in the early part of 2021/22, but ceased after becoming Acting Trust Chair at HUTH. There is cross NED membership with other Trust Board sub-committees.

The Committee continued to meet virtually via MS Teams throughout 2021/22. The virtual meeting format has continued to work well, having been adopted at the on-set of the Covid-19 pandemic in 2020, with ad-hoc attendees dialling in only for their item in line with their allocated time slot.

The Committee met on six occasions during 2021/22 - four full meetings plus an additional meeting for the audited accounts to be approved and an extraordinary meeting to receive the External Auditors Annual Report in order to issue the Audit Certificate for inclusion in the Trust's Annual Report. The Committee has discharged its responsibilities for scrutinising risks and controls that affect all aspects of the Trust's business.

A record of attendance by Committee members and regular attendees is provided at **Appendix 1**. The record shows excellent attendance from both core members and regular attendees, with a good cross section of other officers attending on an ad-hoc basis to provide assurance to the Committee on various matters as and when necessary.

4. Principal Review Areas

4.1 Governance, Risk Management and Internal Control

During 2021/22 the Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS), the Head of Internal Audit Opinion (HoIAO), External Audit opinion and other appropriate independent assurances. The Committee considers that the AGS for 2021/22 is consistent with the Committee's view on the Trust's system of internal control.

The Committee received regular reports during the year on the Trust's Board Assurance Framework and Strategic Risk Register (BAF/SRR). The Committee also reviewed and commented on certain risks and their associated scores contained within it.

4.2 Internal Audit

The Trust's internal audit service is provided by Audit Yorkshire, who replaced KPMG on 1 June 2018, following a competitive procurement exercise in early 2018. The contract for the internal audit service was for a period of three years, with the option to extend for a fourth and final year. The extension option was discussed and approved at the October 2020 meeting of the Committee, meaning that 2021/22 was the fourth and final year of the contract. As a result, a further competitive procurement exercise commenced in January 2022 to award a new contract commencing 1 June 2022. This process concluded in April 2022 with Audit Yorkshire being awarded a new three year contract, commencing with the 2022/23 financial year, with the option to extend for a fourth and final year. An agreed Internal Audit Charter is in place with Audit Yorkshire.

The Committee received the Annual Internal Audit Report for 2020/21 from its internal auditors at its June 2021 meeting.

An internal audit plan was considered and agreed for 2021/22 at the April 2021 meeting of the Committee. As in previous years, the Committee has sought to work effectively with Internal Audit throughout the year to review, assess and develop internal control processes as necessary. The Committee reviewed progress against the agreed internal audit work plan for 2021/22 via routine written progress reports from its internal auditor at each meeting, at which an internal audit representative was always present. Written progress reports outline the

status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate.

During 2021/22 Internal Audit completed 18 reviews, of which 2 were pieces of advisory/benchmarking work and an assurance rating not applied. Assurance ratings, as to the adequacy and effectiveness of control arrangements in place, for the remaining 16 reviews were as follows:

- 2 reviews with High Assurance rating;
- 13 reviews with Significant Assurance rating (2 reports at draft stage);
- 1 reviews with Limited Assurance rating;
- 0 with Low Assurance rating.

The 2021/22 Head of Internal Audit Opinion was also received by the Committee which gave an overall opinion as follows: ***Significant assurance*** *can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently*. The 2021/22 HoIAO is included within the AGS, which forms part of the Trust's Annual Report.

The Trust also formulated its annual internal audit plan for 2022/23. The Executive Team provided suggestions for the plan and these were then discussed further between themselves and refined into a programme of audits for the forthcoming year, in line with the allotted 200 day annual internal audit plan. The proposed internal audit plan for 2022/23 was presented to the April 2022 meeting of the Committee for consideration and approval.

Audit Yorkshire operates an electronic follow-up process for all recommendations made, which involves the relevant managers receiving automated prompts to provide periodic updates and evidence, via the electronic system, on the implementation status of recommendations, including those considered to be closed. A routine report is prepared by Audit Yorkshire to show the status of recommendations made, and this is presented to each meeting of the Committee for assurance or the consideration of further action as appropriate. Long overdue recommendations were a source of concern for the Committee during the year and as such escalated the issue to the Trust Board (from ARGC meetings in July 2021 and April 2022) and also directly to the Executive Team via the Chief Financial Officer. A much improved position was reported to the Committee by Internal Audit at the June 2022 meeting, and is duly reflected in the final HoIAO. The Committee will continue to routinely monitor the implementation of audit recommendations over the coming year.

4.3 Counter Fraud

The Audit, Risk and Governance Committee continued to receive regular written progress reports from the Trust's Local Counter Fraud Specialist (LCFS) throughout the year. Additionally, the Annual Counter Fraud Report for 2020/21 and the Annual Counter Fraud Operational Plan for 2021/22 were also submitted to the Committee during the reporting year.

The LCFS continues working to develop a strong anti-fraud culture, whilst at the same time investigating allegations of fraud to a criminal standard. The LCFS also continued to liaise effectively with the Trust's Human Resources team with a view to applying appropriate internal disciplinary and sanctions as necessary. The Committee was impressed by the level of counter fraud activities performed by the LCFS over the reporting year.

The Trust continues to host and manage an in-house counter fraud collaborative, known as Counter Fraud Plus (CFP) between itself, Doncaster and Bassetlaw Teaching Hospitals NHS

Foundation Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS). This collaborative arrangement commenced in July 2013 (with LPFT and LCHS joining in September 2020) under a formal SLA arrangement. It is designed to provide a more resilient counter fraud service between the organisations involved. The Committee has received reports that the collaborative continues to work effectively and successfully across all five local organisations.

4.4 External Audit

The Trust appointed its current External Auditor, Mazars, in September 2019 following a competitive tendering exercise. The Committee duly supported the Council of Governors with the appointment process. The existing contract is for a term of three years, with the option to extend for a further year, and commenced with the audit of the Trust's financial statements for 2019/20. At the beginning of 2022, the extension option was duly being considered and a fee for the extension year was requested in order to allow the February 2022 meeting of the Committee to make an informed decision on recommending the option year be taken up, to the Council of Governors.

However, upon requesting details of the fee Mazars advised it may not be able to resource and deliver the 2022/23 financial statements audit following a number of retirements and other staff losses within the firm, and felt it only right and proper to inform the Trust of this potential risk to delivery should the extension year be taken up [by the Trust]. To mitigate that risk, the Trust believed it necessary to retender for an external audit partner, a position endorsed by the Committee and approved by the Council of Governors in April 2022.

A tender process will commence in early July 2022 (once potential External Audit service providers have concluded their busiest period of NHS year end work) in order to have a new contract in place for Autumn 2022, commencing with work on the 2022/23 public disclosure statements. As in previous tender exercises for external audit services, a sub-committee of the Council of Governors will be convened. This sub-committee will be supported in the tender process by appropriate advisors from the Audit, Risk and Governance Committee and members of the Finance and Procurement team. A recommendation will then be made from the sub-committee to the full Council of Governors for it to approve the appointment of external auditors, following the competitive tendering exercise.

The Trust's External Auditor attended all meetings of the Committee during 2021/22. Oral or written progress reports are received from the Trust's External Auditor at Committee meetings, including the audit opinion on the Trust's annual financial statements.

In line with Regulator guidance, the Trust has a '*Policy for Engagement of External Auditors for Non-Audit Work*' to avoid any potential conflicts of interest, either real or perceived, in terms of the objectivity of their opinion on the financial statements of the Trust. The policy, which can be found on the documents section of the Trust intranet, is subject to annual review and revisions were duly considered by the Committee at its February 2022 meeting and submitted to the Trust Board for information at its April 2022 meeting. The value of non-audit services is routinely disclosed in the Trust's accounts, however there was no such work performed by Mazars during 2021/22.

During the year a private meeting with both the external and internal auditors took place before the June 2021 meeting of the Committee, and no matters of concern were raised. However, in line with its Terms of Reference, there is an open offer to all parties (the Trust, external auditors and internal auditors) to request a private meeting at any time.

The Committee also formally considered the performance of the Trust's External Auditor at its July 2021 meeting following the conclusion of their year end accounts work. No issues of concern were identified as part of the evaluation.

5. Financial Reporting

At its April and June 2021 meetings the Committee reviewed the draft and audited annual financial statements for 2020/21 before submission to the External Auditor and NHS England / Improvement (NHSE/I), and we understand these were in agreement with our accounting records and the current Regulatory requirements.

Prior to the preparation of the 2021/22 financial statements, the Committee reviewed and agreed the detailed accounting principles at its February 2022 meeting. The Committee also reviewed the draft and audited annual financial statements for 2021/22 prior to the anticipated submission of this report to the August 2022 Trust Board meeting. The Committee approved the 2021/22 financial statements on behalf of the Trust Board (in line with formal delegated authority given by the Board in February 2022), which are due for submission to NHSE/I by the national deadline of noon on Wednesday 22 June 2022.

At the April 2022 Committee meeting the issue of 'Going Concern' status was discussed with the External Auditor. As a result the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise, and this was agreed by the External Auditor.

6. Management Reports

The Committee has requested and reviewed various management assurance reports from a range of Directors and managers within the organisation in relation to relevant areas of enquiry during the financial year 2021/22. We thank all those who have assisted the Committee in these matters.

7. Other Matters Worthy of Note

The Committee followed its agreed annual work plan throughout the year and received regular reports covering Waiving of Standing Orders; Losses and Compensations; Hospitality and Sponsorship declarations; Orders placed with and without Purchase Orders; Salary Overpayments; and Document Control. Additional information is called for as appropriate. The Committee once again received the Local Security Management Specialist (LSMS) work plan and annual report for information and assurance.

Throughout the year the Committee also received the highlight reports and action logs from the Trust's main assurance Trust Board sub-committees in order to assess the effectiveness of the Trust's governance arrangements.

Minutes of the Committee's meetings and a Chair's Highlight Report of matters to be escalated are submitted to the Trust Board for information, assurance or decision as necessary.

The Committee members would like to place on record their thanks to the Trust's external auditors (Mazars), internal auditors (Audit Yorkshire), and our in-house counter-fraud service. All have provided a professional and effective service throughout another challenging year during 2021/22.

8. Conclusion and Plans for 2022/23

The Audit, Risk and Governance Committee's latest refreshed annual rolling work plan for 2022/23 is attached at **Appendix 2**.

The Council of Governors will also receive a copy of this annual report and work plan.

The Committee will remain active in reviewing the risks, internal controls, reports of auditors and audit recommendations and will continue to press for action and improvements where required throughout the coming year.

Appendix 1 - Schedule of Attendance at Audit Committee meetings during 2021/22

Member / Attendee	Apr-21	Jun-21	Jul-21	Aug21*	Oct-21	Feb-22
Members:						
Andrew Smith – NED / Chair (up to and inc. August 21)	**Y**	**Y**	**Y**	**N**	-	-
Simon Parkes – NED / Chair (from October 2021)	-	-	-	-	**Y**	**Y**
Michael Whitworth – NED / Deputy Chair	**Y**	**Y**	**Y**	**Y**[3]	**Y**	**Y**
Neil Gammon – NED (up to and inc. April 2021)	**Y**	-	-	-	-	-
Gill Ponder – NED (from June 2021)	-	**Y**	**Y**	**Y**	**Y**	**Y**
Associate Members (not forming part of quorum):						
Stuart Hall – Associate NED, NLAG / Vice Chair, HUTH	**N**	**Y**[4]	-	-	-	-
Regular Attendees:						
Lee Bond – Chief Financial Officer	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Helen Harris – Trust Secretary / Director of Corporate Governance	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Nicki Foley – Local Counter Fraud Specialist	**Y**	**N**[1]	**Y**	**N**[5]	**Y**	**Y**
Data Protection Officer and Lead for IT (SM)	**Y**	**N**[1]	**Y**	**N**[5]	**Y**	
Head of Procurement (IP)	**Y**	**N**[1]	**Y**	**N**[5]	**Y**	**Y**
Internal Audit (Audit Yorkshire)	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
External Audit (Mazars)	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Deputy Lead Governor (RP)	**Y**	**Y**	**Y**[2]	**Y**	**Y**	**Y**[6]
Ad-hoc Attendees:						
Asst. DoF – Process & Control (NP)	**Y**	**Y**	-	-	-	**Y**
Deputy Director of Estates & Facilities (ST)	**Y**	-	-	-	-	-
Medical Director (KW)	**Y**	-	-	-	-	-
Associate Director of Quality Governance (AL)	**Y**	-	**Y**	-	**Y**	**Y**

Member / Attendee	Apr-21	Jun-21	Jul-21	Aug21*	Oct-21	Feb-22
Ad-hoc Attendees continued…						
Assistant Director of Corporate Governance (AH)	Y	-	-	-	-	Y
Trust Chair (TM)	-	Y	-	-	-	-
CEO (PR)	-	Y	-	Y	-	-
Associate Director of Communications & Engagement (AB)	-	Y	-	-	-	-
EPR & Business Continuity Manager (GJ)	-	-	Y	-	-	-
Head of Safety & Statutory Compliance (BP)	-	-	Y	-	-	-
Chief Information Officer (SM)	-	-	Y	-	-	-
Associate Director of IM&T (SM)	-	-	Y	-	-	-
IT Data Security Manager (TF)	-	-	Y	-	-	-
Head of Quality Assurance (HG)	-	-	-	-	Y	-
Director / Head of Use of Resources – NHSE/I (RW)	-	-	-	-	Y	-
Associate Director of Pathology (MC)	-	-	-	-	-	Y

Notes:

* August 2021 - extraordinary meeting for External Auditor Annual Report
[1] Not required to attend, Final Accounts meeting only
[2] Liz Stones attended in the absence of Rob Pickersgill
[3] Chaired the meeting in the absence of Andrew Smith
[4] Last meeting before becoming Acting Trust Chair at HUTH
[5] Not required to attend, External Auditor Annual Report meeting only
[6] Ian Reekie attended in the absence of Rob Pickersgill

APPENDIX 2 - AUDIT, RISK AND GOVERNANCE COMMITTEE - 12 MONTH ROLLING WORK PLAN

Item of Business		Jun 22 (Public Disclosure Statements meeting)	Jul 22	Nov 22	Feb 23	Apr 23
Audit Committee - Annual Review of Terms of Reference					X	
Audit Committee - Annual Review of Work Plan					X	
Audit Committee - Annual Self-Assessment Exercise & Results					X	
Audit Committee - Annual Report to Trust Board / CoG		X				
Audit Committee - Annual meeting dates/times/locations				X		
Audit Committee - Annual Review of External Auditor Performance			X			
Private Discussion with Auditors (internal and external)		X	as needed	as needed	as needed	as needed
Receive highlight reports & action logs from other Board sub-committees			X	X	X	X
External Audit - Annual External Audit Plan / Timetable / Fees					X	
External Audit - Routine Progress Reports		X	X	X	X	X
External Audit - Year End Report & Letter of Representation		X				
External Audit - Report on Trust's Quality Account (*if required*)		X				
Internal Audit - Annual Internal Audit Plan						X
Internal Audit - Routine Progress Report / Technical Updates			X	X	X	X
Internal Audit - Head of Internal Audit Opinion		X (Final)				X (Draft)
Internal Audit - Annual Report (inc. client feedback survey results)		X				
Receive Status Report on Implementation of IA Recommendations			X	X	X	X
Annual Governance Statement		X (Final)				X (Draft)
Public Disclosure Statements: Review changes to Accounting Policies					X	
Draft annual accounts, quality accounts and VFM conclusion						X
Audited annual accounts		X				
New from April 2020 – Any Covid-19 ARGC Related Business		as needed	as needed	as needed	as needed	as needed

Item of Business		Jun 22 (Public Disclosure Statements meeting)	Jul 22	Nov 22	Feb 23	Apr 23
LCFS - Annual Counter Fraud Report			X			
LCFS - Annual Counter Fraud Work Plan						X
LCFS - Written Progress Reports			X	X	X	X
LCFS - Concluding investigation reports / related issues			as needed	as needed	as needed	as needed
LCFS - Annual review of Fraud and Corruption Policy						X
LCFS - Results of Annual Staff Fraud Awareness Survey			X			
LSMS - Annual Security Management Report			X			
LSMS - Annual Security Management Work Plan						X
LSMS - Ad-hoc reports and updates			as needed	as needed	as needed	as needed
Review of Waiving of Standing Orders			X	X	X	X
Review of Losses and Compensations				X		X
Review of Hospitality and Sponsorship				X		X
Review of Salary Overpayments & Underpayments			X	X	X	X
Review of Procurement KPI data inc. Invoices without PO's and Contracts Update				X		
Review of finance related policies (SFIs / Standing Orders / Scheme of Delegation, Recovery of Salary Overpayments Policy, Standards of Business Conduct Policy, etc.)			as needed	as needed	as needed	as needed
Annual Review of Policy for Engagement of External Auditors for Non-Audit Work					X	
Board Assurance Framework (BAF) and Risk Register report - quarterly		X (Q4)	X (Q1)	X (Q2)	X (Q3)	
Review of Assurance Sub-Committees' Conduct of Risk Oversight			X	X	X	X
Annual Review of Risk Management Strategy / Development Plan Progress Report			X			
Annual Review of Trust's freedom to speak up arrangements				X		
Freedom to Speak Up Guardian				X		
Annual IG Toolkit Return			X			
IG Steering Group Highlight reports - quarterly			X	X	X	X

Item of Business		Jun 22 (Public Disclosure Statements meeting)	Jul 22	Nov 22	Feb 23	Apr 23
Document Control report				X		X
Annual Fire Report			X			
Annual Health and Safety Policy Statement						X
Annual Emergency Preparedness, Resilience and Business Continuity Report			X			
Clinical Audit Annual Work Plan			X			
Review of Data Quality Dimensions (*new item from HFMA checklist 2018*)		as needed	as needed	as needed	as needed	as needed
New HFMA NHS Audit Committee Handbook Items – July 2018						
Cyber security – Review the Trust's information governance and cyber security arrangements annually.		as needed	X	as needed	as needed	as needed
Mergers and acquisitions – review new arrangements		as needed	as needed	as needed	as needed	as needed
Working with regulators - oversee action plans relating to regulatory requirements (e.g. single oversight framework; use of resources)		as needed	as needed	as needed	as needed	as needed
Working at Scale – oversee developing partnership arrangements (e.g. accountable care organisations)		as needed	as needed	as needed	as needed	as needed

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	2 August 2022	
Director Lead	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee	
Contact Officer/Author	Lee Bond, Chair Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes of meeting held on**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 5 May and approved at its meeting on 14 July 2022.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **5 May 2022 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF Trustees
	Gill Ponder	Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Dr Kate Wood	Medical Director
	Paul Marchant	Chief Financial Accountant
	Clare Woodard	HTF Charity Manager
	Christine Brereton	Director of People
	Melanie Sharp	Deputy Chief Nurse
	Victoria Winterton	HEY Smile Foundation
In attendance:	Dr Divyadarshni Vadivel	Presenting Item 6.1
	Cheyenne Devine	Presenting Item 6.2
	Heather Lamont	CCLA Representative
	Donya Sanders	CCLA Representative
	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin Assistant (For the Minutes)

Item 1 05/22 **Apologies for Absence**

Apologies for absence were received from: Mike Proctor; Ellie Monkhouse.

Item 2 05/22 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 05/22 **Minutes of meeting held on 3 March 2022**

The minutes of the meeting held on 3 March 2022 were reviewed for accuracy and completion of actions and following review were agreed as an accurate record.

Item 4 05/22 **Matters Arising**

4.1 HTF Tender Document, agree budget and contract award letter.
(PRIVATE AGENDA ITEM)

4.2 Fairchild Legacy

After discussion at the last committee meeting, it was agreed for Clare Woodard to work with the Chief Nurse directorate to investigate how this legacy could possibly benefit patients by improving dementia facilities across SGH, since the generous legacy was specified for use there.

Clare Woodard gave a brief overview of the paper and informed members that she is currently working alongside Jacky Fenwick and Melanie Sharp to explore possible opportunities.

Jacky Fenwick has kindly organised a day to go and visit Sherwood Forest Hospitals NHS FT to see what dementia facilities they have in place as they are acknowledged as operating at a high standard in this regard.

Melanie Sharp expressed an interest in potentially using part of the money to fund a band 3 post i.e. a Vulnerability Support Officer. This post would enable the Trust to dedicate more time for dementia patients and provide extra wholesome care.

A walk round of Scunthorpe hospital had taken place with Estates and Facilities to identify key areas to improve dementia facilities. Discussions have also taken place with the vulnerability team to improve items such as signage and clocks. These small changes can make such a big positive impact on patients and visitors during their time at the hospital.

Neil Gammon opened the conversation up and encouraged members to ask questions.

Peter Reading shared his views and requested a detailed plan to be produced to enable the project to be well managed as well as ensuring the money being spent wisely. He hoped this would benefit many patients in the future.

Gill Ponder felt in general terms this project sounded excellent, however voiced the need to understand what the Trust will get for its money to guarantee we deliver good value.

Action: Clare Woodard to work up a project plan and bring back to the next committee meeting.

Item 5 05/22 **Review of Action Log**

The chair proposed going forward to provide the action log to the committee with the active actions only listed. If any completed actions need to be retrieved, we have this in our archive files. All members agreed.

The action log was reviewed as follows:

Meeting dates – After discussions with Kate Wood, this meeting would be a case of putting a date in the diary as there does not seem to be one date that suits all attendees required. Kate Wood asked Clare Woodard to link in with Sarah Meggitt to source the best date, bearing in mind the need for this to be undertaken before October 2022. Gill Ponder reminded members that NEDs work part time.

Quarterly Newsletter – Clare Woodard confirmed that this had been completed and trust that all Trustees have received a copy. The newsletters will be produced around April, July, October and January each year. Gill Ponder proposed that a copy of these to be placed in waiting areas as well as thank you letters being sent to donors.

TOR – Neil Gammon confirmed that these had been approved and signed off by the Trust Board.

Item 6 05/22 **Items for Discussion / Approval**

6.1 Wish Ref 041/22 – Portable Vent for MRI SGH
Total Funding Request £27,000
Dr George Thomas / Dr Divyadarshni Vadivel, Department of anaesthetics

Neil Gammon welcomed Dr Divyadarshni Vadivel and introductions took place.

Dr Vadivel presented to Trustees and explained why the portable MRI scanner would be beneficial to patients as well as the Trust.

It was highlighted that this machine was installed at DPOW some time ago and that it would be of huge benefit to have one at the SGH site. This would reduce the number of transfers to DPOW and save valuable time for both the patients and staff.

Maneesh Singh queried how many patients this would affect on a monthly basis and what the consumable costs would be. Dr Vadivel confirmed that on average 5 or 6 patients a month would benefit from this piece of equipment and that the consumable costs would probably be covered by the division.

Gill Ponder found this request quite compelling but felt the costs required refining to provide a complete picture.

Kate Wood noted the disparity across the two main sites. She continued by stating that this piece of equipment is not a necessity, however it would vastly improve patient benefit and reduce the amount of pressure on the ambulance service as transfers would not be required. It was hoped that the Divisional Finance Manager within Medicine would identify the amount of money saved in staffing costs when purchasing this piece of equipment.

Lee Bond supported the wish, but on rough workings informed Trustees of a £9.5k per year cost pressure to the Trust, through the associated cost of capital for this new equipment.

Peter Reading also supported this wish as it meets the charitable criteria and voiced his confusion as to why DPOW have this piece of equipment but SGH have gone without.

Trustees raised their concerns around the 'wish' paperwork not being fully completed, for example the financial implications were missing. For this committee to make well led decisions, all information on the wish request forms need to be completed in full. Diligence is required to ensure the money is spent appropriately. The Chair asked Clare Woodard and her team to ensure that future 'wish' applications were completed in full by those requesting.

All trustees were in favour of this 'wish' and it was signed off as approved.

6.2 Wish Ref 102/22 – Siemens Innovision – MRI Ambient Experience SGH
Total Funding Requested £58,200
Cheyenne Devine, Acting Head of CT/MRI Blue Sky Imaging Suite

Cheyenne Devine provided a background to the submission of this wish and explained how claustrophobia is a major issue for many patients who visit our hospitals for an MRI scan. Due to this phobia, patients either do not attend their appointments, cancel, or stop their scan's part way through the scanning process. This causes the department more work and time is lost due to having to re-schedule appointments.

This modern piece of equipment will help to reduce patient anxiety and make the whole MRI process a lot better for both the patient and the staff involved.

Kate Wood fully supported this wish and stated how it will reduce the number of patients in General Anaesthetics. The only concern was whether this install of equipment would cause the MRI machine to have downtime. Cheyenne Devine reassured members that there would be no downtime required as the kit will simply attach to the current MRI machine. All equipment is provided and maintained by Siemens. Costs for the maintenance contract with Siemens are currently being sought. Kate Wood raised her concern around the financial element of the form not being completed and reminded those present of the importance of this information to enable Trustees to make an informed decision but supported the principle of the wish.

Lee Bond acknowledged the reason for the wish but without quantifiable evidence he was not convinced this piece of equipment would improve the DNA rate.

Peter Reading strongly supported this wish, adding that MRI experiences are not very pleasant. The Health Tree Foundation previously funded a similar piece of equipment at DPOW. Cheyenne Devine was advised to review the figures to firm up the evidence within the wish documentation.

Maneesh Singh supported this request and highlighted the fact of improving patient experience which is one of the main reasons for funding being approved. He volunteered himself to trial out the new experience.

Several questions were raised, and Cheyenne Devine responded with the following:

- Information leaflets would be sent out with appointment letters including a telephone number to contact if the patient has any worries or concerns. If a patient were to ring the department, they would be offered the MRI scanner with this equipment to ensure they have the best, most comfortable experience.
- The life span of this equipment is around 5 to 7 years, noting it would be provided by Siemens who provide proven reliable services.
- It was confirmed that cancer patients would benefit from this wish.

Trustees referred to the paperwork not being fully completed with all the financial information required and that going forward any requests will be declined until all the relevant information has been completed. However, on this occasion only, this wish has been approved with terms of the financial information being completed retrospectively.

Victoria Winterton apologised for the lack of information on the forms and ensured the committee that this will not happen in the future.

Item 7 05/22 **Updates from Health Tree Foundation**

7.1 HTF Update Report

Revision of the KPIs is still in progress, with any input from Trustees welcomed. The revised KPIs will reflect the delivery plans for the new contract and these will be presented at the next committee.

Gill Ponder questioned the new digital communicator role stated within the report and asked whether this is good use of charity funds.

Clare Woodard explained that the role will enable the team to undertake deep dives into the donations data which seems to be the one element the team is missing at present. It was suggested that the naming of the role should be amended to more accurately reflect the duties entailed. Clare Woodard agreed to do this.

Action: Clare Woodard to review and amend the job title of the role discussed above.

Item 8 05/22 **Sparkle Programme**

8.1 Sparkle Update

Kate Wood thanked Clare Woodard for the report and asked whether the Health Tree Foundation were aware of the ongoing work regarding the QI project. Kate Wood informed the group of a recent scenario which she was made aware of by a staff member who was advised to pursue different routes to gain help, however, was turned away each time. Kate Wood continued and explained that often a simple small change can help and benefit staff morale in a huge way.

Neil Gammon asked Clare Woodard and Victoria Winterton to think about said scenario and build upon it. Victoria Winterton confirmed that if a request is submitted but does not meet the HTF wish criteria, the requestee will always be advised of different routes to gain funding.

Action: Clare Woodard agreed to work with the QI Lead to develop 'Wishes' that would support the QI theme and to publicise how HTF could support QI.

Item 9 05/22 **Finance Update**

9.1 Finance Report – Year ended 31 March 2022

Paul Marchant presented the report and highlighted the key points, including:

- Income for the 21/22 year was £785k, compared to a budget of £850k and revised forecast of £800k. Legacy income included in the above was £359k.
- Expenditure for the 21/22 year was £815k compared to a budget of £1,260k and a revised forecast of £850k.
- Investment gains in the year were £138k
- Investments at 31 March 2022 were valued at £1,772k
- Closing bank balance at 31 March 2022 was £246k

Gill Ponder noted that we are undershooting our spend targets and that going forward it would be beneficial to have a financial plan visible to discuss and track the spend at each committee meeting. This would be to ensure we do not go another year being underspent.

Neil Gammon highlighted that trustees rely on wishes being submitted to ensure peoples donations are appropriately spent. Further work needs to be undertaken to ensure that a steady stream of appropriate requests, of varying costs, comes to the HTF.

Lee Bond asked trustees to refer to the finance highlights table and noted that if trustees were to ignore the legacies, the return on the Trusts investment is low. He added, the growth we are planning needs to come from enhanced fundraising and that he was concerned that sufficient emphasis was not being placed on this aspect.

Peter Reading reminded trustees of the discussion which took place pre pandemic regarding major appeals. He urged trustees to go back to their divisions to discuss some ideas around launching big appeals as well as submitting wishes to HTF.

9.2 Revised Financial Plan – 2022 / 2025

Victoria Winterton presented the revised financial plan for the next three years and highlighted the key points, including:

- Income in year 1 of £950k increases to £1,000k in year 3
- Expenditure in year 1 of £1,282k increases to £1,345k in year 3
- Fund balances the start of year 1 of £2,025k reduce to £1,089k at the end of year 3

To support the revised plan the HTF team would be increased by two additional posts – COW Admin Assistant and a Digital Coordinator.

The key point of this plan is to spend 50% of the existing fund balances over the 3-year period.

The plan was approved by trustees.

9.3 CCLA Investment Update

The chair welcomed Heather Lamont and Donya Sanders from CCLA to the meeting to present the investment update.

The following key points were highlighted:

- Markets had been less favourable since January 2022 although the forecast annual income remains steady at £50k (a yield of 2.9%).
- Equity selection was the principal negative factor at a difficult time for most sectors
- IT stocks are heavily represented in the portfolio and these had had a weak 1st quarter of 2022. The portfolio's avoidance of oil and gas was also a big negative factor in this quarter.
- The fund objective is to provide a long-term total return benchmark of inflation (CPI) plus 5% pa.
- The portfolio has been de-risking since late 2021 with selective equity trims reinvesting in alternatives and property and holding higher cash balances.
- The long-term relative performance of the portfolio remains strong, the focus remains a portfolio of high quality, real economic assets, selected on the basis of fundamental characteristics and attractive valuations with the aim of delivering string risk-adjusted returns over time.

Peter Reading commented that trustees planned to increase expenditure over the next 3 years which will require the sale of some of the portfolio.

Neil Gammon thanked Heather Lamont and Donya Sanders for attending.

Item 10 05/22 Any Other Business

Neil Gammon highlighted the importance of the front sheets being completed correctly and requested to extend future meetings by a further 30 minutes.

Item 11 05/22 **Matters for Escalation to the Trust Board**

- The approval of two wishes
  - Portable Ventilator for the MRI at SGH
  - A Siemens Innovision – MRI Ambient Experience for SGH
- Approval of the financial plan.
- HTF to work with QI to support the QI theme appropriately.
- Following the tender assessment HEY Smile were awarded the contract.

Item 12 05/22 **Date and Time of the next meeting:**

Thursday 7th July 2022
9.30am – 12.00pm
Via MS Teams

Post Meeting Note: A diary clash with a Trust Board event means that this will have to be re-scheduled to Thursday 14th July at 15:00 – 17:00 via MS Teams.

Attendance Record:

Name	July 2021	Sept 2021	Nov 2021	Jan 2022	March 2022	May 2022
Neil Gammon	✓	✓	✓	Cancelled	✓	✓
Peter Reading	✓	✓	✓		✓	✓
Terry Moran						
Linda Jackson	Apols	-	Apols			
Gill Ponder	✓	Apols	✓		✓	✓
Mike Proctor	Apols	-	✓		✓	Apols
Maneesh Singh		✓	✓		✓	✓
Lee Bond	Apols (Rep)	Apols	✓		✓	✓
Jug Johal	✓	✓	Apols (Rep)		Apols	-
Kate Wood	✓	✓	✓		✓	✓
Ellie Monkhouse	Apols (Rep)	Apols (Rep)	Apols (Rep)		✓	Apols (Rep)
Christine Brereton	-	✓	Apols (Rep)		-	✓
Paul Marchant	✓	✓	✓		✓	✓
Andy Barber	-	Apols	-		-	-
Victoria Winterton	✓	✓	✓		Apols	✓
Clare Woodard	✓	✓	✓		✓	✓
Adrian Beddow	Apols (Rep)	✓	Apols (Rep)		-	-
Ian Reekie (Governor)	Apols	Apols	-			
Tony Burndred					✓	-
Total	**8**	**9**	**10**		**10**	**10**

NLG(22) 149

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	2/8/2022	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up – August 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights some of the key projects the Communications team are working on to improve staff morale and engagement and reputation through external communications. It covers May and June 2022 and includes an overview of team plans and progress.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	☐ Workforce and Leadership ☐ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

August 2022

Kindness • Courage • Respect

August update 2022 – covering May and June

Contents

Headlines

3,700+ Members of the staff Facebook group

261 Ask Peter questions asked

145 General enquiries dealt with

100 Staff attended 1st Team Brief Live

98% Of media enquiries dealt with on deadline

Progress and plans

Improve Trust reputation through external communications and patient experience	Improve staff morale and engagement
What we've already done • Launched a new website in line with accessibility requirements • Consistently achieved goals around responsiveness to media enquiries • Responded to 95%+ FOIs within statutory time limits. **What we're working on** • How we can work more closely with our local media, providing positive news stories • Introduce more video content where relevant • Reviewing our social media channels	**What we've already done** • Created a regular drumbeat for internal communications – Monday Message, Weekly Wednesday News, Building our Future on Thursdays and #ThumbsUpFriday • Put in place a new Thank You System for staff to easily share compliments as a way to boost morale • Created a safe space for staff to raise concerns via the Ask Peter forum • Set up a staff Facebook group to reach staff with infrequent access to the Hub/emails (3.7k members) • Introduced Team Brief Live • Re-invigorated the way we share compliments on social media – swapping #ThankYouTuesday for #ThankYouNHS **What we're working on** • Targeted line management communication • Work with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing, new staff induction and Culture Transformation work.

Supporting the Trust's priorities

Trust Priority 1 – Our People

In June we launched 'Team Brief Live' which was attended by 100 people. It gave our Chief Executive and Director of People the opportunity to update staff on the Culture Transformation Programme and to answer any questions.

All staff who gave feedback after the session said they'd attend again. Comments included:
"I found the session extremely valuable."
"I liked that the style was conversational."
"Excellent to hear from Peter (Chief Executive) directly. Very informative."
"We far too often find ourselves engrossed in our working role to not find the time to understand what the "bigger picture" is overall and being able to attend a meeting like this gives us all the opportunity to understand the driving force and what is necessary to work towards."
Further sessions are planned.

Trust Priority 2 – Quality and Safety
The team supported the CQC inspection preparation by sharing updates on progress since the last inspection and alerting staff to inspectors arriving on site. This has included sharing Monday Messages, all staff emails, a CQC focussed SLC briefing and updating staff inspection packs. During the week daily briefing sessions were held with senior staff to share feedback. We are also supporting the well-led part of the inspection.

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Supporting the Trust's priorities

Trust Priority 8 – Capital Investment
Building Our Future
May and June also saw high levels of engagement with our content around our Capital Programme – boosted by the first National Healthcare Estates and Facilities Day, which has been evaluated separately for this report.
The potential total audience for our content on the subject is now in excess of 15,708,053, and our content has received almost 82,000 positive interactions on our channels.

Trust Priority 9 – Digital
We continued to focus on internal communications around our Digital improvements over May and June.
The main themes were:

- Updates on the development of our new PAS
- Warnings to staff about the latest cyber threats and how they can help us to protect the Trust from them
- Upgrading to Microsoft 365 (which included targeted messaging being sent directly to more than 3,500 staff)
- Upgrades to unsupported operating systems
- Asking for feedback for the National Tech Survey
- The launch of our new Digital Store Front for stationery and reprographics orders

Our measurable internal comms on Digital Services to date have received almost 5,000 positive engagements – such as likes, clicks, comments and media views.

Trust Priority 10 – The NHS Green agenda
We continue to support the Green agenda with various campaigns including 'Go green go paperless', disposing of clinical waste correctly and reducing internal mail. We also attended the Arrive and Drive/Sustainability event at Grimsby hospital.

Improving staff morale and engagement

Keeping staff informed

All staff emails

Each week we send to all staff the Monday Message (a blog from a senior leader on a key topic), Wednesday Weekly News (an e-news round-up of news and updated) and on Thursdays we have a dedicated 'Building Our Future' update covering updates on the capital programmes in both estates and digital. In addition to this there are times when we need to issue a separate all staff email, such as notifying staff of the start of our CQC inspection and cyber security alerts.

Staff Facebook group

Our closed staff Facebook group continues to grow and is one of our most used communication channels. It's a useful way of reaching staff who do not work in front of a computer all day so have limited access to the Hub, emails etc. We have more than 3,700 staff members on there and popular topics include bank incentives, celebrating long service and the Trust lottery Summer SuperDraw. Feedback from staff includes this comment: "Issues, concerns and questions an be answered and disseminated to many staff throughout the Trust. It is a valuable site for positive feedback, staff well-being and information."

"Issues, concerns and questions can be answered and disseminated to many staff throughout the Trust. It is a valuable site for positive feedback, staff well-being and information."
Staff Facebook Group member

Facebook group stats
3,719 members
879 posts in this period
4,237 comments
15,814 reactions

Improving staff morale and engagement

Monday Message

Topics have included:
- Celebrating IPC achievements
- Focus on scanning improvements
- Team brief live
- CQC prep
- NHS green agenda
- Update following the Trust Board meeting

Peter's Monday Message

Your weekly update from the Chief Executive

NHS
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Senior Leadership Briefing

88 senior leaders attended the SLC briefing in May and 97 joined in June.
Updates included:
Health and wellbeing
Digital update
Focus on CQC – improvements made since 2019

97
Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Giving staff a voice

Ask Peter
An extremely popular forum for staff to raise concerns and ask questions about absolutely anything.
The number of Ask Peter's is increasing month on month with 129 in May and 132 in June.

Hot topics include bank incentives, parking permits, facemasks and fire doors. Posts now have to be approved by the Communications Team before they are published and remain pending until reviewed. We have re-introduced the 'like' button but anonymously as a result of feedback via the forum.

261
Ask Peter questions

Staff Thank You
Since the 'Thank you' system launched in January staff have sent more than 700 compliments to their colleagues to date. These are emailed directly to the staff member and can also be shared with their manager and/or the Communications Team. Many of these are shared in the Wednesday Weekly News.

"I just wanted to take the time to thank you for the professional , kind and compassionate way you respond to resolving incidents reported by staff, your understanding, respect, responsiveness and accountability shines through in every word you say."

Key Campaigns

Campaigns and awareness weeks

May is one of the busiest months for awareness weeks and campaigns. Whilst we cannot support them all we have covered Deaf Awareness Week, International Day of the Midwife, Mental Health Awareness Week, International Nurses' Day, International Clinical Trials Day, National Breastfeeding Week, Clean Air Day and more.

On June 15 we celebrated the first National Healthcare Estates and Facilities day, sharing internal and external posts showcasing the hard work of our teams; the many and varied career paths available within E&F, and sharing messages of thanks and support for the teams from other directorates. Over the course of the day, the content we shared prompted more than 1,000 positive reactions (likes, positive comments, shares or clicks to read more); and our visuals (infographic/ photos/ videos) were viewed almost 1,900 times.

The biggest success of the day was the public gratitude shown for the team. Comments included:

"Such a great team! A day for our heroes to be celebrated and acknowledged for their hardwork team E&F 🙌"

"Without Estates and Facilities teams the NHS would grind to a halt - thank you for all that you do to support every area of service provision 👏"

"Massive thanks to the E&F teams especially at SGH.. always with a smile and willing hand - they clean it shift it move it store it power it and deliver it .. you are all amazing 🙌"

"Brilliant, friendly, caring, effective and outstanding work. Without the bolt in place grinders would not work. Each cog needs it's team mates.
Thank you all."

Improving reputation through external communications

Media coverage

There were 69 stories about the Trust in the media during this period. 87% of media coverage was positive or neutral in tone. 93% of coverage was in print or online media.

We categorise the media coverage into themes – in this period '**other'** was the top theme, mainly due to a former Trust doctor being struck off**.** **'**Care issues and 'fundraising' were the next most categorised themes.

We issued 7 proactive news releases and the most covered was a story was on a £20,000 donation to the Trust's charity. Staff have been interviewed on maternal mental health week and dying matters week

National media coverage of note: Former doctor at the Trust has been struck off and a pre inquest hearing into the death of a patient who was overprescribed on paracetamol in 2018.

Family Services have had the most positive media coverage.

87%
Of media coverage was positive or neutral

Media enquiries

44 media enquiries were handled in this time, 98% were dealt with within the requested timescale.
The majority of requests, 41%, came from radio outlets.

The top theme for media enquiries was 'other'. 4 came in on the back of proactive news releases. The main reason journalists got in touch was to put in an interview request. 6 reactive statements were issued in this period

98%
Of media enquiries dealt with on deadline

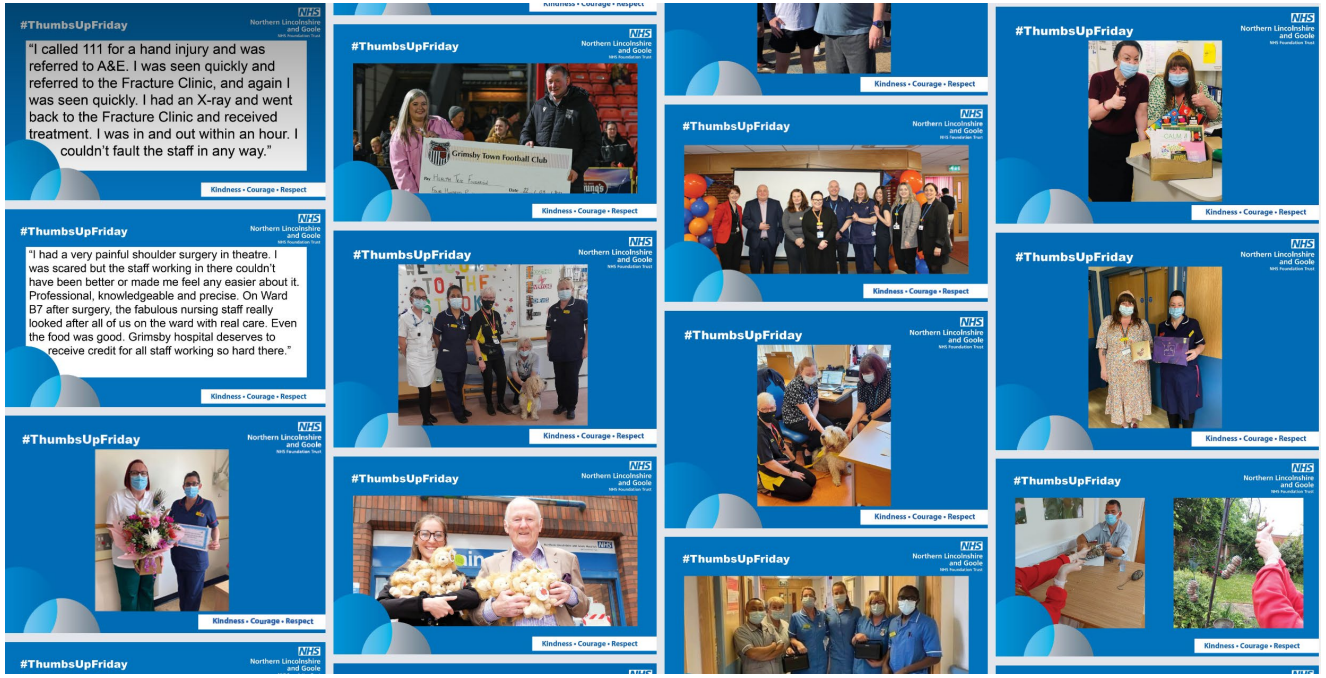
Improving reputation through external communications

Social media

Followers update for the Trust's corporate accounts:

- 12,327 on the Trust's Facebook page
- 5,224 followers on Twitter
- We are rated 4.6 out of 5 stars on reviews on Facebook

We shared 25 #ThankYouNHS posts and 18 #ThumbsUpFriday posts in this period



Improving reputation through external communications

Twitter
Our top tweet, (by impressions) was a post celebrating International Nurses' Day and our top mention was from a doctor volunteering at a Platinum Jubilee event

Top tweet May

Top Tweet earned 2,726 impressions

It's International Nurses' Day, an opportunity to thank our nursing teams and celebrate the excellent job they all do in caring for our patients 👏💙 **#IND2022 #BestOfNursing** pic.twitter.com/STf00UDyl9

2 4 18

Top tweet June

Top Tweet earned 848 impressions

We are delighted and so proud our End of Life team has been shortlisted for Team of the Year! 🌟🌟🌟 twitter.com/NursingTimes/s…

1 4 27

MAY 2022 SUMMARY

Tweets 86	Tweet impressions 35.2K
Profile visits 6,696	Mentions 270
New followers 45	

JUN 2022 SUMMARY

Tweets 89	Tweet impressions 28.5K
Profile visits 7,137	Mentions 214
New followers 51	

Top mention May

Top mention earned 305 engagements

Donna Smith
@DSmithNLAG · May 17

Such a warm welcome from everyone I met **@NHSNLaG** yesterday. After 16 years in an organisation it's a huge step outside my comfort zone but I know it's gonna be great **@helen_tur @rachelgreenbeck @antrosevear @ellie_nursing** pic.twitter.com/69eudsla97

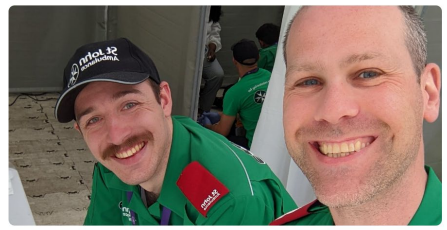
8 43

Top mention June

Top mention earned 411 engagements

Mark
@medic_m_a_c · Jun 4

Ran into fellow **@NHSNLaG** doctor **@Albert6025** on The Mall - both of us volunteering our weekend as part of the huge team effort from **@stjohnambulance** to ensure that this once in a lifetime event goes safely **#PlatinumJubileeConcert** pic.twitter.com/tfO4mHigJu



4 2 78

This report covers May and June 2022

Improving reputation through external communications

Facebook page
The Facebook post with the highest engagement was on International Day of the Midwife. Meanwhile a post on our security teams preventing a bike theft reached more than 15,000 people.

May 5, 2022 05:26pm — Northern Lincolnshire and Goole NHS Foundation Trust

Today on International Day of the Midwife we've been celebrating our Midwives and midwifery staff for the fantastic work they do around the clock caring for our pregnant patients, their babies and families 🤰👶 Our Chief Nurse, Ellie Monkhouse, said: "I'd like to say a huge thank

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
3,653	297	16,601	13,960	24.01%	–

June 30, 2022 12:26pm — Northern Lincolnshire and Goole NHS Foundation Trust

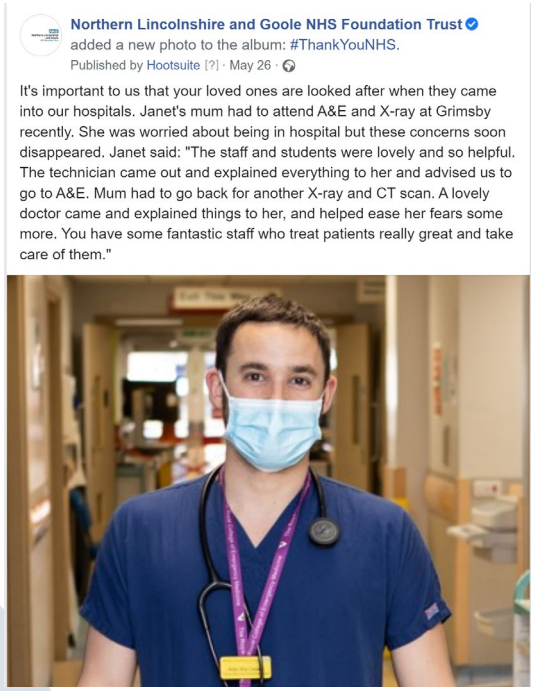
Is this your bike If so, please be aware that our Security team at the Diana, Princess of Wales Hospital in Grimsby has just prevented it from being stolen. However, the lock had been significantly damaged, so the team has removed it and are now keeping the bike safe for you.

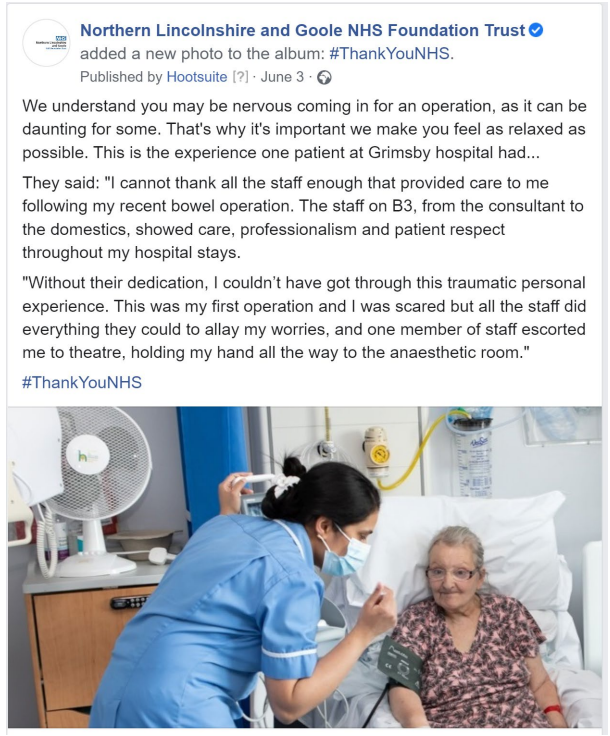
Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
2,549	65	15,745	15,057	17.03%	–

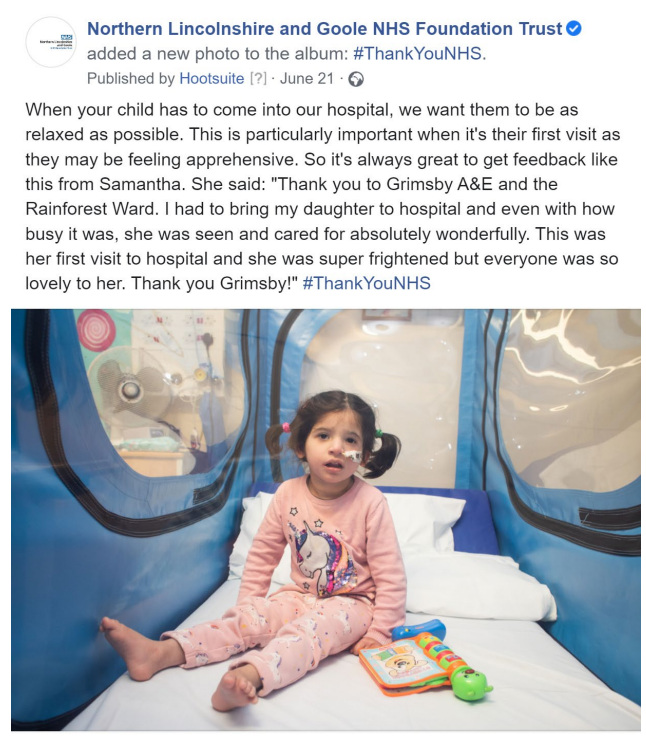
Improving reputation through external communications

#ThankYouNHS

We have moved away from ‘Thank You Tuesday’ instead sharing compliments throughout the week using the national hashtag ‘ThankYouNHS. We’re trying to use more data in our posts to show the breadth of the work staff do as well as using a photo with every post and a new tone of voice/writing style. We are choosing compliments that have more of a patient focus, saving the staff thank yous for the closed staff Facebook group and also highlighting some of our lesser featured teams such as the switchboard. This new approach has already shown higher levels of engagement. A few examples are included below:







Improving reputation through external communications

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 145 were received and dealt with. These can be anything from chasing appointments and results to providing feedback on services. For many of these the team act as a conduit for the Trust and filter them to other teams to deal with, but some are more complex and take more time.

Freedom of Information requests (FOIs)

Complex FOIs are continuing to require more time than in the past to pull together an appropriate response which meets the statutory requirements. There were 104 submitted in this period – of these 91 are closed, 10 are still in progress and 3 are awaiting a response from the requester.

External website – www.nlg.nhs.uk

Key stats:

- 42,136 users, 72,067 visits and 196,284 page views
- 72.5% of visitors were new users
- 86% of users were in the UK
- Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system
- 80% of people came to the website via a search, 16% direct, 2.3% from social media (mainly Facebook) and 1.6% from other websites
- Most visited page: staff page followed by the Grimsby hospital home page

The top three news releases viewed on the website were ‘please return your equipment’, ‘new decked car park open’ and ‘text reminders introduced’.

145
General enquiries dealt with

104
FOIs received

196,000
Page views on our website

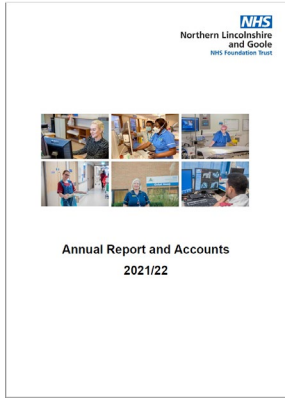
This report covers May and June 2022

Other work

The Trust's **Annual report 2021/22** is now complete and submitted. This is the culmination of many months of work. We are also working on an accessible overview for the Trust website.

Staff Lottery: We have supported the staff lottery committee in communicating the changeover to a new lottery provider, promoting the draws including the 10k lottery draw and raising awareness of the staff benefits fund. 47 people have signed up to the lottery recently and over the year we are up 62 players in total.

Health Tree Foundation:
We continue to support the Health Tree Foundation and have put out media releases on how to get involved in events to fundraise, and £20,000 raised for bowel cancer equipment by a Cleethorpes charity shop. The latter was featured on BBC Radio Humberside.



THE HEALTH TREE FOUNDATION
Your hospital charity

NLG(22)150

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	2 August 2022	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	As Above	
Title of the Report	**Documents Signed Under Seal**	
Purpose of the Report and Executive Summary (to include recommendations)	The report below provides details of documents signed under Seal since the date of the last report (June 2022 – NLG(22)102).	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
270	SGH MRI Scanner	26.07.2022
271	CT Scanner	26.07.2022
272	CCU Removal, DPOWH	26.07.2022

Action Required

The Trust Board is asked to note the report.