Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 7 June 2022, UCNL, Ashby Road, Scunthorpe, DN16 1BU
Time – 9.00 am – 12.30 pm
(Lunch – 12.30 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** Jo Loughborough, Senior Nurse – Patient Experience & Emma Watts, Learning Disability and Complex Transition Specialist Nurse	Note	09:05 hrs	Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09.20 hrs	Verbal
2.2	**To approve the minutes of the Public meeting held on Tuesday, 5 April 2022** Sean Lyons, Chair	Approve		NLG(22)077 Attached
2.3	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.4	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(22)078 Attached
2.5	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:30 hrs	NLG(22)079 Attached
2.6	**Integrated Performance Report (IPR)**	Note		NLG(22)080 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Key Issues – Quality & Safety** Ellie Monkhouse, Chief Nurse, Angie Legge, Associate Director of Quality Governance and Kishore Sasapu, Deputy Medical Director	Note	09:40 hrs	NLG(22)080 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:50 hrs	NLG(22)081 Attached

3.3	**Ockenden Progress Update** Ellie Monkhouse, Chief Nurse & Jane Warner, Associate Chief Nurse Midwifery	Note	09:55 hrs	Verbal
3.4	**Annual Quality Account** Angie Legge, Associate Director of Quality Governance	Approve	10:05 hrs	NLG(22)082 Attached
3.5	**Volunteer Strategy** Ellie Monkhouse, Chief Nurse & Jo Loughborough, Senior Nurse – Patient Experience	Note	10:15 hrs	NLG(22)083 Attached
3.6	**Key Issues – Performance** Shaun Stacey, Chief Operating Officer	Note	10:20 hrs	NLG(22)080 Attached
3.7	**Finance & Performance Committee Highlight Report and Board Challenge – Performance (including Self-Assessment of the Committee)** Fiona Osborne, Non-Executive Director	Note	10:30 hrs	NLG(22)084 Attached
BREAK – 10:35 hrs – 10:45 hrs				
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Key Issues – Workforce** Christine Brereton, Director of People	Note	10:45 hrs	NLG(22)080 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	10:55 hrs	NLG(22)085 Attached
4.3	**Freedom to Speak Up Guardian Annual Report** Liz Houchin, Freedom to Speak up Guardian	Note	11:00 hrs	NLG(22)086 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Key Issues – Finance – Month 01** Lee Bond, Chief Financial Officer	Note	11:10 hrs	NLG(22)087 Attached
5.2	**Finance & Performance Committee Highlight Report & Board Challenge – Finance – April & May 2022** Fiona Osborne, Non-Executive Director	Note	11:20 hrs	NLG(22)088 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Key Issues – Strategic & Transformation** Kerry Carroll, Deputy Director of Strategic Development	Note	11:25 hrs	NLG(22)089 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – May 2022** Gill Ponder, Non-Executive Director	Note	11:35 hrs	NLG(22)090 Attached
6.3	**Humber Acute Services Development Committee Highlight Report & Board Challenge (Committees in Common)** Sean Lyons, Chair	Note	11:40 hrs	NLG(22)091 Attached
6.4	**Strategic Development Committee Highlight Report & Board Challenge** Simon Parkes, Non-Executive Director	Note	11:45 hrs	NLG(22)092 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	None			

8.	**Governance**			
8.1	**Audit Risk & Governance Committee Highlight Report & Board Challenge – April 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Note	11:50 hrs	NLG(22)093 Attached
8.2	**Board Assurance Framework (BAF) – Quarter 4** Dr Peter Reading, Chief Executive	Note	11:55 hrs	NLG(22)094 Attached
9.	**Approval (Other)**			
9.1	**Health & Safety Policy Statement** Jug Johal, Director of Estates & Facilities	Approve	12:05 hrs	NLG(22)095 Attached
9.2	**Finance & Performance Committee Terms of Reference** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Approve	12.15 hrs	NLG(22)112 Attached
10.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:20 hrs	
11.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 5 July 2022, 9.00 am - TBC **Public & Private Meeting** Tuesday, 2 August 2022, 9.00 am - TBC	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – February & March 2021** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(22)096 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – March & April 2022** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(22)097 Attached
10.3	**Nursing Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(22)114 Attached
	Workforce Committee	
10.4	**Workforce Committee Minutes – March 2022** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(22)098 Attached
	Audit, Risk & Governance Committee	
10.5	**Audit, Risk & Governance Committee Minutes – February 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)099 Attached
	Health Tree Foundation Trustees' Committee	
10.6	**Health Tree Foundation Trustees' Committee Minutes – March 2022** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(22)100 Attached
	Other	
10.7	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(22)101 Attached
10.8	**Documents Signed Under Seal** Dr Peter Reading, Chief Executive	NLG(22)102 Attached

NLG(22)077

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 5 April 2022 at 9.00 am
By MS Teams

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Kevin Allen	Governor
George Baker	Trust Member
Diana Barnes	Governor
Adrian Beddow	Associate Director of Communications
Megan Bedford	Hempsons Solicitors
Christine Brereton	Director of People
Jon Clark	Trust Member
Cllr Tony Ellerby	Trust Member
Neil Gammon	Chair of the Health Tree Foundation Trustees' Committee
Paul Grinell	Trust Member
Stuart Hall	Associate Non-Executive Director
Alison Hurley	Assistant Director of Corporate Governance (representing Helen Harris)
Madeleine Keyworth	Trust Member
Jo Loughborough	Senior Nurse – Patient Experience (for item 1)
Ivan McConnell	Director of Strategic Development
Dave McGuire	Trust Member
Shauna McMahon	Chief Information Officer
Shiv Nand	Governor
Joanne Neal	Beachcroft Solicitors
Fiona Osborne	Associate Non-Executive Director
Ian Reekie	Lead Governor
Maneesh Singh	Associate Non-Executive Director

Simon Tighe	Deputy Director of Estates & Facilities (representing Jug Johal)
Mike Waites	Freelance Journalist
Kathleen Young	Trust Member
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

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

1. Patients' Story and Reflection

Jo Loughborough provided the Board with a summary of the Patients' Stories shared over the past year. One of the stories was in relation to a staff member and this had shown the impact on staff who had cared for patients with COVID. It illustrated how staff had dealt with caring for patients that had sadly passed away and how the families of those patients had been supported. Jo Loughborough explained the support that had been offered to staff which included wellbeing support.

During COVID the Family Liaison role had been introduced and some of these staff were still in post. As the Trust remained in a restrictive period due to COVID one of the main issues highlighted continued to be the lack of communication, this therefore, continued to be reviewed on how this was managed for patients and families.

The format of sharing the Patients' Story would change in future as it would be linked to a theme of the month. Set topics would then be covered throughout the year. The divisions would also be more involved and be invited to attend the Trust Board meetings for this section.

Ellie Monkhouse advised Jo Loughborough would continue to be the overarching lead in sharing the messages. The importance of changing the way these stories were shared going forward was explained as it would better reflect the work being addressed across the Trust. The initiatives and actions being undertaken would also be shared. It was noted the team would continue to be open and transparent about the concerns that were highlighted through these stories.

Stuart Hall queried whether the stories could be structured to reflect points of interest for the public, for example Ockenden. Sean Lyons felt this would be a useful way forward. Ellie Monkhouse advised the team would do this in future.

Fiona Osborne supported the move to highlighted themes and asked if the divisions could also provide actions that had been completed and would be monitored in respect of the stories.

Sean Lyons was pleased to see there had been an array of stories shared, however, there was a need to remember that behind every story there was a patient and family that had been affected. Sean Lyons thanked Jo Loughborough for the story shared.

2. Business Items

2.1 Chair's Opening Remarks

Sean Lyons welcomed everyone to the meeting and advised that in attendance there was also members of the public and governors.

2.2 Apologies for Absence

Apologies for absence were received from Helen Harris (represented by Alison Hurley, Assistant Director of Corporate Governance) and Jug Johal (represented by Simon Tighe, Assistant Director of Estates and Facilities).

2.3 Declarations of Interest

No declarations of interests were received.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 7 December 2021 – NLG(22)028

The minutes of the meeting held on the 7 December 2021 were accepted as a true and accurate record and would be duly signed by the Chair.

2.5 To approve the minutes of the Public Meeting held on Tuesday, 1 February 2022 – NLG(22)029

The minutes of the meeting held on the 1 February 2022 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Dr Kate Wood referred to page two, final paragraph. The wording should be changed to say for sharing the story.
- Dr Kate Wood referred to page 12, item 3.5, final paragraph. The wording should be changed to say Jug Johal had been an integral part of supporting the team working together.
- Dr Kate Wood referred to page 16, item 6.1. The wording in the final paragraph should be changed to it was a risk to programme one moving forward.
- Lee Bond referred to page 14, third paragraph. The wording should be changed to current forecast underlining deficit was circa £20 million. The third sentence should read allocations for next year were still being interpreted.

2.6 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.

2.7 Trust Board Action Log – Public by exception NLG(22)030

Sean Lyons invited Board members to raise any further updates by exception in relation to the Trust Board Action Log. It was noted those actions highlighted in

green would be moved to closed actions for the next meeting. The following updates were received.

- Point 8.2 from the meeting held on 7 December 2021. Christine Brereton advised a meeting had taken place and it had been agreed to move part of Strategic Objective Two to Strategic Objective One, this would be completed when the BAF was reviewed for 2022/23. It was agreed to close this item.
- Point 3.2 from the meeting held on 1 February 2022. Mike Proctor advised a paper would be shared at the Governor Assurance Group (GAG) which advised the Governors of the quality priorities for the year. It showed the process that had been undertaken including stakeholder involvement and finally a request was made to Governors on how they would like to be involved going forward. The next GAG would be held on 13 April 2022 and this item would be discussed at that meeting. It was agreed to close this item.

2.8 Chief Executive's Briefing – NLG(22)031

Dr Peter Reading advised that following the update provided there had been some developments of the Integrated Care System (ICS). Guidance had emerged nationally on Integrated Care Partnerships (ICP) so it was anticipated the local ICS would start developing the ICP locally. One other item to highlight was that the Ockenden Part 2 Report had been published and an update on this would be provided by Ellie Monkhouse, Chief Nurse.

Linda Jackson referred to the point regarding rota co-ordinators going back to being managed by the divisions as this had not previously worked. Shaun Stacey advised the auditing and review would be maintained centrally, however; the actual work would move into the divisions. This would help communication issues that had been identified over recent months and link the medical staff rotas along with training and job plans. Although this was a small change it would also smooth out the development of the resource centre. It was felt that the advantage of three operational divisions would give the opportunity of building the leadership structure within divisions both clinically and from a service delivery perspective. Linda Jackson felt the Trust was in a more stable position than previously so it appeared this would be a positive change.

Gill Ponder queried what the impact was on patients in respect of the changes in clinical support services in terms of quality and capacity. Shaun Stacey advised there would be no impact on patients, however the quality and outcomes measured by making these changes would smooth the journey for patients.

Sean Lyons referred to the staff survey and queried whether there were any comments in respect of this. Dr Peter Reading confirmed the results were very disappointing. The Health Service Journal (HSJ) had published that the Trust was in the bottom five in the country for key questions around staff engagement at the Trust. There was also a deterioration in the score, however, this had affected the majority of Trusts across the country. The staff survey had unfortunately been an issue at Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) for several years. Some progress had started to be made; however, this had now been

negated so there was a need to continue work within the organisation on culture and behaviour. It had been highlighted at a recent HSJ Summit that Trusts that do score high in the staff survey were those that concentrate on staff wellbeing, so it was evident this was key to staff morale. Dr Peter Reading wanted the public to be aware the Trust would take action in relation to making improvements and this would be included within the Trust Priorities.

Sean Lyons wanted to highlight the approval of the business case for the investment in the building of the Acute Assessment Units (AAU) at both sites. Congratulations were also given to Shauna McMahon in respect of the joint Chief Information Officer (CIO) post at NLAG and Hull University Teaching Hospital (HUTH).

Ellie Monkhouse advised the Ockenden 2 Report had been released on the 30 March 2022. The report focussed on four pillars which were safe staffing, well trained staff, learning from incidents and listening to families. There were 15 areas of national actions and within those there were 90 individual actions. It was acknowledged that to address this would be a huge undertaking for NLAG. There would be national and regional oversight and scrutiny along with a regional scheduled visit and annual monitoring visits. A Multi-Disciplinary Team (MDT) approach would be undertaken to include all areas of staff from back office functions through to clinical staff and teams within governance. Discussions had already taken place on learning and development and how this would move forward. Ellie Monkhouse advised the Trust had a dedicated Quality Improvement Manager in post in Maternity Services and the post had been extended for a further year to support this work. The post would also be required longer term. A review of meetings in place would be undertaken which would include current attendance levels. Progress reports and updates would be provided to the Board going forward.

Dr Kate Wood supported actions being put in place but wanted to note the report would impact on the whole Trust due to work that would be required. This would mean additional support being required from the executive team in terms of working through actions. Maneesh Singh had recently visited Maternity and wanted to note that staff had been very open and transparent. Fiona Osborne queried whether the original establishment review shared in December 2021 would need to be amended due to the report highlighting safe staffing levels. Ellie Monkhouse advised it would not as the original establishment review did not included Maternity services. A review had been undertaken the previous year and there had been an investment in this area through Ockenden. It was noted that birth rate plus had just been completed and was now being analysed. The results from this would be put forward in the May establishments which would allow a review of the Ockenden report. There may also be some supported funding in terms of the report that would focus on staffing. It was noted all Trusts were currently struggling to recruit midwives, so this was part of the concern. Lee Bond advised there had been an announcement the previous week that further national funding would be available to support the report. It was felt this would in the first instance be allocated on an ICS basis and decisions would then be made on how to deploy those resources. A key focused would be on safe staffing and the continued roll out of continuity of carer. Each maternity unit would continue to have those discussions in respect of balancing the risk moving forward.

2.8.1 Trust Priorities 2022/23 – NLG(22)032

Dr Peter Reading advised the Trust Priorities purpose was to enable NLAG to identify key areas for focus over the next year. The priorities would be supported by business plans and individual objectives of the Executive Team. It was noted that some would be difficult to deliver and this particularly related to emergency care. One new priority for the year was around reducing health inequalities which was also a national priority. The priorities had been developed with the Executive Team and approval had then been sought by the Trust Management Board (TMB).

Lee Bond referred to the priorities in respect of the reference to the Humber Coast and Vale (HCV) ICS as this would need updating to reflect the change in name to Humber and North Yorkshire Health & Care Partnership. Dr Kate Wood referred to Priority Two and amendments which would be required in relation to receipt of the Ockenden Report. Dr Peter Reading agreed relevant changes would be made. Ellie Monkhouse advised no formal notification had been received in respect of the Ockenden Report so changes would not be required at present, and the Local Maternity Systems (LMS) would continue to make the decision of when the Trust would move to the next scale. It was agreed the document would be amended once the guidance was received.

Sean Lyons confirmed the Trust Priorities would be approved with the agreement that once the guidance was received the relevant amendments would be made. Changes would then be delegated to Dr Peter Reading, Ellie Monkhouse and Dr Kate Wood.

The Trust Board agreed the Trust Priorities.

2.9 Integrated Performance Report (IPR) – NLG(22)033

Sean Lyons advised the IPR had undergone a review and now included Key Issues for Quality & Safety, Workforce and Performance. This update would now replace the separate Executive Highlights on the public agenda and instead referred into the one IPR paper.

3. Strategic Objective 1 – To Give Great Care

3.1 Key Issues – Quality & Safety - NLG(22)033

Dr Kate Wood referred to the IPR key highlights and lowlights. From a mortality perspective NLAG remained in the ‘as expected’ range, as per the previous 18 months. This was due to the continued work and support by the relevant teams, and deep dives into the statistics continued to be undertaken. One ongoing concern was around deteriorating patients’ metrics, which remained a priority for the year. For assurance the Trust triangulated any concerns in this area where possible. Although documentation for the escalation of deteriorating patients what not as effective as required, assurance was received that the appropriate actions had been undertaken and the lack of documentation through the electronic reporting had been identified as the issue.

The Trust Venous Thromboembolism (VTE) performance had appeared to be poor, but as previously noted it was considered to be due to data quality and how this was uploaded. It was noted the issue had now been resolved and a true reflection would be reported on the Trust's position in the report at the next meeting. Shauna McMahon confirmed this was now at 90%. Dr Kate Wood thanked colleagues for perseverance in respect of the issue. It was hoped the same would be reported in respect of sepsis management and deteriorating patients over the next few months. In respect of Serious Incidents (SIs) NLAG currently had 25 open for which 15 had been extended due to clinical pressures. It was confirmed 23 SIs directly related to pressures ulcers.

Ellie Monkhouse highlighted the current infection control position as the Trust remained in an extremely challenged position from an operational perspective. It was felt the norovirus cases would soon peak. The Trust currently had around 145 closed beds due to norovirus and COVID cases. The Board were assured that quality and safety continued to be maintained across sites during this time.

Linda Jackson referred to the dip in the medical staffing Performance Achievement & Development Reviews (PADRs) for the year and queried the cause. A further query was in relation to how work was progressing with North East Lincolnshire (NEL) in respect of Out of Hospital, Summary Hospital Mortality Indictor (SHMI) as this was out of NLAGs control due to support required from partners. Dr Kate Wood responded to the PADR query and advised there had been some delays as the data was not in the required report. The current rate was 85% for all doctors connected to NLAG, and after 'exceptional circumstances' were taken into consideration for PADRs not being completed, the rate increased to 94%. It is a requirement through the General Medical Council (GMC) for NLAG to track PADRs, so this was undertaken on a regular basis. These issues would be resolved within the next month. It had been identified that there had been a flaw in the way PADRs were reported over the past year, which would be rectified moving forward. In respect of the Out of Hospital SHMI this was higher at Grimsby than Scunthorpe due to a number of attributable factors identified including that NEL had less palliative care provision than North Lincolnshire (NL). It was noted that the key roles had been advertised the previous week, but it was recognised that there may be some difficulty recruiting to the posts and a further plan was in place should this occur. It was noted that there was a converse perception that having a high Out of Hospital SHMI was a positive position, as it meant the Trust had identified patients that came into hospital that would prefer to die in a different residence to the hospital.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(22)034

Mike Proctor advised the Quality & Safety Committee (Q&SC) had approved the latest submission for Ockenden on behalf of the Board. Assurance had been provided for the submission from discussion at the Q&SC along with the Maternity Transformation Board. A separate Confirm and Challenge meeting had taken place with external midwives in attendance. Mike Proctor attended all meetings. The committee had agreed a framework to establish Patient Safety Partners at the Trust, which had emerged from the National Patient Safety Strategy and it had been agreed to do address through the Volunteer Policy. Some Governors had

raised concerns about how the role would work as the Governor role was normally seen as bringing the patient perspective to the Board. It was noted there would be an attempt for Governor involvement at each stage within the development of the role.

A further point raised related to cancer as it had been identified there was a difference in views on how to marry single strategic oversight with governance structures. There was now a way forward which would see the committee deepen the focus on patient experience through the cancer pathways. The change had been reflected in the committee workplan; formal approval of the change would be sought if required. It was noted there may be a future need for the Board to examine the role of sub-committees in respect of agendas. The self-assessment of the Q&SC had been undertaken and was attached for information.

Sean Lyons queried if the Q&SC reviewed the extension of the SIs process and whether the committee captured the major learning of incidents in a timely manner. It was advised the committee had oversight of SIs. A weekly SI Panel chaired by Mr Kishore Sasapu was in place and all potential SIs were reviewed at that meeting, all requests for extensions were also approved at that meeting. All extensions underwent a challenge process of why requests had been made, and not all extensions were granted. It was clarified that when an SI was reported it was reviewed to identify immediate learning rather than waiting for the investigation to be concluded, and learning was condensed and shared with the appropriate clinical teams.

Fiona Osborne advised queries had been raised at the Q&SC in respect of extensions and a request was made to expedite the investigation if possible, to enable the patient to receive the response as quickly as possible.

3.3 Ockenden Update – NLG(22)035

Ellie Monkhouse advised the update shared was in response to a letter received from Ruth May, Chief Nursing Officer for discussion to take place at Board level in relation to the first part of Ockenden and Nicky Foster; Deputy Head of Midwifery was in attendance to present the item.

Nicky Foster referred to the paper and highlighted key points. The Board were advised the Trust had seven immediate actions and were compliant with six of them with partial compliance for the remaining one. It was noted the Q&SC had oversight of the Ockenden Action Plan and Care Action Plan.

Linda Jackson queried whether the correct resources where in place to support the current workload of the maternity team. There was concern that requirements could be missed if this was not addressed. It was felt a review should be undertaken of what the team were expected to respond to at the moment as Ockenden requirements was not the only issue. Ellie Monkhouse thanked Nicky Foster for attending the meeting and welcomed Linda Jackson's comments as this issue had already been raised. It was confirmed that there would be a need to review what resources and funding would be available to address the requirements and respond to all requests, and a meeting to discuss this was due to be held that week. An Improvement Plan / Maternity Strategy was being worked through to

enable a public facing declaration to be available of what actions NLAG intended to undertake. Dr Peter Reading agreed the division would need to be resourced to absorb requirements and pressures. It was agreed Lee Bond and Ellie Monkhouse would meet outside of the meeting with Dr Peter Reading to discuss the options.

Sean Lyons thanked Nicky Foster for attending the meeting and felt it was important the team highlighted achievements to the Board.

3.4 Key Issues – Performance – NLG(22)033

Shaun Stacey highlighted key points from the IPR and again confirmed the continued challenges around the high prevalence of COVID and other infections at NLAG, which had affected the workforce and continued delivery of care. The continued delivery of the urgent care walk-in minors service had improved, however, it was unfortunate to report that due to challenge on inpatient flow Accident and Emergency (A&E) had not improved overall. This had been despite significant work with managing patient flow and the front line. There had been a continued increase in 60 minute ambulance handovers and only 64% of patients had then been transferred within 4 hours to a hospital bed. Walk-ins with minor injuries was a positive to report as this was 98% for being seen within four hours. There was disappointment that the discharge to assess position had not continued to hold the improved start from the beginning of programme and the average length of stay of 21 days and over had now increased by 12% due to capacity issues in the local communities. This related to a range of issues which included workforce absences and work was being undertaken to address the issues identified. The Trust still remained in the top 10 for discharge to assess.

In respect of electives NLAG continued to see a reduction in the 52 week wait position, however, there would be a circa of around 100 patients that would be waiting over that period at the end of the year. The Trust continued to use the independent sector for cancer services but there was some challenge around those services, a backlog remained in respect of 104 day waits and the 62 day referrals had increased.

Linda Jackson queried whether there was any indication of some improvements with discharge to assess into the community or whether support from the Board was required to progress this. An observation was noted in respect of the improvement of the Diagnostic Waiting Times and Activity (DMO1), which had been an excellent achievement. Shaun Stacey confirmed there had been effective engagement with the community so far in respect of discharge to assess. A further change was to be adopted which would allow the opportunity to use quality improvement to support delivery. In terms of risk, it was clear there were different levels of risk for NL and East Midlands Ambulance Service (EMAS), with a current significant risk in the patient population and community. There was a regulatory challenge around the issues for discharging patients as nursing homes had been closed by Public Health which had meant no support being offered for NLAG. A request had been made the previous day being Monday, 4 April, for full divert of emergency departments, however, NLAG partners had been unable to support the request.

Sean Lyons noted there was currently a huge national pressure on waiting lists and ambulance handovers, and due to this national meetings were being held. To support this a flash report would be shared with Board members going forward.

Stuart Hall queried how the Trust had interacted with the ambulance service to reduce handover times. Shaun Stacey advised NLAG was working closely with EMAS and Yorkshire Ambulance Service (YAS) which had led to a reduced number of ambulance attendances over the last six months. This was reflective of patients being treated through the Same Day Emergency Care (SDEC) service or locally by primary or community services, and had resulted in some improvements. The Trust continued to communicate four times a day with the ambulance services to review the plans in place.

Lee Bond referred to A&E department attendances and queried how many went through the urgent care pathway as it referred to the figure as being 98%. Shaun Stacey explained the current workstream was seeing between 80 to 90 patients a day which on some days peaked at around 120. The Trust challenge related to the significant delay in exit flow and exit blocks for moving patients into a ward bed. The Trust currently had 100 patients in hospital that could be discharged home or to a community bed with dedicated support, however, due to various issues this had not been undertaken. Those patients would be classed as no right to reside.

Ellie Monkhouse provide assurance to the Board that discussions had taken place with Dr Kate Wood in respect of the current situation, and the focus on quality of care continued during peak times. It was confirmed that decisions had sometimes been made based on quality as opposed to performance.

3.5 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(22)036

Gill Ponder advised the report detailed the discussion that had taken place at the Finance & Performance Committee (F&PC) in respect of the four hour waits and ambulance handover delays. The F&PC had not been assured in respect of the four-hour standard so a further update would be provided at a future meeting. The F&PC had received a presentation on the Draft Operational Plan for 2022/23 and assurance was received following a detailed discussion. Gill Ponder drew the Board's attention to the Improvement Notice received from Anglian Water in respect of the coldwater tanks. The work required had been included in the 2022/23 funding and if was received the work would be completed by the next inspection in October 2022. The committee had requested a quarterly update on all Improvement and Enforcement Notices against the Trust on a quarterly basis. A deep dive on cancer performance had also been undertaken at the F&PC.

Fiona Osborne queried whether there was a register of enforcement notices at the Trust in respect of the request through the F&PC. Lee Bond advised the Trust did not receive many enforcement notices, so a register was not maintained and it was confirmed that Jug Johal notified relevant staff when they were received. Simon Tighe concurred and advised the previous notice received was in 2015. Anglian Water carried out annual assessments on the primary supply of water and this issue had been picked at that time. The Trust was already aware of this and a plan was in place to address the issue, which was also part of the critical

infrastructure works carried out the previous year. A tender process for the works would be undertaken shortly.

Dr Peter Reading referred to the report and provided assurance to Gill Ponder and Fiona Osborne that when notices were received Board members would be notified.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Key Issues - Workforce – NLG(22)033

Christine Brereton advised a number of indicators were above target and a number of deep dives had been undertaken at the Workforce Committee. Sickness absence remained high due to COVID, which was not expected to reduce for the winter period, and further actions would be put in place during the summer months to address this. It was noted the Sickness Absence Policy had been reviewed and approved at the Trust Management Board (TMB). The overall targets for mandatory training were being met, however, there was some hot spot areas with regards to medical staff which were being addressed through the Performance Review Improvement Meetings (PRIMs), and teams were also being notified directly. A discussion had taken place regarding the unregistered nursing vacancy target as this had increased to 11.6% against a target of 2%, and the committee proposed an increase in the target to 8%. A deep dive on turnover and retention had also taken place at the committee.

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(22)037

Michael Whitworth advised the Workforce Committee had approved the Gender Pay Gap Report on behalf of the Trust Board in line with the 30 March submission. The Modern Slavery Statement and Disciplinary Procedure had also been formally approved by the Committee. It was noted that due to the cross working of Christine Brereton and Shauna McMahon's teams the data provided had improved.

Ellie Monkhouse noted the change in the Health Care Support Worker (HCSW) vacancy target which may carry some risk as there was a national requirement for a zero percent to be place and the Trust should not lose sight of this. It was also recognised that recruitment to these posts remained a national issue. Christine Brereton noted the expectation of the zero percent for HCSW and advised the target was in relation to unregistered nurses which covered more roles than this role. Going forward this section would be sub-categorised in the IPR to highlight this. Potential options for recruitment to HCSW posts along with discussions around the retention of staff in this role were being considered.

4.3 Gender Pay Gap – NLG(22)038

Christine Brereton advised the Gender Pay Gap had been shared at the Workforce Committee and approved for Trust Board agreement.

The Trust Board approved the Gender Pay Gap.

4.4 Modern Slavery Act – NLG(22)069

Christine Brereton advised the Modern Slavery Act had been shared at the Workforce Committee and approved for Trust Board agreement.

The Trust Board approved the Modern Slavery Act.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 11 - NLG(22)068

Lee Bond advised the Month 12 position was currently being collated and it was expected NLAG would have met the financial obligations for 2021/22. At the end of Month 11 NLAG were on plan with a mixture of surplus income which had offset overspends particularly relating to pay. The overspends had again been driven by medical and nursing staff as in previous months.

5.2 Finance & Performance Committee (F&PC) Highlight Report and Board Challenge – Finance - NLG(22)039

Gill Ponder advised the F&PC had discussed Month 11 and the end of year position and had been fully assured. A detailed presentation was shared in respect of the Draft Operational and Financial Plan for 2022/23 and a discussion had taken place.

The committee self-assessment had been undertaken and would be shared at the Board meeting in June. Lee Bond referred to the report in respect of the Capital Business Case for theatres at both sites supported by the Target of Investment. Approval was still awaited but if agreed it would be very positive for NLAG.

Fiona Osborne queried whether Lee Bond was comfortable with the margin of error with all the current changes at the Trust. Lee Bond agreed the environment NLAG was operating in was difficult and had been reflected within the plan. There was very little movement in respect of the financial element of the plan, and it was confirmed that a more detailed discussion would take place during the private Board meeting to follow.

5.3 Key Issues – Estates and Facilities – NLG(22)040

Simon Tighe took the report as read and sought questions and comments. Lee Bond referred to the plans for replacing the heating at the Scunthorpe General Hospital (SGH) site which had previously been unable to be undertaken due to the timing of the works required. However, it had now been identified that there was hot water below the SGH site which would allow NLAG to progress key work leading to being able to request a further grant. It was noted this was a further reflection of the great work Simon Tighe and the team had undertaken. Sean Lyons thanked Simon Tighe for the very encouraging update.

Dr Kate Wood drew the Board's attention to the increase in accommodation requirements at the SGH site as a key issue which had been highlighted. The accommodation was in a poor condition and it was queried whether there were any

improvement plans that could be shared. Simon Tighe advised there were a number of options and the current primary focus was Project Anchor, the regeneration of Scunthorpe town centre which would incorporate new accommodation built by the local authority. The new hospital build once agreed, would also include accommodation. Sean Lyons offered to support if this if required as it was important the Scunthorpe site was able to attract experienced staff and retain current staff in respect of this.

Gill Ponder queried what actions were planned in respect of the resource risk detailed on page six. Simon Tighe explained there were only six Engineering Authorised persons (APs) per site and those at the SGH site also covered Goole District Hospital (GDH). As there were currently many projects at NLAG this had meant those staff being drawn away from "business as usual" in maintaining the estates contracts. The team had recently recruited two veterans which had helped with the team skill set and long-term plans were to work with colleges to recruit apprentices and engage with new employees and train them through NLAG.

Stuart Hall referred to the slide on page three and queried the 'step away from local suppliers' for orders and how the Trust managed relationships with local suppliers to fulfil requests made was queried. Simon Tighe advised in the future NLAG would look at hybrid working but unfortunately at the moment local suppliers did not have the resilience to sustain this type of service. One recent change NLAG had introduced was the sandwich making facility in house which had meant local suppliers could be used in terms of ingredients. Sean Lyons noted that the Scunthorpe Catering Department had recently received a five star hygiene award rating.

Ellie Monkhouse acknowledged the importance of the cleanliness standards referred to on page one as this would be a huge undertaking across the organisation. It was also noted that the facilities team had recently supported the work required in response to the current position with infections across the site. This had resulted in some out of hours working to clean clinical areas at short notice, and thanks were noted to the team.

Simon Parkes referred to the Public Sector Decarbonisation Scheme (PSDS) energy works at SGH which appeared very positive and whether the funds would be available for the remainder of the project and any impact on the Trust. Simon Tighe advised phase one had been applied for in November 2020, which was limited to six months but then extended to one year. As lessons had been learnt in respect of this, phase three was now considering three year projects. This phase was released in November 2021 and monthly meetings had been held to monitor progress. The expectation was that the next phase would be around September or October this year with early release for 2023. The concept had been approved which would enable primary heating for that part of the hospital and colleagues would be sighted on the application as it progressed. Simon Parkes queried whether this would meet the criteria and the impact on the Trust in respect of capital spend. Lee Bond advised there was a plan to keep this as an asset under construction in the balance sheet.

Dr Peter Reading confirmed that Jug Johal had agreed to take the role of Executive Lead for the Anchor Institution status and would be developing this over the next year.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(22)041

Ivan McConnell advised the Trust continued to play an active role in areas of collaboration. All programmes would be subject to a significant independent review and multiple areas were underway.

From a capital perspective an expression of interest had been submitted to NHS England / Improvement (NHSE/I) and the Secretary of State, however, the announcement for receiving the funds had now been further delayed. It was hoped this would be received by July 2022 at the latest. As NLAG remained in the System Oversight Framework (SOF) Four, any investments would require approval by the regional and national team.

Mike Proctor raised a question as to why there was still only an Acute Provider Collaborative. Ivan McConnell confirmed the recognised need for greater joint working in order to avoid silo working. Dr Peter Reading concurred and advised that in other parts of the country there was more joined up working than there was in the system that NLAG was placed in.

6.2 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – March 2022 – NLG(22)042

Gill Ponder advised the Committee had approved the Terms of Reference at the meeting. A suggestion had been supported for the Charity Manager to work with Trust colleagues to mark the Jubilee. The Draft Financial Plan had been discussed at the meeting and whilst members were content with the paper, further development had been requested. It had been agreed to share this again at the next meeting.

6.3 Annual Review of the Health Tree Foundation Trustees' Committee Terms of Reference – NLG(22)042

Gill Ponder advised the proposed amendments were shown by track changes and sought Trust Board for approval of the changes.

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

Sean Lyons attended a recent meeting and referred to the amount of funds within the charity and encouraged the appropriate processes be used to draw on funds that may be required to support patients.

6.4 Humber Acute Services Development Committee Highlight Report & Board Challenge - NLG(22)044

Sean Lyons wanted to highlight that Linda Jackson and Stuart Hall would be paying attention to programme one and a meeting on had been held the previous day being Monday, 4 April. Stuart Hall advised the meeting had included confirmed clear actions that would require review to enable focus.

6.5 Strategic Development Committee (SDC) Highlight Report & Board Challenge – NLG(22)045

Linda Jackson advised assurance was provided in respect of programme one and a Project Management Office (PMO) would be established to support requirements. A key issue related to clinical leadership; however, plans were in place to move this forward. In respect of programme three the NEDs had requested an update on what Plan B would look like if the relevant funds were not received and this had been provided by Ivan McConnell at a recent meeting, which had provided a level of reassurance. An update had been provided by Shauna McMahon at the meeting on the Strategic Digital Programme. An update on the Electronic Patient Record (EPR) had also been provided at the meeting which included progression for both sites.

7. Strategic Objective 5 – To Provide Good Leadership.

7.1 Leadership Strategy – NLG(22)046

Christine Brereton advised a detailed report had been shared with the Board and delivered a presentation on progress and the plans in place on the Leadership Strategy.

Sean Lyons thanked Christine Brereton for the presentation and sought comments from the Board.

Stuart Hall queried whether the changes would include issues in respect of staff turnover and PADR completion and what the key themes would be to measure this. Christine Brereton explained some indicators to be utilised were already captured in the IPR, however, some indicators within the model employer would measure the softer issues required. This would include whether staff members were supported by individual line managers in respect of well-being amongst other aspects. This would then measure how individual leaders worked. Work would also be undertaken with NHSE/I on how to measure leadership and culture.

Dr Peter Reading felt there were three items that could take the organisation into a sustainable workplace, particularly medical engagement due to the significant progress in this area. The second was in respect of quality improvement work and the third was to create an environment where every leader had first class leadership skills.

Gill Ponder queried how the impact of the changes would be measured, and whether a staff cohort of non-leaders had been considered to feedback what was

felt could make this a success. Sean Lyons welcomed this interesting point and asked if Gill Ponder would liaise with Christine Brereton outside of the meeting.

Action: Gill Ponder / Christine Brereton

Sean Lyons suggested there could be some Board personal experiences which could support with the progress of the programme. Christine Brereton explained the progress of the programme would be monitored through the Workforce Committee. It was noted the Pride and Respect work would also continue to be supported going forward. Christine Brereton thanked Board members for the support offered.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – NLG(22)047

Simon Parkes highlighted key points from the report shared. One was in respect of salary overpayments which had increased during quarter three, and actions to alleviate this. One long standing issue discussed at the committee was in respect of document control as documents were still not being updated within timescales.

Dr Kate Wood advised that an update was now available for item one of the report in respect of the Medical Staff Job Planning Internal Audit Report. It was confirmed that in May 2021 there had been less than 20% of medical staff on job plans, however, this had now improved as of last week to over 80%.

Sean Lyons asked Simon Parkes whether the committee required any further support in respect of document control. Simon Parkes confirmed colleagues were addressing this.

A further issue identified by the committee was the abusive messages directed at the payroll team, which required urgent attention as it was unacceptable. Sean Lyons concurred. Dr Peter Reading referred to previous discussions in respect of this behaviour on Ask Peter and other forums and advised the processes had now been changed to try and alleviate this. Unfortunately, this approach was not possible with social media. Christine Brereton was in the process of developing some standards of behaviour for Ask Peter. In respect of behaviour towards the payroll team, a working group had now been developed to consider how messages were communicated to staff in respect of pay and other issues, and the to progress the introduction of a central inbox for staff complaints as opposed to being directed to individuals.

8.2 Annual Review of the Audit, Risk & Governance Committee Terms of Reference – NLG(22)048

Simon Parkes shared the report with the Board and sought Board approval.

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

8.3 Board Assurance Framework (BAF) – Quarter 3 - NLG(22)049

Alison Hurley advised the BAF had been considered at all sub-committees except the ARGC. The Trust Board were asked to review and advise of any further reassurance required. Attention was drawn to strategic risks that remained over 15 and whether any further actions were required. Alison Hurley would be reviewing the Quarter four report over the next month with Directors.

9. Approval (Other)

There were no items of approval.

10. Items for Information

The following items were shared at the April 2022 meeting:

- F&PC Minutes – December 2021
- Q&SC Minutes – January & February 2022
- Patient Experience Report
- Guardian of Safe Working Hours – Quarter 2
- Workforce Committee Minutes – November 2021
- Freedom to Speak Up Guardian Quarter 3
- A&RGC Minutes – October 2021
- Results of the AR&GC Self-Assessment Exercise
- HTFTC Minutes – November 2021
- Communication Round-Up
- Clinical Strategy Reporting Framework

11. Any Other Urgent Business

Shaun Stacey requested that thanks to the Emergency Department, Medicine and Surgery teams be noted for the support offered to United Lincolnshire Hospital due to the recent fire that had been experienced. Despite challenges the NLAG team had responded very well. Dr Peter Reading wanted to highlight the regional team had also been made aware of the support offered.

12. Questions from the Public

Sean Lyons asked for questions from the public.

Jon Clark was in attendance as a Trust Member but also worked as an NLAG Volunteer. The volunteer work undertaken by Jon Clark was patient transport, it was noted that the majority of feedback received during this time was of a positive nature. The need to highlight the good work being undertaken by the Trust was brought to the Trust Board's attention.

13. Date and Time of the next meeting

Board Development

Tuesday, 3 May 2022, Time: TBC

Formal Trust Board Meeting

Tuesday, 7 June 2022, Time: TBC

The Private Trust Board meeting was due to follow at 13.00 hours.

Sean Lyons closed the meeting at 12.36 hrs.

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

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

NLG(22)078

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2022/2023

Kindness · Courage · Respect

ACTION LOG & TRACKER

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?
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

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board Public Meeting

2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
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	

Key:

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

NLG(22)079

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	7 June 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, some of which are covered in more detail elsewhere on the agenda.	
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	✓ 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, focusing 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. NHS England stands down National Incident

On 19 May 2022, the Chief Executive of the NHS (Amanda Pritchard) reclassified to Level 3 (Regional), the Level 4 (National) Incident declared on 13 December 2021 to help the NHS prepare for the predicted surge in Omicron and to deliver the COVID-19 vaccination booster Raj. Accordingly, NLaG is standing down most of the organizational infrastructure established to manage our response to the National Incident.

Associated with the very substantially reduced impact of COVID-19 on the NHS, NLaG has gradually returned to close to pre-pandemic arrangements for visiting, infection prevention and control and wearing of PPE (Personal Protective Equipment).

2. NHS England consultation on proposed revisions to trust Provider Licence

NHS England has published (for a six week consultation closing on 8 July 2022) three draft documents that will sit under a revised Provider Licence (currently in development) which will soon apply to all trusts. The documents reflect the passing of the Health and Care Act 2022, updating governance arrangements where relevant. I am grateful to the NHS Providers *On the day briefing* for most of the content below.

Among these draft documents is a proposed new NHS provider *Code of Governance* which would replace the *NHS Foundation Trust Code of Governance* which was last updated in 2014. For the first time, the Code will apply to all trusts. There is also a draft *Addendum to Your statutory duties – reference guide for NHS foundation trust governors,* and *Draft Guidance on Good Governance and Collaboration.*

The provisions of the proposed new NHS provider *Code of Governance*, in general, do not greatly differ from the 2014 version since the Health and Care Act 2022 does not change the statutory role, responsibilities and liabilities of provider trust boards of directors. However, there are some themes underlying the key changes:

- Incorporation of the requirement for boards of directors to assess the trust's "contribution to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), and place-based partnerships" as part of its assessment of its performance, and "system and place-based partners" are highlighted as key stakeholders throughout.
- Inclusion of the board's role in assessing and monitoring the culture of the organisation and taking corrective action as required, alongside "investing in, rewarding and promoting the wellbeing of its workforce". The previous code only mentioned wellbeing in the context of the finances of the organisation.
- A new focus on equality, diversity and inclusion, among board members but also training in EDI should be provided for those undertaking director-level recruitment. The board should have a plan in place for the board and senior management of the organisation to reflect the diversity of the local community or workforce, whichever is higher.
- For foundation trusts, potentially greater involvement for NHS England in recruitment and appointment processes, including utilising NHSE's Non-Executive (NED) Talent and Appointments team in preference to external recruitment consultancies and having representation from NHSE on NED recruitment panels. When setting remuneration for NEDs, including the chair, foundation trusts should use the *Chair and non-executive director remuneration structure*

The draft *Addendum to Your statutory duties – reference guide for NHS foundation trust governors* seeks to place the legal duties of councils of governors into the context of system working. It addresses holding the non-executive directors (NEDs) to account for the performance of the board, representing the interests of trust members and the public, and approving or not, significant transactions, mergers, acquisitions, separations or dissolutions. This addendum only applies to a council of governors' role within its own foundation trust's governance.

The *Draft Guidance on Good Governance and Collaboration* is issued under the NHS provider licence and sets out what NHS England expects from providers in terms of collaboration and the good governance that must be in place to support it. It reflects the expectation for providers to collaborate with partners to agree shared objectives through integrated care partnerships (ICPs) and to collaborate on the delivery of the five-year joint plan and annual capital plan through system, place-based arrangements, and provider collaboratives. The guidance also forms the basis of how NHSE will oversee this aspect of provider performance under the NHS System Oversight Framework (SOF).

In addition to their existing duties to deliver safe, effective care, and effective use of resources, the success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the integrated care system (ICS). The guidance sets expectations of providers in terms of collaboration in three key areas and gives illustrative (non-exhaustive) minimum behaviours.

Providers will be expected: to engage consistently in shared planning and decision-making; consistently to take collective responsibility with partners for delivery of services across various footprints including system and place; and consistently to take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives, or any other relevant forums.

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

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

In anticipation of this, the infrastructure and key personnel of HNY continue to take shape. 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.

Peter Reading
Chief Executive

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	Tuesday 07 June 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 5. **4. Workforce** The executive summary of the Workforce section is provided over on page 7. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR (April Data) Quality and Safety – IPR (February / March Data) Workforce – IPR (April 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

1. ACCESS & FLOW – Shaun Stacey

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

- Percentage of Inpatient Waiting List Risk Stratified – 100% April 2022
- Outpatient Did Not Attend (DNA) Rate – 6.5% April 2022
- Cancer – Two Week Wait – 93.9% April 2022 (unvalidated)

Lowlights: (share 3 areas of challenge/struggle)

- Emergency Department Waiting Times (4 Hour Performance) – 58.9% for April 2022
- Number of Decision to Admit (DTA) 12 Hour Waits – 725 for April 2022
- Cancer Waiting Times – 62 Days GP Referrals – 55.1% for April 2022 (unvalidated)

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)	UCS implemented on both sites	Increase in patients being seen in under 4 hours
Number of Decision to Admit (DTA) 12 Hour Waits	LLOS patient review already implemented but process reviewed	Decrease in LLOS patient which implies an increase in patient flow and a decrease in number of DTA 12 Hour Waits
Cancer Waiting Times – 62 Days GP Referrals	Breast Medical Workforce Reviewed and interim plan put in place to manage increased demand	Decrease in waiting times for patients on Cancer pathways

2. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- The Trust had a C.difficile objective of no more than 33 cases and ended the year on 20 reported cases which is 40% within the allocated trajectory and 29% reduction to last year. This was the lowest number of cases for a District Hospital in the region and one of the lowest in the UK
- The total number of falls reported in March 2022 has decreased with the largest decrease being reported at DPOW
- The rate of omitted medications on ward areas continues to demonstrate a reduction with a rate of 2.2% reported for March 2022.
- Audit results highlighted 100% of patients admitted to IAAU, whose weight was 50kg, complied with the prescribing weight for dosing standard.
- The Trusts' rolling 12-month SHMI continues to decrease, with the most recent figure (November 21) reported at 105.7.
- The number of adults who had their observations recorded on time remains in line with the target for April 2022.

Lowlights: (share 6 areas of challenge/struggle)

- Mixed Sex breeches- all 13 were reviewed individually and escalated by S&CC and all occurred due to Operational pressures
- The number of new complaints and PALS has increased in March with themes around communication seen. As the Trust reopens visiting these concern numbers will be monitored.
- Within the Trust there are currently 67 unestablished escalation beds which are being monitored daily for staffing levels and Quality and Safety
- Audit results demonstrate that screening for Sepsis (using the formal tool), and the completion of the Sepsis Six pathway (where a red flag is triggered), low compliance rates for both adults and children.
- Escalation following a NEWS (National Early Warning Scores) score of 5 or more (within the specified time period) remains at 0% for March 2022.
- Compliance in the rate of PEWS (Paediatric Early Warning Scores) undertaken/recorded within the specified time period has dropped to 75% for April 2022.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Lack of documentation to retrospectively evidence escalation/responses of deteriorating patients.	Escalation via WEB V systems explored with Trust's WEB V lead Targeted support/education offered to wards where concern has been identified.	Increase in the number of patients escalated in line with Trust policy. Automated system to support escalation Increased emphasis on the importance of the deteriorating patient.
Drop in the number of children where the PEWS (Paediatric Early Warning Scores) were completed within the specified time period.	Targeted training and education provided to student nurses working on the paediatric wards. Standard of the month centred around quality assuring student nurse entries.	Increased knowledge and education regarding the importance of accurately recording PEWS for all children admitted to the wards in a timely manner, resulting in improved compliance.

3. WORKFORCE – Christine Brereton

Highlights:

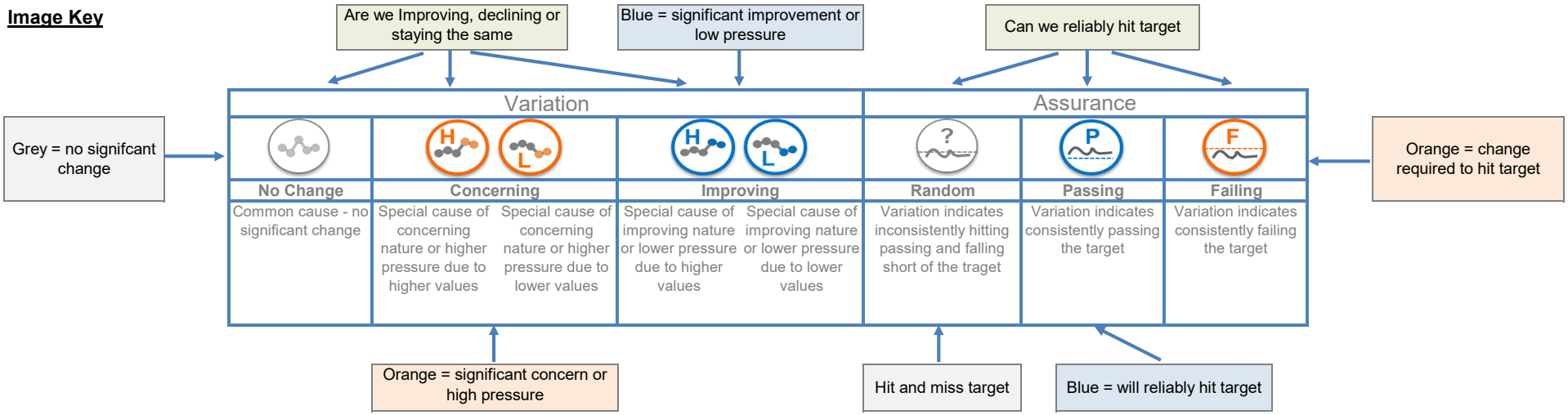
- The Core Mandatory Training position overall currently stands at 92%, Compliance continues to be above the Trust target of 90%
- The Registered Nursing vacancies position is 7.4% this continues to be below target of 8%
- The Medical vacancies position is 12.1% this continues to be below target of 15%

Lowlights:

- Hotspot areas of low compliance for Statutory /Mandatory training in medical workforce
- Turnover continues to be above target. The latest turnover data point 12.1%
- Unregistered Nursing vacancy positions continues to increase to 11.6% against a target of 2% (Target increase from April 2022 data)

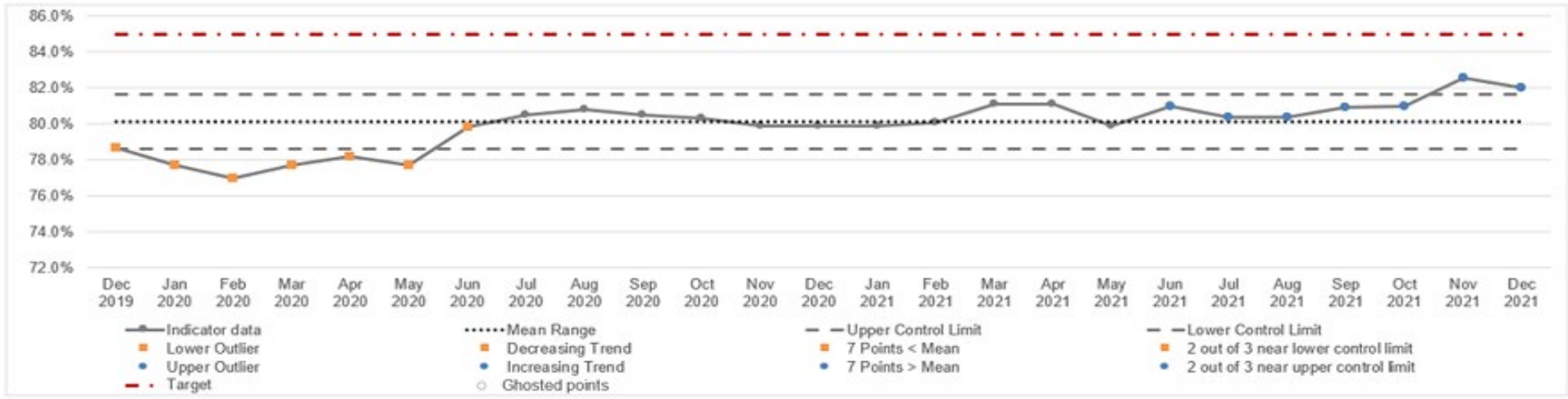
Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
ETD are also working closely with the ESR Team to monitor compliance through Power BI for MT and PADR. This will allow managers to look at real time data, so it is imperative that our data is accurate. Power BI is at the final sign off stage. A project to review and revise processes relating to leavers is underway, considering supportive conversations and methods to gather accurate leavers data. A Rapid Process Improvement Workshop is planned, supported by QI and NHSi/e to review the whole Unregistered Nursing process from sourcing to induction and retention	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. 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	Increased recruitment and retention of unregistered nursing. With the completion of the rapid process improvement workshop for unregistered nursing staff. 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

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).

SPC Key - example SPC chart



Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

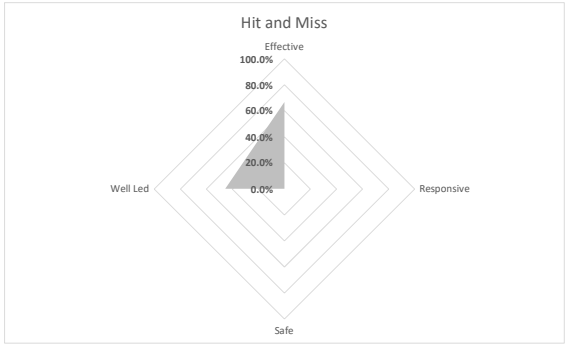
Consistently Passing

Total: 2

Core Mandatory Training Compliance Rate
Total Inpatient Waiting List Size

Hit and Miss

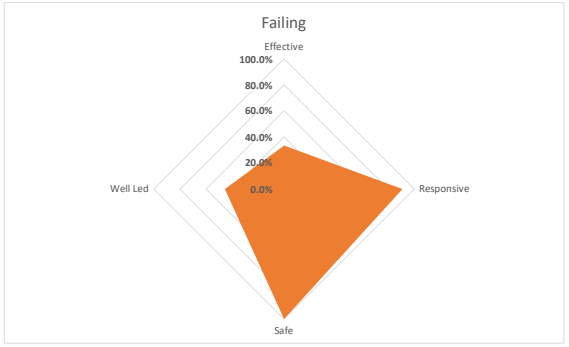
Total: 11



% Discharge Letters Completed Within 24 Hours of Discharge
Bed Occupancy Rate (G&A)
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
Registered Nurse Vacancy Rate
Medical Vacancy Rate
Sickness Rate

Consistently Failing

Total: 19



% 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
Patients With Confirmed Diagnosis Transferred By Day 38*
Percentage Under 18 Weeks Incomplete RTT Pathways*
Venous Thromboembolism (VTE) Risk Assessment Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Unregistered Nurse Vacancy Rate
Trustwide Vacancy Rate
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H / L	Core Mandatory Training Compliance Rate	Inpatient Non Elective Average Length Of Stay Registered Nurse Vacancy Rate	% 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
	Common Cause			% Discharge Letters Completed Within 24 Hours of Discharge Bed Occupancy Rate (G&A) Inpatient Elective Average Length Of Stay Complaints Responded to on time Medical Vacancy Rate	% Inpatient Discharges Before 12:00 (Golden Discharges) Number of Overdue Follow Up Appointments (Non RTT) Cancer Request To Test In 14 Days* Cancer Waiting Times - 104+ Days Backlog* Emergency Department Waiting Times (% 4 Hour Performance) Patients With Confirmed Diagnosis Transferred By Day 38* Percentage Under 18 Weeks Incomplete RTT Pathways* PADR Rate Unregistered Nurse Vacancy Rate
	Special Cause Concern	H / L	Total Inpatient Waiting List Size	% of Extended Stay Patients 21+ days Turnover Rate Role Specific Mandatory Training Compliance Rate Sickness Rate	Ambulance Handover Delays - Number 60+ Minutes Cancer Waiting Times - 62 Day GP Referral* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Combined AfC and Medical Staff PADR Rate Trustwide Vacancy Rate

Scorecard - Access and Flow

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
* 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*	Apr 2022	69.8%	92.0%	Action Required		F
	Number of Incomplete RTT pathways 52 weeks*	Apr 2022	232	0	Action Required	L	F
	Total Inpatient Waiting List Size	Apr 2022	11,355	11,563	Action Required	H	P
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Apr 2022	23.9%	1.0%	Action Required	L	F
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Apr 2022	28,869	9,000	Action Required		F
	Outpatient Did Not Attend (DNA) Rate	Apr 2022	6.5%	No Target		L	n/a
	% Outpatient Non Face To Face Attendances	Apr 2022	28.0%	No Target			n/a
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Apr 2022	55.1%	85.0%	Action Required	L	F
	Cancer Waiting Times - 104+ Days Backlog*	Apr 2022	31	0	Action Required		F
	Cancer - Patients With Confirmed Diagnosis Transferred By Day 38*	Apr 2022	26.7%	75.0%	Action Required		F
	Cancer - Request To Test In 14 Days*	Apr 2022	80.2%	100.0%	Action Required		F
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Apr 2022	58.9%	95.0%	Action Required		F
	Number Of Emergency Department Attendances	Apr 2022	11,904	No Target			n/a
	Ambulance Handover Delays - Number 60+ Minutes	Apr 2022	906	0	Action Required	H	F
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Apr 2022	725	0	Action Required	H	F
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Apr 2022	39.7%	40.0%	Action Required	H	F
	% of Extended Stay Patients 21+ days	Apr 2022	13.1%	12.0%	Action Required	H	?
	Inpatient Elective Average Length Of Stay	Apr 2022	2.1	2.5			?
	Inpatient Non Elective Average Length Of Stay	Apr 2022	3.9	3.9		L	?
	Number of Medical Patients Occupying Non-Medical Wards	Apr 2022	330	No Target	Action Required	H	n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Apr 2022	88.8%	90.0%			?
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Apr 2022	17.7%	30.0%	Action Required		F
	Bed Occupancy Rate (G&A)	Apr 2022	93.0%	92.0%			?
COVID	Number of COVID patients in ICU beds (Weekly)	Apr 2022	6	No Target			n/a
	Number of COVID patients in other beds (Weekly)	Apr 2022	150	No Target	Action Required	H	n/a
	% COVID staff absences (Weekly)	Apr 2022	24.9%	No Target		H	n/a

Scorecard - Quality and Safety

Northern Lincolnshire and Goole NHS Foundation Trust

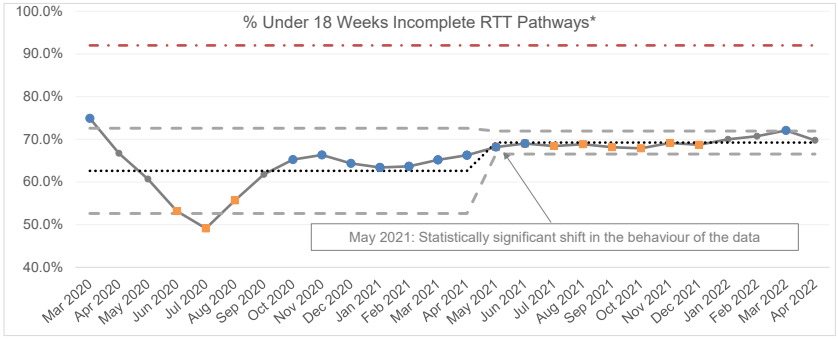
Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Mar 2022	0.00	No target			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Mar 2022	0.10	No target			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Mar 2022	0.05	No target			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Mar 2022	0.10	No target			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Mar 2022	0.16	No target			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Feb 2022	100.1	As expected		L	As expected
	Summary Hospital level Mortality Indicator (SHMI)	Nov 2021	105.7	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Mar 2022	100%	100%		H	n/a
	Number of Serious Incidents raised in month	Mar 2022	15	No target			n/a
	Occurrence of 'Never Events' (Number)	Mar 2022	0	0		n/a	n/a
	Duty of Candour Rate	Feb 2022	100%	No target			n/a
	Falls on Inpatient Wards (Rate per 1000 bed days)	Mar 2022	4.9	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Mar 2022	4.8	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Mar 2022	93.4%	95.0%	**Action Required**	H	F
	Care Hours Per Patient Day (CHPPD)	Mar 2022	8.3	No target	**Action Required**	L	n/a
	Mixed Sex Accommodation Breaches	Mar 2022	13	0		n/a	n/a
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Feb 2022	8.7	No target			n/a
	Complaints Responded to on time	Feb 2022	71.0%	85.0%			?
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Mar 2022	1124 out of 1190	No target		n/a	n/a
	Number of Positive A&E Scores	Mar 2022	478 out of 750	No target		n/a	n/a
	Number of Positive Community Scores	Mar 2022	182 out of 192	No target		n/a	n/a
	Number of Positive Outpatient Scores	Mar 2022	38 out of 43	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Mar 2022	16 out of 18	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Mar 2022	104 out of 106	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Mar 2022	0 out of 2	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Mar 2022	36 out of 42	No target		n/a	n/a

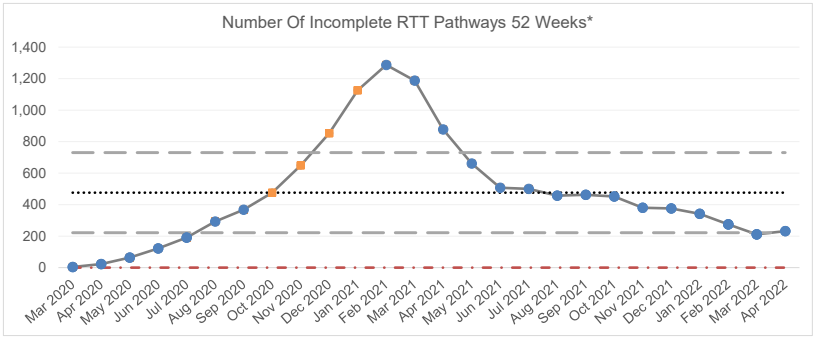
Scorecard - Workforce

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

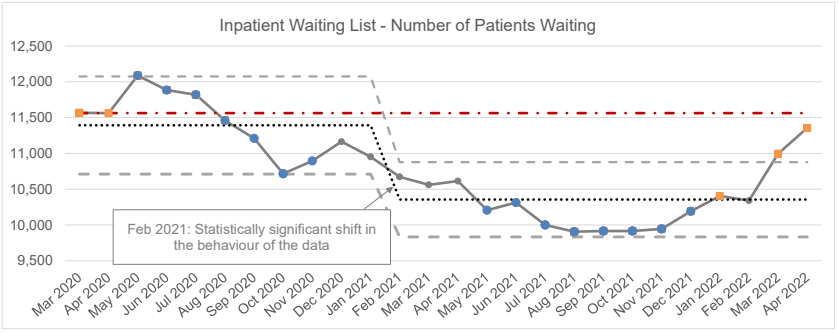
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Mar 2022	11.6%	2.0%	Action Required		F
	Registered Nurse Vacancy Rate	Mar 2022	7.4%	8.0%		L	?
	Medical Vacancy Rate	Mar 2022	12.1%	15.0%			?
	Trustwide Vacancy Rate	Mar 2022	9.3%	7.0%	Action Required	H	F
Staffing Levels	Turnover Rate	Apr 2022	12.1%	10.0%	Action Required	H	?
	Sickness Rate	Mar 2022	6.9%	4.1%	Action Required	H	?
Staff Development	PADR Rate	Apr 2022	79.0%	85.0%	Action Required		F
	Medical Staff PADR Rate	Apr 2022	84.0%	85.0%	Action Required	H	F
	Combined AfC and Medical Staff PADR Rate	Apr 2022	77.8%	85.0%	Action Required	L	F
	Core Mandatory Training Compliance Rate	Apr 2022	92.0%	90.0%		H	P
	Role Specific Mandatory Training Compliance Rate	Apr 2022	76.0%	80.0%	Action Required	L	?



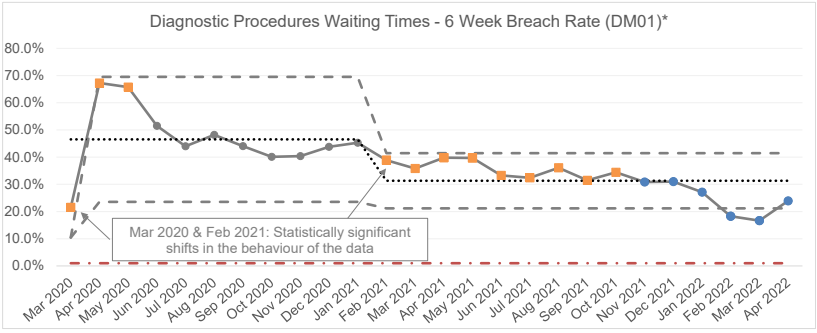
Apr 2022: 69.8%
Target: 92.0%
Variance: Common cause - no significant change
Assurance: Variation indicates consistently falling short of the target



Apr 2022: 232
Target: 0
Variance: Special cause of improving nature or lower pressure due to lower values
Assurance: Variation indicates consistently falling short of the target



Apr 2022: 11,355
Target: 11,563
Variance: Special cause of concerning nature or higher pressure due to higher values
Assurance: Variation indicates consistently passing the target



Apr 2022: 23.9%
Target: 1.0%
Variance: Special cause of improving nature or lower pressure due to lower values
Assurance: Variation indicates consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Performance has stabilised following the onset of the pandemic last year, this is reflected in the process limit recalculation. 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 caused by the pandemic. The target will not be met without process redesign.
Inpatient waiting list: There has been a significant reduction in the size of the inpatient waiting list over the course of the pandemic, although the latest figures are high compared to recent months. Based on the data, the indicator can reliably be expected to achieve the target.
Diagnostics 6 Week Wait (DM01)*: There has been a significant improvement in this indicator following the impact of covid, based on the unvalidated latest figure of 23.9%. Process re-design is required in order to meet the target.

Challenges:

- Capacity to deliver required demand - surge in referrals seen in March 2022 which has impacted on DM01 position for April
- Significant down-time across several diagnostic modalities in month (April) has reduced capacity available for delivery
- Ability to secure theatre / anaesthetic capacity to support delivery of diagnostic procedures required to be completed under GA
- Mutual aid for HUTH and York is creating new long RTT waits that need treating - numbers are coming through for Urology, Orthopaedics and General Surgery
- Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted
- Echo DM01 waiting times increased - insufficient capacity in core - secured IS provider, need to continue into 2022/23
- High vacancy rate in Gastroenterology and Cardiology

Key Risks:

- Ageing diagnostic equipment at high risk of breakdown risk on delivery of activity
- Business case for 3rd scanner at SGH not supported - risk not only to delivery of planned activity but reduces resilience within the service, if the current 2nd scanner develops a fault or breakdown all planned activity will cease
- Sonographer workforce establishment insufficient to match demand current reliance on IS to deliver activity
- Potential further COVID waves
- Carry over of annual leave - clinician availability
- Unable to mitigate the activity gaps of tenders not being realised - ENT and Ophthalmology
- Theatre nurse staffing vacancy, retention and high sickness rates
- Contracting agreements for use of Independent Sector not yet agreed for 22/23, therefore no activity planned with IS beyond April 22
- Removal of Waiting List Initiative additional sessions by NLaG clinicians

Actions:

- Additional capacity for Endoscopy to be utilised during May & June to prevent further deterioration in performance - due to be complete by end of June 2022.
- Capacity, demand and establishment review to be completed for Ultrasound - due to commence June 2022.
- Explore alternative sources of funding for diagnostic equipment replacement - on-going.
- Additional clinics scheduled to clear backlog and improve RTT, to be operational during June 2022.
- Breast Medical Workforce reviewed and interim plan put in place to manage increased demand, anticipated impact by May 2022.
- Recovery plans aligned to the 22/23 activity and performance planning - ongoing
- Ophthalmology, Orthopaedics, General Surgery, Urology and Ophthalmology continue to mitigate some capacity shortfall by using the IS in April
- Robust recruitment plan being implemented for theatre nursing staff May 2022

Mitigations:

- Use of IS for delivery of diagnostic activity.
- Use of staff overtime & bank to deliver additional diagnostic activity
- 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.
- Surgery & Critical Care have a robust structure in place to regularly review waiting lists and focus on long waiting and high risk patients.
- 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 stratification to ensure allocation of appointments, including pre-anaesthetic assessment is led by clinical priority of patients.

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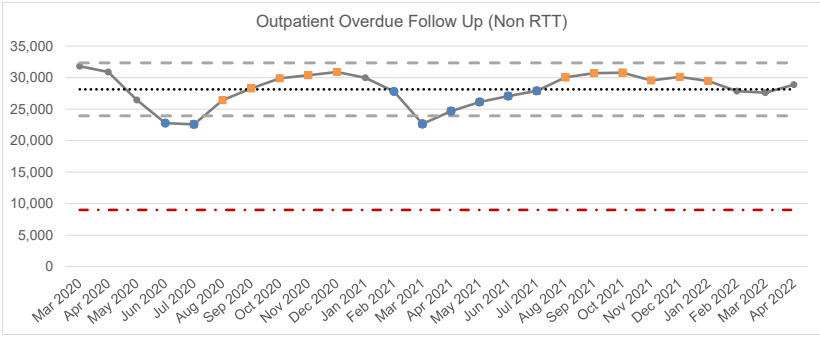
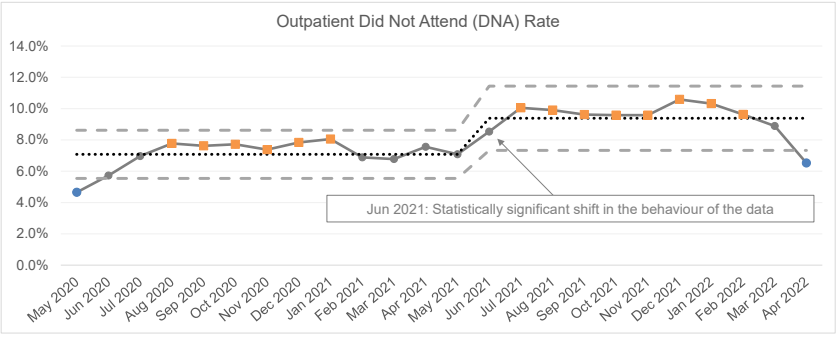
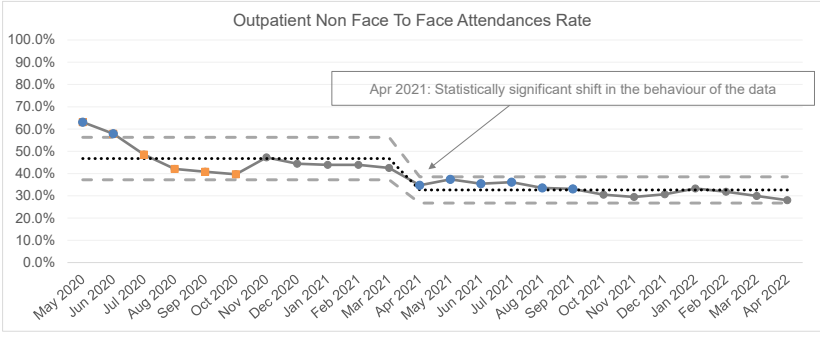


Apr 2022	Target	Variance	Assurance
28,869	9,000	Common cause - no significant change	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
6.5%	No Target	Special cause of improving nature or lower pressure due to lower values	There is no target, therefore target assurance is not relevant



Apr 2022	Target	Variance	Assurance
28.0%	No Target	Common cause - no significant change	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. From this point DNA rates are as expected.

Non Face To Face Outpatient Attendances: Process limits were recalculated from April 2021 to reflect the statistically significant shift in the behaviour of the data. Performance has been stable for the past 12 months.

Challenges:

- Implementation of the text reminder service appears to have had a marked improvement on DNA rate. Ongoing monitoring will determine if this is a continuing trend
- The number of patients added to a PIFU pathway continues under trajectory - delivery of the 5% at current adoption rates will be challenging
- The reduction down to 2% IS capacity will have a detrimental effect on the OP follow-up position in Medicine, which will be challenging to make up with core capacity due to ongoing emergency pressures

Key Risks:

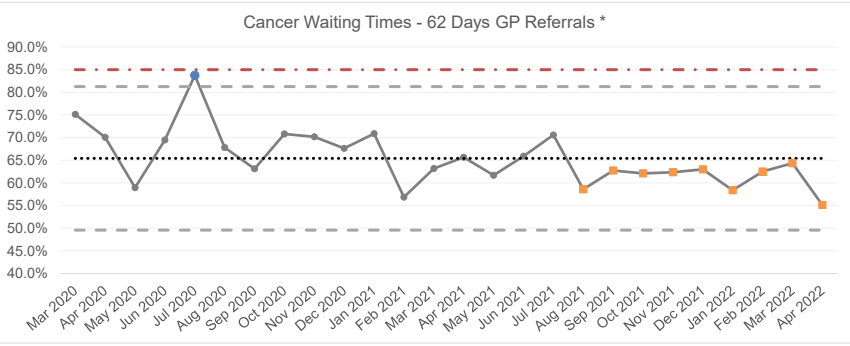
- CHN clinics during May/June have been significantly impacted due to capacity, there is a risk clinics will continue to be stood down and this will have a detrimental effect on the project and the relationship that has been carefully built up
- There is a high risk that the percentage of virtual appointments will drop due to the reduction in IS capacity, as both Medefer and Medinet deliver a large proportion of their activity virtually, similarly with the CHN clinics

Actions:

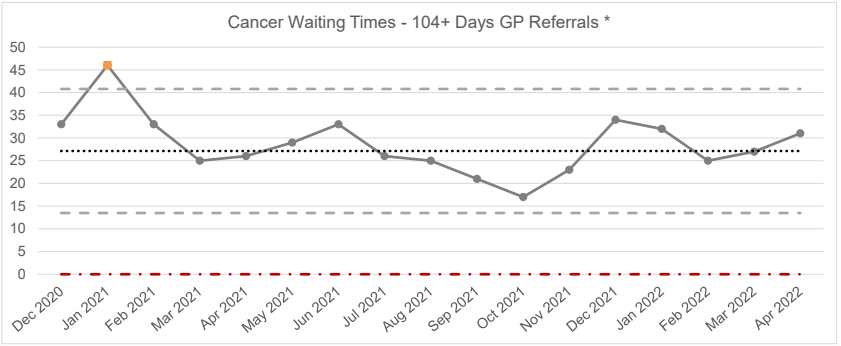
- Deep dive into DNA rates for virtual compared to face to face is complete - analysis due June 2022
- We have advertised for a clinical lead to help drive OP Transformation - closing date 29th May
- Work continues to identify further pathways that can be assigned to PIFU to improve on the March percentage - ability to do this ends 31st May
- Targeted work with other 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.
- CHN continues with cardiology seeing reduction in overall waiting list position. Completed and Ongoing.
- Further collaborative work with Primary Care Networks: Clinics being held by GPWSI in Rheumatology. Implemented in Rheumatology and ongoing.
- Heart Failure at home being trialled as part of PKB in Cardiology. Implemented and Ongoing

Mitigations:

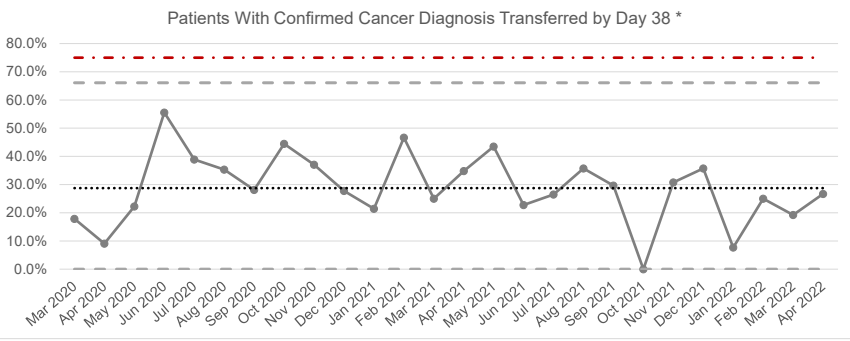
- It has been agreed for Cardiology CHN clinics sessions to be split across the week an extra session, rather than as a set 3 hr session.
- Weekly assurance meetings on the activity planning numbers - we continue to see a reduction in longer waiters and movement towards achievement of constitutional standards
- Risk Stratification of outpatient waiting lists
- Mutually agree the majority of out-patient appointments, to minimise DNA rates.



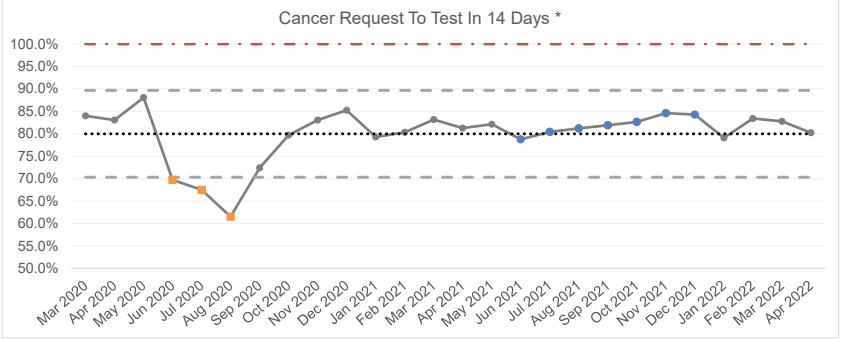
Apr 2022	Target	Variance	Assurance
55.1%	85.0%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
31	0	Common cause - no significant change	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
26.7%	75.0%	Common cause - no significant change	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
80.2%	100.0%	Common cause - no significant change	Variation indicates consistently falling short of the target

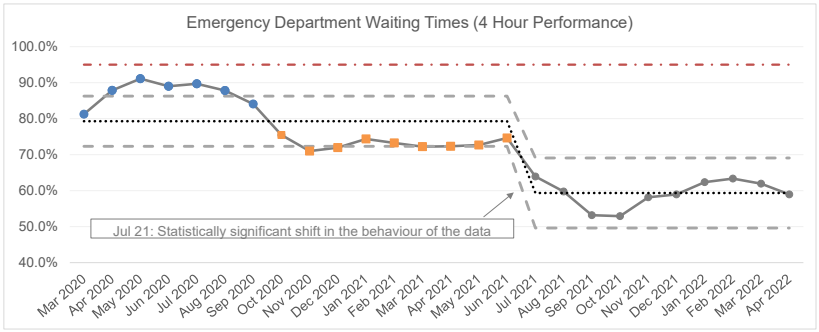
Data Analysis:
62 days GP referral*: The rate has fallen below the average for the last nine months and has therefore triggered a cause for concern in terms of data variation. This target has not been achieved over the last 2 years and the indicator will fail to meet the target without process re-design.
104+ days GP referrals*: This indicator has recorded no statistically significant change since November 2020. However, the target of zero has not been met for at least two years and this will continue 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 pathology turnaround times
• Colorectal is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required
• 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 are under further review

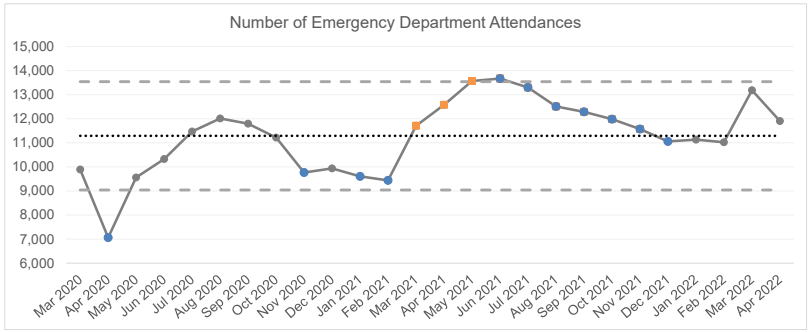
Key Risks:
• For Upper GI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
• Lack of Oncology Capacity for 1st appointments
• Covid positive patients
• One Clinician at SGH running Straight To Test Upper GI service - manageable as small numbers but during leave and sickness leaves service vulnerable
• HUTH have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times
• 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 - as you are aware the oncology concerns when pts transferring to HUTH.
• Request to test (14 days) - in order to meet 28 day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days.
• Meeting the 38 day IPT standard is impacted through delays occurring with tertiary diagnostics/staging TAT, and visiting consultant/oncology services (urology - prostate)

Actions:
• Breast Medical Workforce reviewed and interim plan put in place to manage increased demand, anticipated impact by May 2022
• Breast Pain Clinics introduced from May 2022 in order to manage patients through alternative pathway and release capacity within Cancer Pathway
• Colposcopy and Hysteroscopy demand and capacity reviewed and plans being put in place to increase capacity by June 2022
• Introduction of CNS led STT colorectal service and robust process to work alongside RDC capacity to ensure full utilization of capacity due to low update of RDC pathway - already in place
• Additional Consultant Led Endoscopy Clinics to enable decision making at time of procedure - on going
• Colorectal - CNS straight to test commenced both sites in January and already making an impact on 28 day faster diagnosis - review of impact currently taking place to be completed by June 2022.
• UGI - consultant led straight to test commenced at SGH 1 Feb 2022
• Urology pathway review taking place and complete before June 2022 to improve 7 day initial contact turnaround time
• Urology one stop clinics introduced April 2022 to improve 28 day faster diagnosis times. Additional service modelling has taken place and will be included in Consultant/CNS Job Plans from June 2022
• Single Lung MDT with HUTH & NLaG - expected end of May 2022.

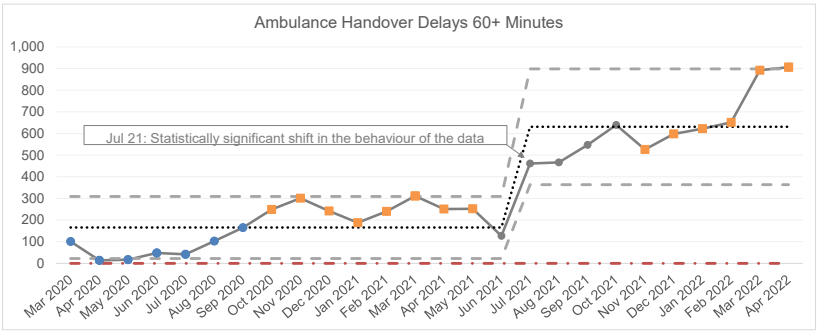
Mitigations:
• Increase RDC capacity to work alongside Straight To Test to streamline service in Colorectal
• Funding approved to recruit to Band 3 and Band 2 admin support
• RDC to be opened up to non site specific pathway from 1st May 2022
• The pathway analyser tool that has been developed within 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



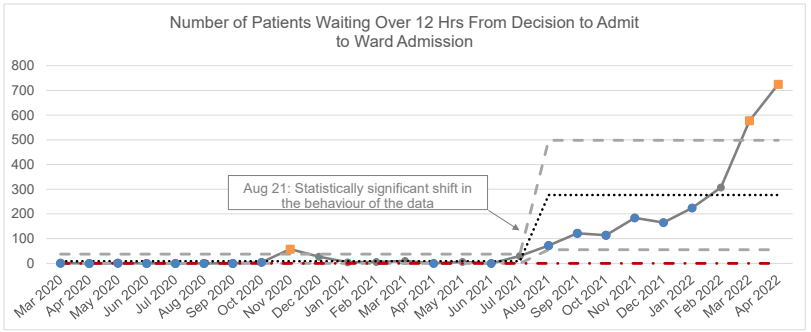
Apr 2022	Target	Variance	Assurance
58.9%	95.0%	Common cause - no significant change	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
11,904	No Target	Common cause - no significant change	There is no target therefore target assurance is not relevant



Apr 2022	Target	Variance	Assurance
906	0	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
725	0	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target

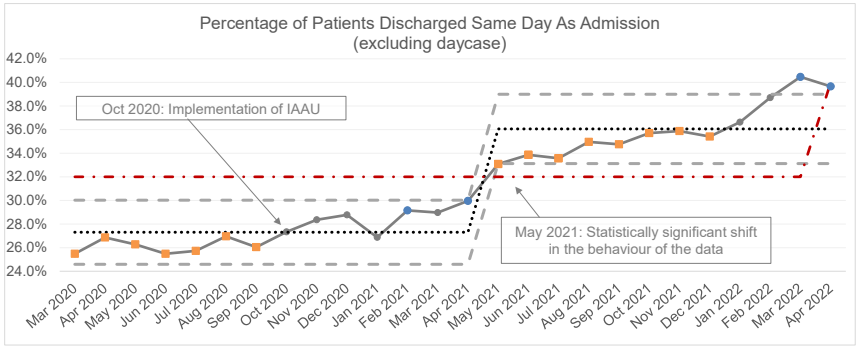
Data Analysis:
ED 4 hour performance: There has been a significant deterioration in performance for the past ten months despite a re-calculation of the process limits from July 21. The target has not been achieved for more than 2 years and the indicator will continue to fail the target without process re-design.
ED Attendances: The number of attendances has been falling from a peak last June but remains within the expected range for the data.
Ambulance handover 60+ minutes: The indicator is showing deteriorating performance with month on month increases for the past six months. There was a re-calculation of the process limits from July 21. The target will not be met without process re-design.
DTA 12 hours: This indicator has recorded deteriorating performance for the past nine months, despite a re-calculation of process limits from Aug 21. In April there were more than 700 recorded against this indicator. The target will not be met without process re-design.

Challenges:
- ED attendances continue to be higher than last year
- Workforce sickness, covid-19 isolation, low morale & impacts on staff wellbeing continue to challenge rota fill with a reduction of bank/agency pick up
- Northern Lincolnshire is experiencing the highest levels of acuity for EMAS conveyances and this is resulting in longer waits in resus and an increase in numbers
- There has been a large number of ward closures due to Covid and Norovirus and this has led ED reaching beyond full capacity each day due to lack of patient flow. This has reduced within the area to offload incoming ambulances and has led to delays in wait to be seen times
- Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED
- Patients remaining in resus after stabilisation for too long due to lack of prompt access to HDU/CC
- Delays in diagnostic imaging at times and in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards
- Inappropriate attendances to ED due to lack of access to alternative, more appropriate services
- There has been a large number of 12 hour breaches occurring due to a lack of bed availability and patient flow out of the Emergency Department
- Risk of harm to patients kept in ECC for more than 12 hours

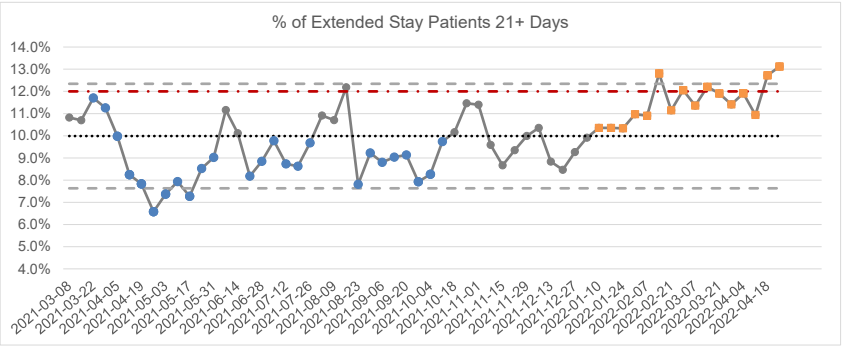
Key Risks:
- Shortages in available workforce to meet service needs (skill mix and experience)
- Inappropriate attendances and conveyances to ED
- Covid-19 impacting physical capacity within the current ED footprint

Actions:
- The Urgent Care Service (UCS) at SGH and DPOWH is providing improved patient experience - Implemented and ongoing.
- New patient pathways with streamlined access from arrival to seeing a clinician within the UCS - Implemented and Ongoing.
- Work progressing to access NEL Urgent GP appointment slots from DPOWH ED - Meetings with commissioners with review of pathways underway - expected completion during Q2 2022-23.
- NHS111 First Initiative to reduce avoidable ED attendances - Implemented and ongoing.
- New ED/AAU builds in development to increase ED physical capacity and bring ED and IAAU to a joint location - on track. Scheduled in Q2 2022-23.
- Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital - Implemented and ongoing.
- Senior second reviews and long length of stay (LOS) reviews carried out - Implemented and ongoing.

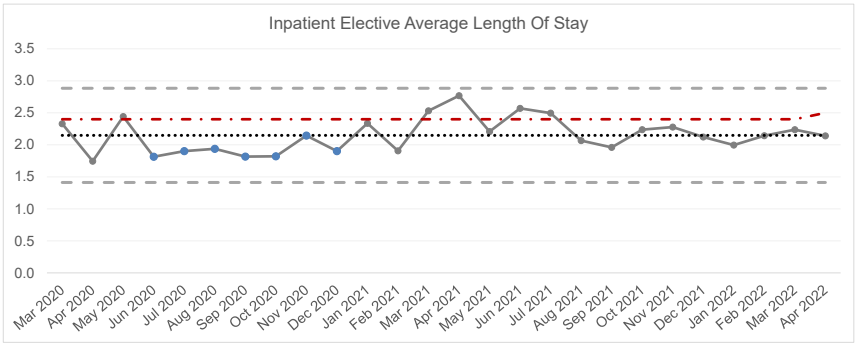
Mitigations:
- Category 5 Call Transfer from EMAS to Single Point of Access continues, with expanded operating hours of 08:00 - 17:00.
- 2 Hour Urgent Community Response pathway implemented and continues to embed.
- COVID Virtual Ward and OPAT Pathways remain in place as an alternative to acute care for patients meeting the criteria
- Tier system of Medicine senior management in place for prompt escalation, resolution and support for ED
- Fast track paediatric process in place
- Senior clinician reviews taking place in ambulances when delays to offloading occur
- Increased staffing in ED
- 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



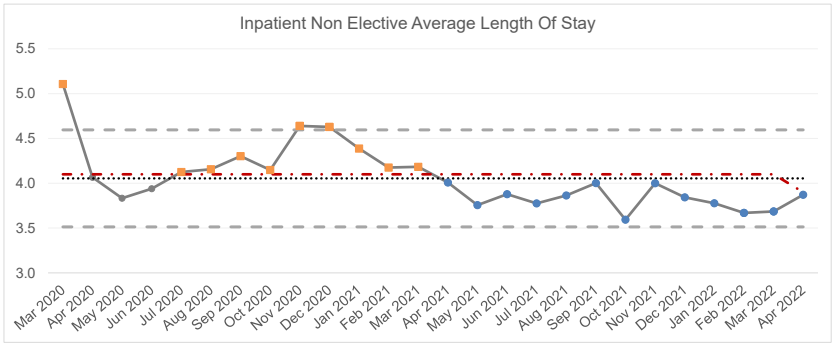
Apr 2022	Target	Variance	Assurance
39.7%	40.0%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
13.12%	12.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2022	Target	Variance	Assurance
2.1	2.5	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2022	Target	Variance	Assurance
3.9	3.9	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target

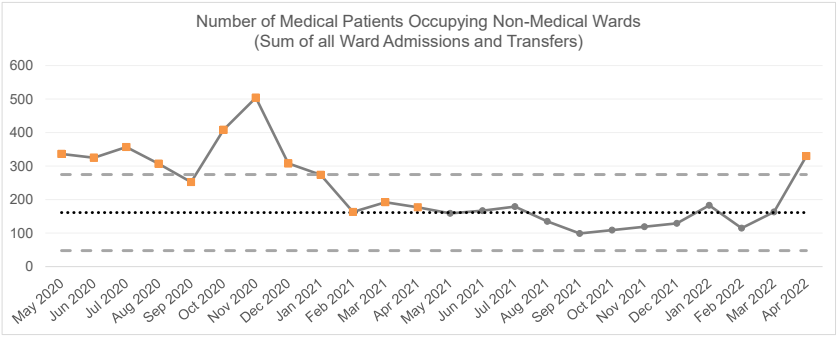
Data Analysis:
Discharged same day as admission: Following implementation of the IAAU in October 2020 this indicator has continued to show steady improvement. Since that time the trend has shown significant change. The local target has been increased from 32% to 40% with effect from April 2022.
% Extended stay 21+ days: The performance of this indicator has deteriorated since the end of last year and will not reliably achieve the target without process redesign
Elective length of stay: The performance of this indicator continues to fall within the expected range. The target has been increased from 2.4 days to 2.5 days with effect from April 2022 and can be expected to achieve and fail at random.
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 target has been decreased from 4.1 to 3.9 and 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

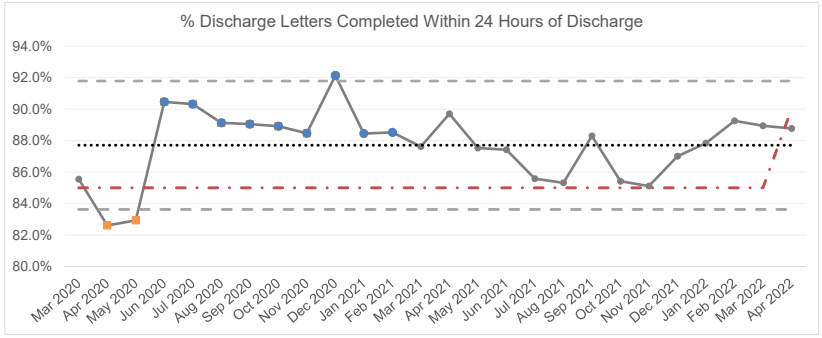
Key Risks:
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting physical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requiring admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge
- Multiple Care home closures to new patients/repatriations due to COVID outbreaks

Actions:
- Daily board rounds on wards
- Discharge rounds at weekends - Implemented and Ongoing
- LLOS reviews in place for medicine twice per week led by the senior tri - Implemented, however is being reviewed in May 2022 to undertake assessment of impact on elective/op
- Regular meetings with system partners to understand current delays/issues - Implemented and Ongoing
- Discharge improvement plan currently being developed which pulls together all areas of 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.

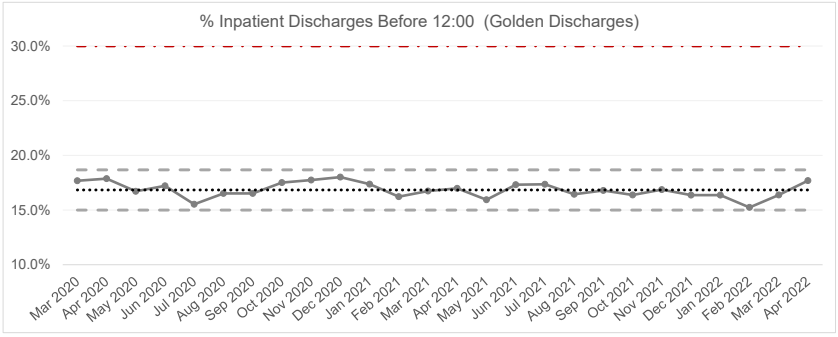
Mitigations:
- Daily board rounds on wards - work to further develop these to ensure they are effective and timely
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased
- 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. Any outstanding are escalated through their internal agencies with an outcome/plan for discharge to reported back by 2pm. if there is still no confirmation on a plan for the patient to leave the acute bed on that day this is then escalated to the system strategic leads for further action
- Themes are collated during the week from these escalations and fed back to a fortnightly discharge improvement meeting and this feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire.



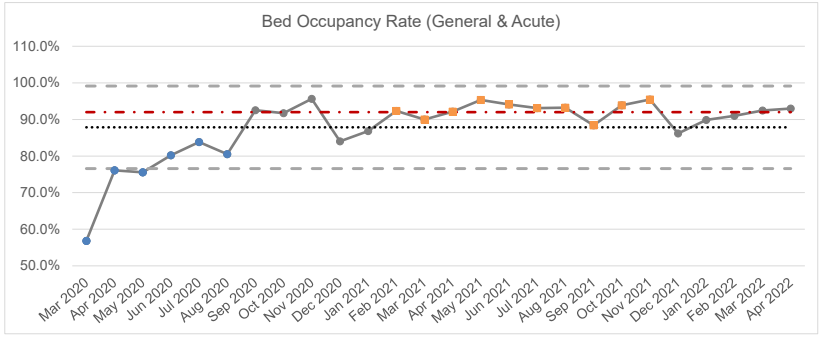
Apr 2022	Target	Variance	Assurance
330	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Apr 2022	Target	Variance	Assurance
88.8%	90.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2022	Target	Variance	Assurance
17.7%	30.0%	Common cause - no significant change	Variation indicates consistently falling short of the target



Apr 2022	Target	Variance	Assurance
93.0%	92.0%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Medical patients in non-medical wards: This indicator has recorded a higher than expected figure for April compared with the data over the previous year. The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed useage of wards out of usual scope. The data is being interrogated to understand if the recent peak in April 22 is of real concern.

Inpatient discharge letters: Following 18 months of recording above target figures, the local target of 85% has been increased to 90% with effect from April 2022. The indicator can be expected to achieve and fail the target at random.

Inpatient discharges before 12:00: Performance is currently stable and as expected. Currently, the highest performance that can be expected without process re-design is 19% against a target of 30%. This indicator will not achieve the target without process re-design.

G&A Bed Occupancy: Performance is 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:

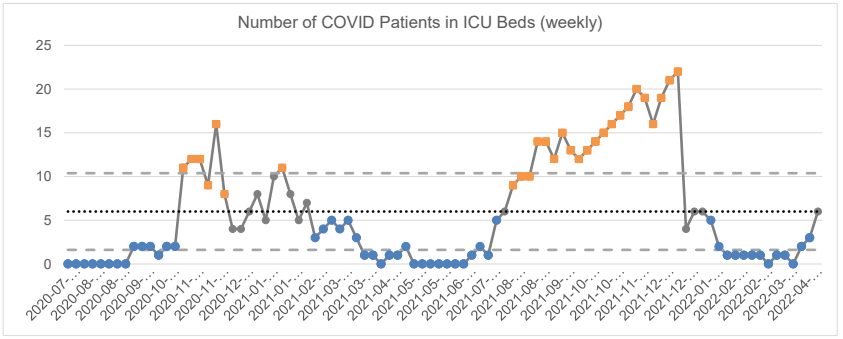
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting physical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requiring admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge
- Multiple Care home closures to new patients/repatriations due to COVID outbreaks

Actions:

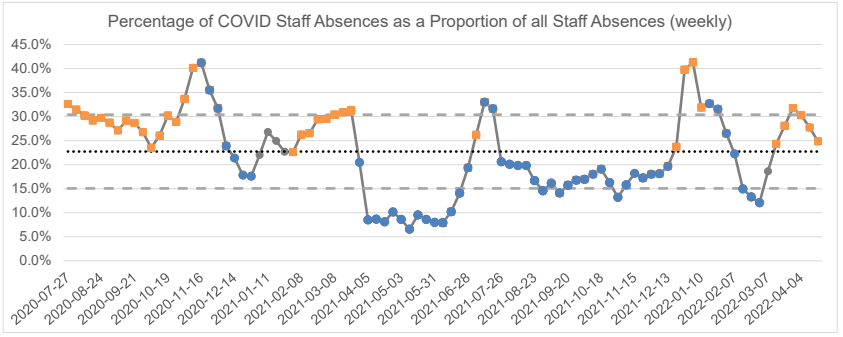
- Daily board rounds on wards • Discharge rounds at weekends - Implemented and Ongoing
- LLOS reviews in place for medicine twice per week led by the senior tri - Implemented, however is being reviewed in May 2022 to undertake assessment of impact on elective/op
- Regular meetings with system partners to understand current delays/issues - Implemented and Ongoing
- Discharge improvement plan currently being developed which pulls together all areas of 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:

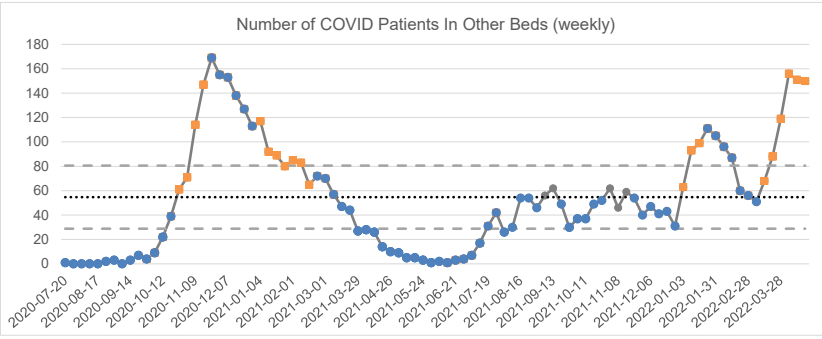
- Daily board rounds on wards - work to further develop these to ensure they are effective and timely
- Discharge rounds at weekends
- LLOS reviews in place for medicine twice per week led by the senior tri, next step is to ensure this is in place for surgery as LOS for surgery have increased
- Work 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. Any outstanding are escalated through their internal agencies with an outcome/plan for discharge to reported back by 2pm. if there is still no confirmation on a plan for the patient to leave the acute bed on that day this is then escalated to the system strategic leads for further action
- Themes are collated during the week from these escalations and fed back to a fortnightly discharge improvement meeting and this feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire.



Apr 2022	6
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Apr 2022	24.9%
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target, therefore target assurance is not relevant



Apr 2022	150
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target, therefore target assurance is not relevant

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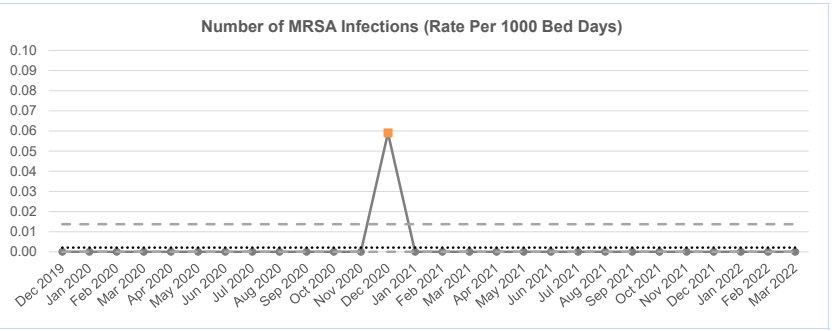
Data Analysis:
COVID Patients In ICU beds: The number of covid patients in ICU beds has decreased significantly since December 2021.
COVID Patients In Other Beds: The number of covid patients in other beds has recorded significantly high figures for the past seven weeks and as such it is showing concern.□
COVID Staff Absences: The proportion of staff absences due to covid has been volatile since mid December with repeated changes between concerning and improving performance.

Challenges:
• Omicron variant more transmissible with less symptoms more difficult to identify.
• 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 regular 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



Mar 2022
0.00

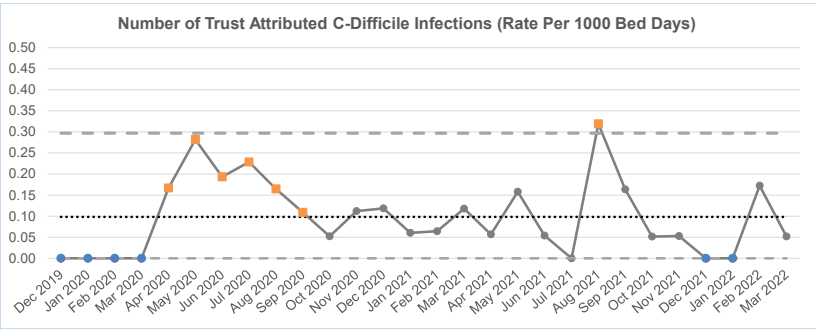
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Mar 2022
0.05

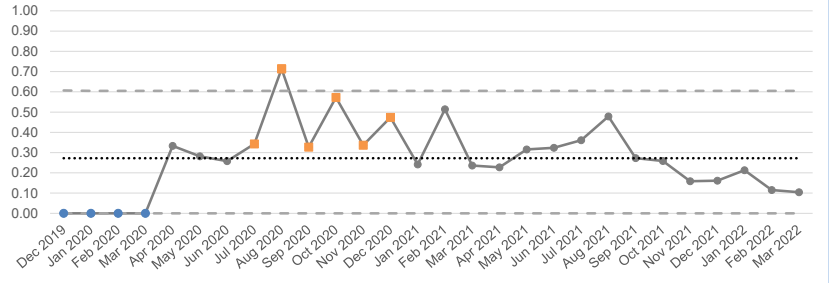
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Mar 2022
0.10

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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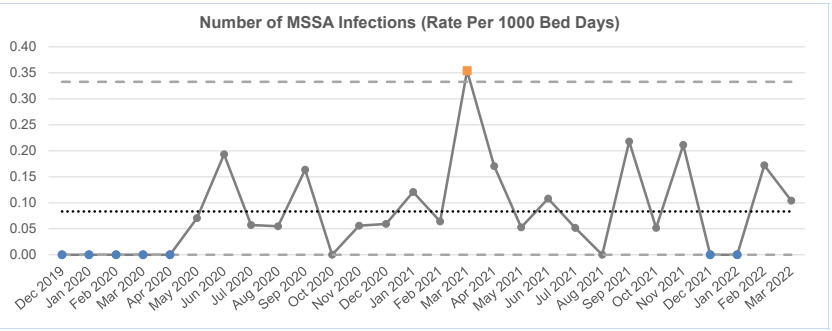
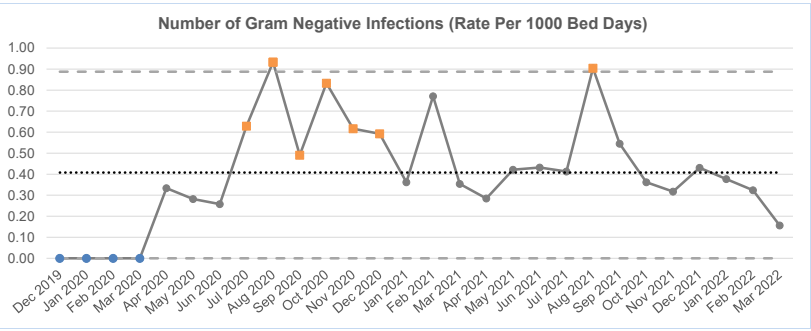
Data Analysis:
MRSA: This is now reported per 1000 bed days. The rate for March 2022 is 0.000
C Diff: This is now reported per 1000 bed days. The rate for March 2022 is 0.052.
E Coli: This is now reported per 1000 bed days. The rate for March 2022 is 0.104

Commentary:
The Trust is performing very well against the alert organism KPIs.



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



Mar 2022
0.16
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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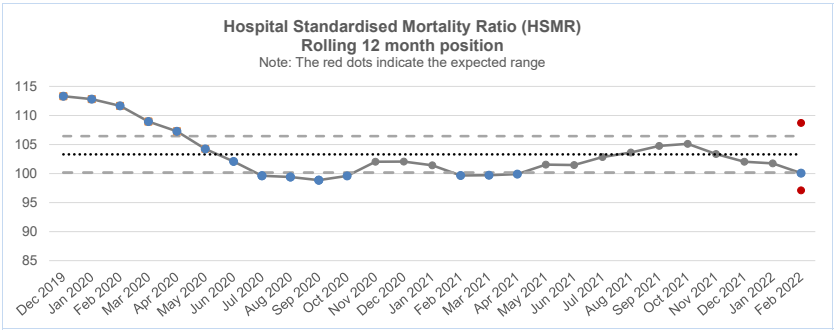
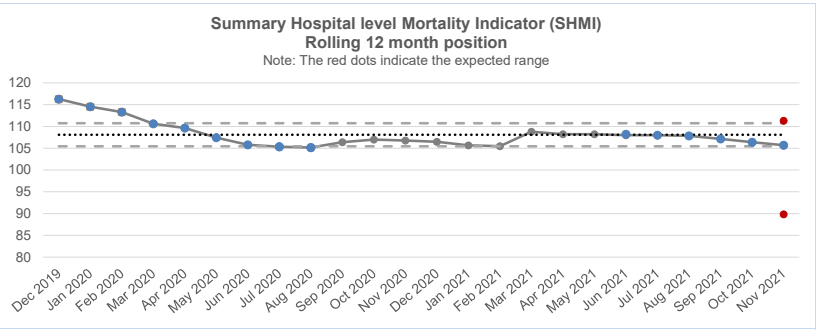
Data Analysis:
MSSA: This is now reported per 1000 bed days. The rate for March 2022 is 0.104
Gram Neg: This is now reported per 1000 bed days. The rate for March 2022 is 0.156.

Commentary:
The number of cases reported are in line within expected ranges. The Gram negatives are showing early signs of a reduction pattern but will likely rise due to seasonal variation and warmer weather.



Feb 2022
100.1
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'Expected' range



Nov 2021
105.7
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'Expected' range

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Data Analysis:
HSMR: 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.

February's HSMR continues to demonstrate a statistically significant improvement, remaining stable within the expected range and in line with the national level.

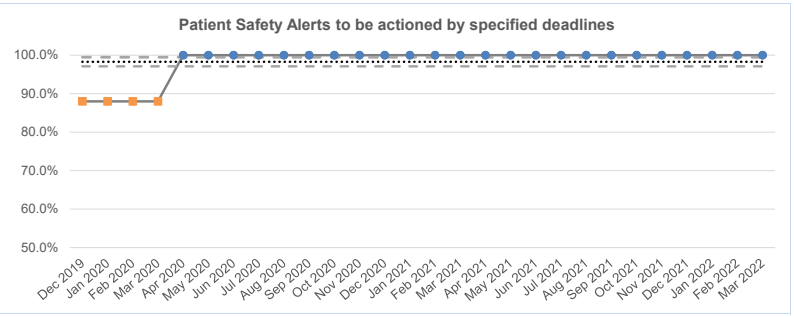
Mitigations: The HSMR along with other mortality indices are overseen by the Trust's Mortality Improvement Group (MIG).

SHMI
The official SHMI for the Trust, along ith site specific SHMI, remains stable and within the 'as expected' range for the period of December 2020 – November 2021.

Issues/Risks:
There is a risk of breaching the Trusts 'expected range' if the out of hopsital SHMI rises.
A dip in the depth of coding has been 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.
- 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 the official SHMI alerts relating to Cancer of Bronchus / Secondary Malignancy.
- Dip in depth of coding currently being reviewed by Information ServicesTeam to ascertain if this is in line with what other Trusts (Inc HUTH) 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.



Mar 2022
100.0%

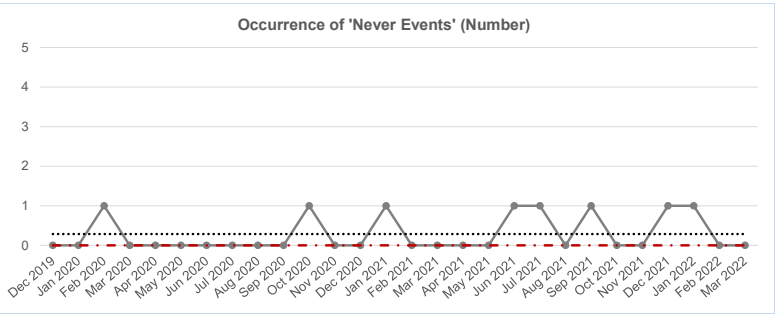
Target
No target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Mar 2022
0

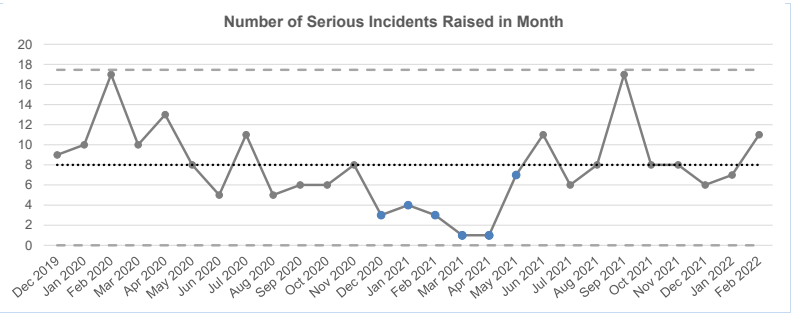
Target
0

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.



Mar 2022
15

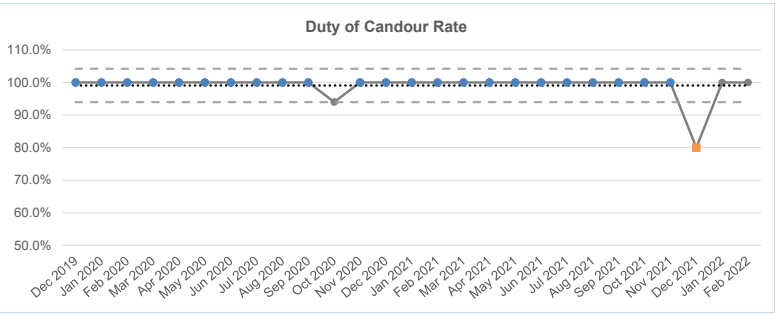
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Feb 2022
100.0%

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

Data Analysis:
Patient Safety Alerts: Performance for March continued at 100%.
Never Events: Note the never events data is a subset of the serious incidents data. There were 0 never events recorded in March 2022 and this is the latest data provided.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents and also includes the patient safety alerts. There were 15 serious incidents recorded for March 2022 and this is the latest data provided. The data is within the expected range of variation.
Duty of Candour: Performance has generally remained stable since November 2019. The latest data provided is for February 2022.

Commentary:

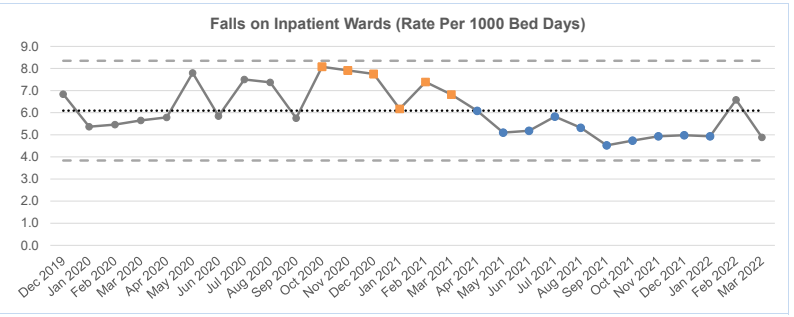
Never Events:
There have been no Never Events declared since January 2022.

Mitigations:
Ergonomist work which links to themes identified in Never Events has been concluded and a report produced. Actions for impovement are beting finalised.

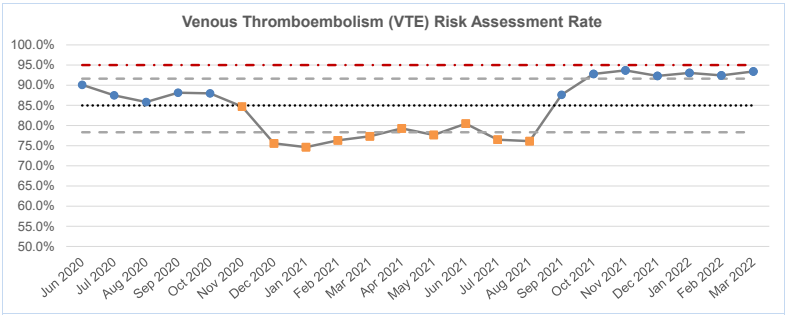
Duty of Candour: Duty of Candour for serious incidents is 100%, there is a gap at present in relation to ensuring duty of candour is completed for all instances of moderate level harm. This presents the risk of non-compliance against regulations, which may result in a financial penalty. The position 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/overdue.

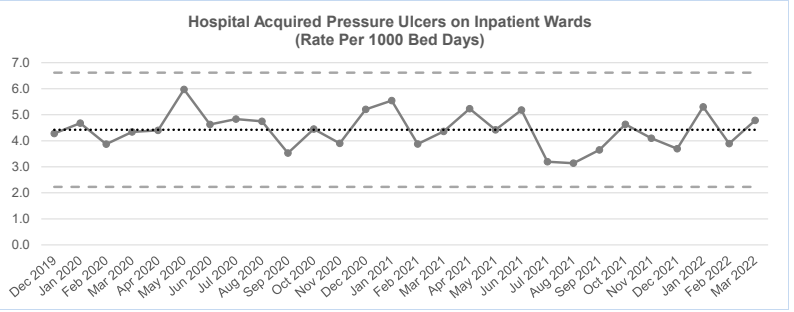
Actions: Work is ongoing with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed (monitored through SI panel with significant improvement noted). Duty of Candour Reports are availiable on Ulysses and are being monitored at divisional level as well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



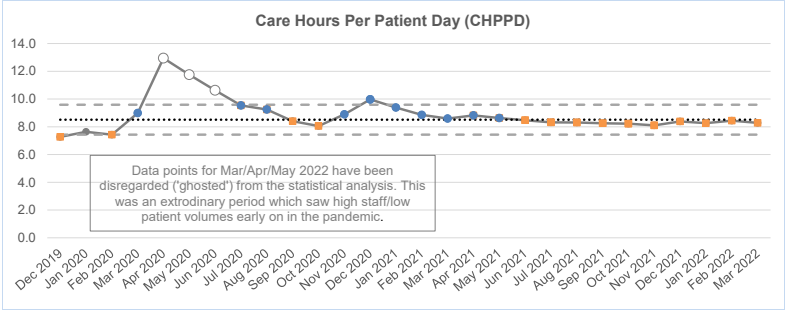
Mar 2022	4.9
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Mar 2022	93.4%
Target	95.0%
Variance	Special cause of improving nature or higher pressure due to higher values
Assurance	Variation indicates consistently failing the target



Mar 2022	4.8
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



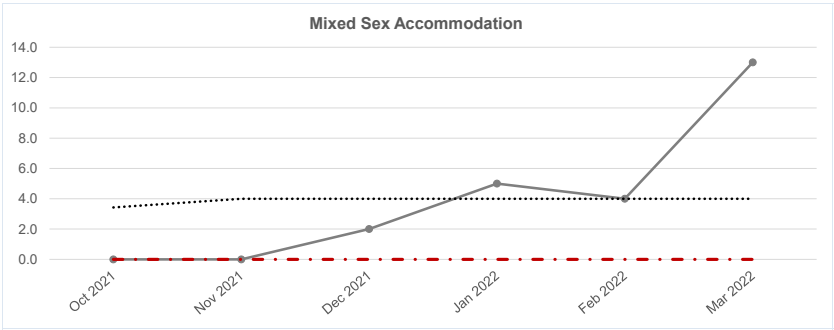
Mar 2022	8.3
Target	No target
Variance	Special cause of concerning nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant

Data Analysis:
Falls on Inpatient Wards: After a significant reduction last year, this indicator has been on a improvement trend since April 2021. This is within the expected range of variation.
VTE Risk Assessment: Performance has shown a significant improvement over the past 6 months, with March 2022 being close to the target at 93.4%
Hospital Acquired Pressure Ulcers: The rate of hospital acquired pressure ulcers was 4.8 per 1000 bed days for March 2022. This is within the expected range of variation.
Care Hours Per Patient Day: Performance has been consistently in poorer performance since June 2021 which is triggering concern on the chart.

Commentary:
Falls - following a period of sustained improvement, the number of falls reported in February 2022 increased significantly for the first time in over six months. This has now returned to the "as expected" range and will be monitored and triangulated with other metrics to establish if this is a new emerging trend.

VTE Risk assessment figures now have the correct denominator, which shows improved performance over the past 6 months. A new VTE Lead has been identified and work is underway to look at how to improve the current position to meet the target level.
The Trust's VTE policy has been updated to mirror national NICE guidance and is almost ready for circulation for approval.
Mitigation: Monitored by the Quality Governance Group.

CHPPD was 8.3 in March 2022 which is in line with the latest model hospital data for February 2022 which indicates a national median of 8.1 and recommended peer median of 8.4



Mar 2022
13

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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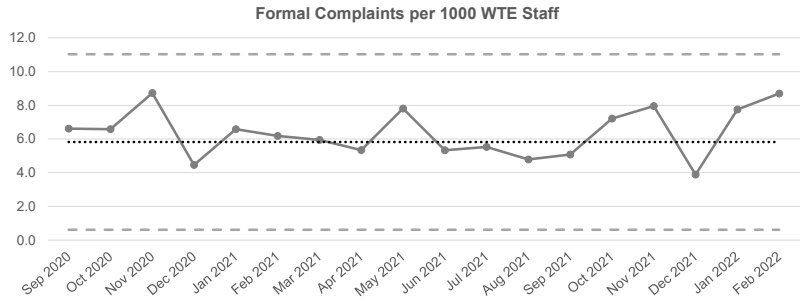
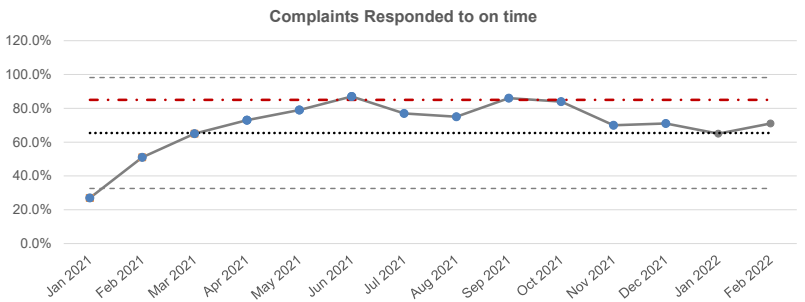
Data Analysis:

Mixed sex accommodation: The MSA return was suspended due to COVID and has now resumed. There were 13 reported for March 2022.

Commentary:



Feb 2022	This space is intentionally blank
9	
Target	
No target	
Variance	
Common cause - no significant change	
Assurance	
There is no target for this indicator, therefore target assurance is not relevant	



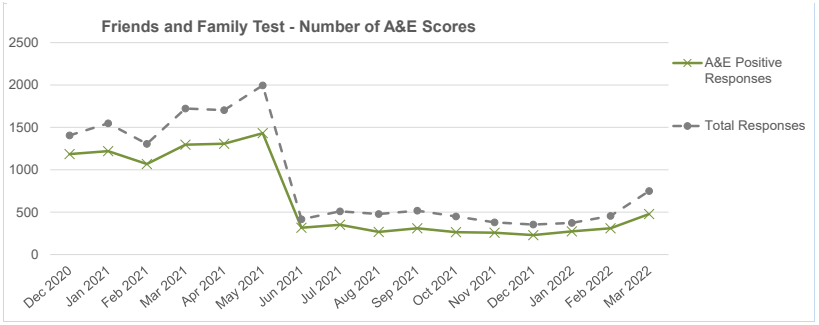
Feb 2022	This space is intentionally blank
71.0%	
Target	
85.0%	
Variance	
Common cause - no significant change	
Assurance	
Variation indicates inconsistently hitting passing and failing the target	

Data Analysis:

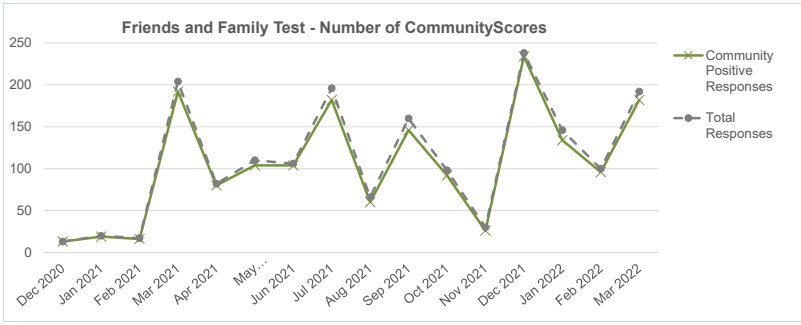
Formal Complaints: In February there were 9 formal complaints per 1000 WTE staff.

Complaints Responded to on time: This indicator has remained fairly stable with the latest position being 71.0% in February 2022. This is within the expected range of variation.

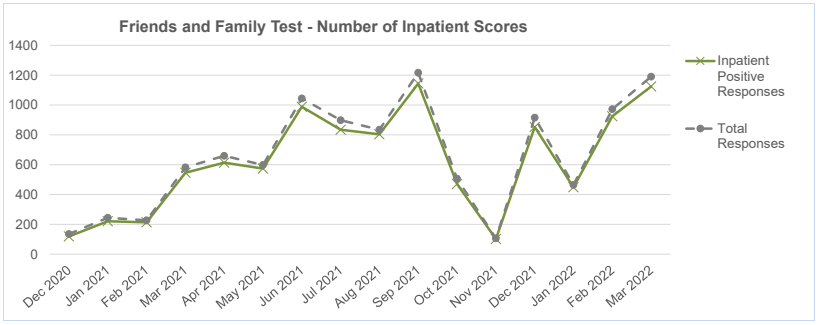
Commentary:



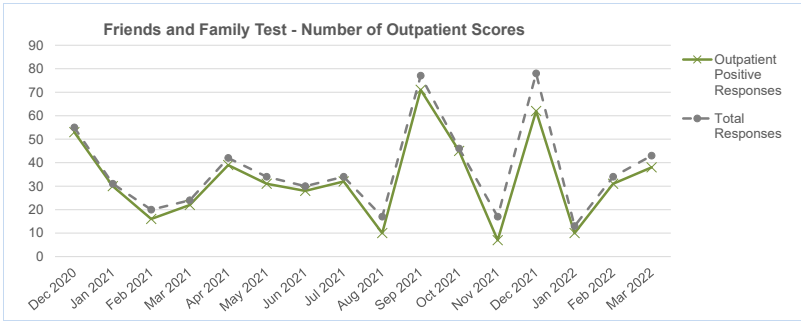
Mar 2022
478 out of 750
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2022
182 out of 192
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



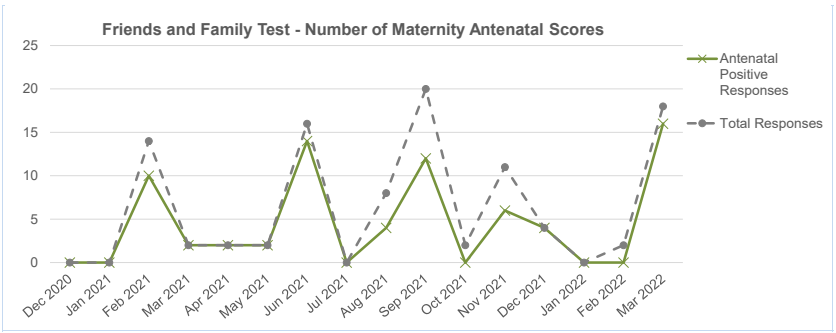
Mar 2022
1124 out of 1190
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



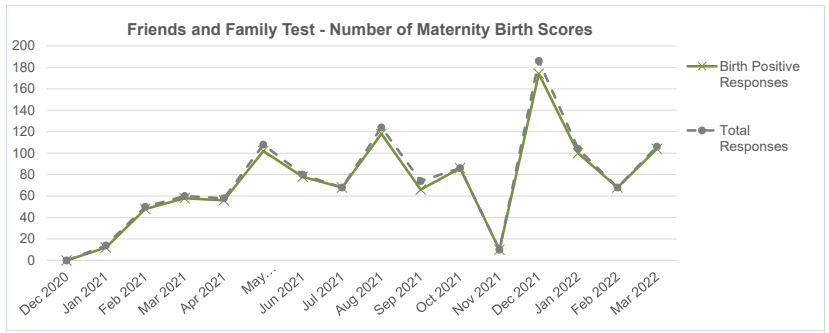
Mar 2022
38 out of 43
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
A&E FFT: There were 750 responses received in total for March 2022, and 478 were positive.
Community FFT: There were 192 responses received in total for March 2022, and 182 were positive.
Inpatient FFT: There were 1190 responses received in total for March 2022, and 1124 were positive.
Outpatient FFT: There were 43 responses received in total for March 2022, and 38 were positive.

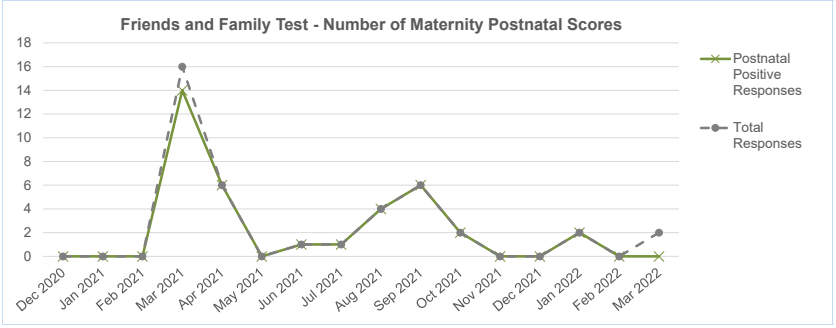
Commentary:



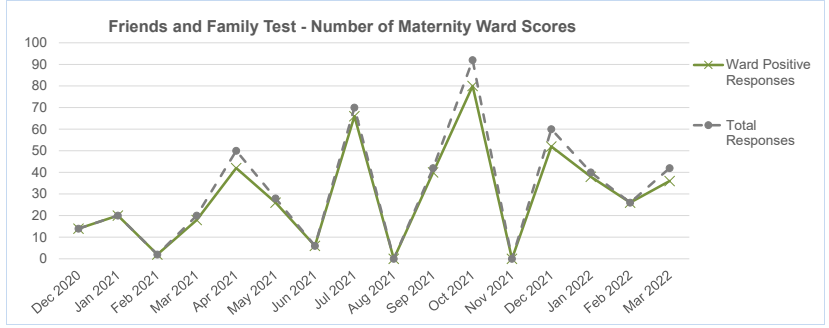
Mar 2022
16 out of 18
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2022
104 out of 106
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Mar 2022
0 out of 2
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

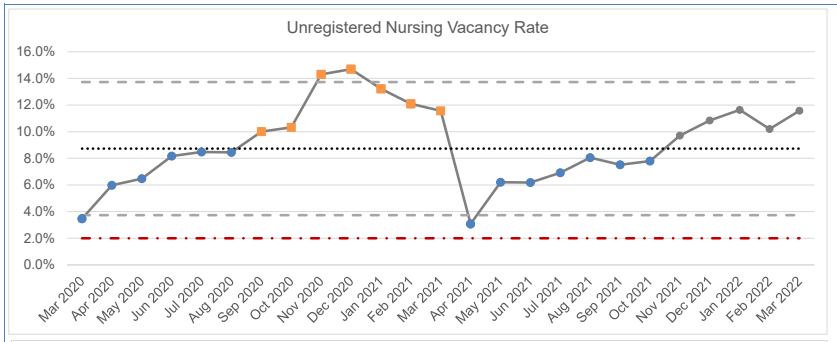


Mar 2022
36 out of 42
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

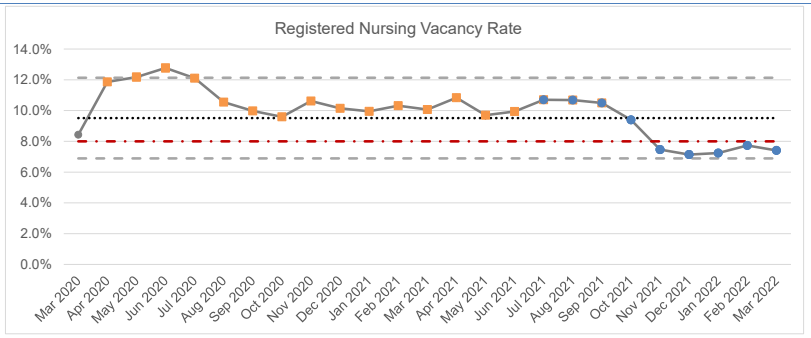
Data Analysis:

Maternity Antenatal FFT: There were 18 responses received in total for March 2022, and 16 were positive.
Maternity Birth FFT: There were 106 responses received in total for March 2022, and 104 were positive.
Maternity Postnatal FFT: There were 2 responses received for March 2022, and 0 were positive.
Maternity Ward FFT: There were 42 responses received in total for March 2022, and 36 were positive.

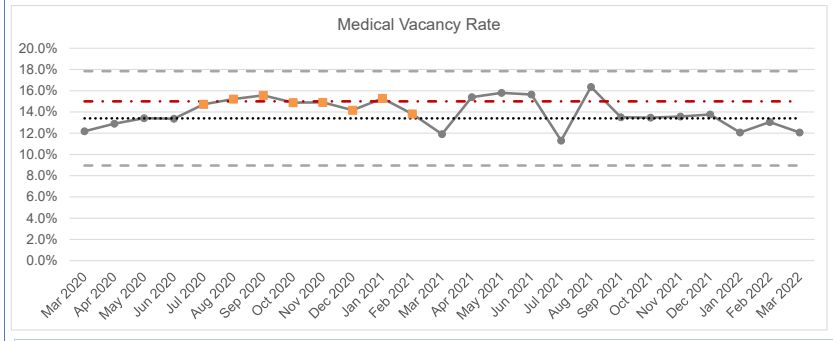
Commentary:



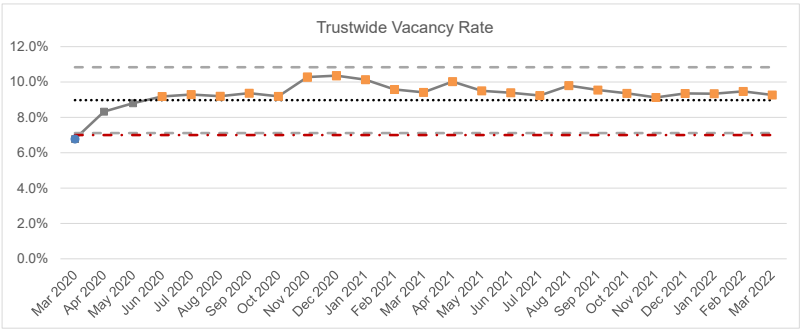
Mar 2022	11.6%
Target	2.0%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently failing the target



Mar 2022	7.4%
Target	8.0%
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates inconsistently hitting passing and failing the target



Mar 2022	12.1%
Target	15.0%
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and failing the target



Mar 2022	9.3%
Target	7.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates consistently failing the target

Data Analysis:
Unregistered Nursing Vacancies: After a significant reduction last spring, the rate has gradually been increasing but is within the expected range. From April 2022 the target will change from 2% to 8%.
Registered Nursing Vacancies: For the past five months the figures have improved, however it is too soon to be confident that this indicator will continue to achieve the target.
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: The performance has been consistently showing poor performance since June 2020 and will continue to fail the target without process redesign. From April 2022 the target will change 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 52.86 WTE awaiting start. Further interviews ongoing, with a revised process in place including utilising a webinar for information regarding the Trust and the role to mitigage risks of individuals not fully appreciating the role and the impact on retention. Information on the HCA role is also provided to candidates at the interview stage, and also by CPD team as part of the induction process. A project to review and revise processes relating to leavers is underway, considering supportive conversations and methods to gather accurate leavers data. A Rapid Process Improvement Workshop is planned, supported by QI and NHSi/e to review the whole Unregistered Nursing process from sourcing to induction and retention. A nursing workforce plan is in development.

Actions: Continue advertising to maintain the pool of HCA appointments ready for allocation. Undertake RPIW process and nursing workforce plan.

Registered Nursing Vacancies:

Issues/Risks: Travel restrictions/difficulties obtaining visas overseas are impacting start dates. 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.

Commentary Vacancies Cont/d:

Medical Vacancies

Issues/Risks: Travel restrictions/difficulties obtaining visas overseas are impacting start dates. Availability of accomodation can delay recruitment processes.

Actions: Ongoing recruitment activity across specialties.

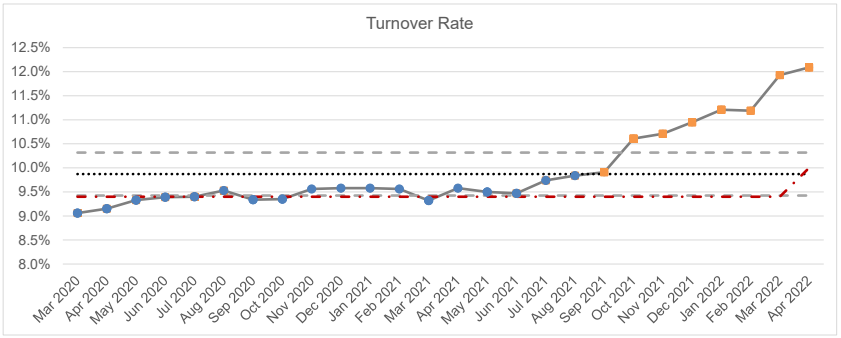
Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 51 medical staff has been established, with 10 scheduled to start in April and May and further starts in the longer term. A network of private landlords has been established to support accomodation needs where the Trust 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. A review of the l recruitment process is under way with engagement with operational groups to gather feedback and identify efficiencies.

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. A review of the whole recruitment process is underway to consider efficiencies and candidate experience.



Apr 2022
12.1%

Target
10.0%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and failing the target

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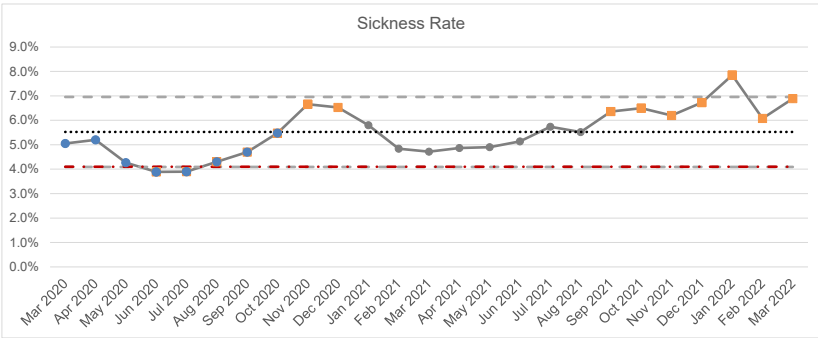

Mar 2022
6.9%

Target
4.1%

Variance

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

Assurance

Variation indicates inconsistently hitting passing and 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 last summer and has recorded concerning performance for the past 8 months. The target has increased from 9.2% to 10.0% from April 2022.
Sickness Rate: This indicator has recorded a general increase in sickness rates since last summer and is showing concern for the past seven months. It is unlikely that the target will be achieved without process redesign.

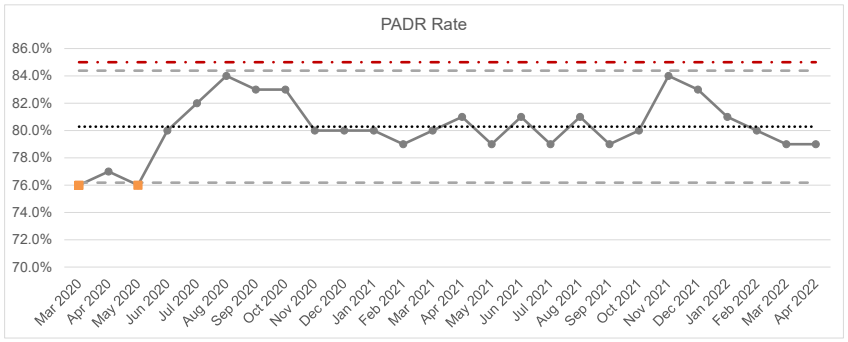
Commentary:
Analysis of the increased trajectory of turnover from Aug-21 - April 22, shows a steady increases in turnover with two marked sharp increases at August-21 and Feb 22. Our exit data at this time indicates these increases can be predominantly attributed to Nursing, Administration and Unregisterd Nursing staff groups. We could speculate as to reasons including continued operational pressures, absence of carrrer devlopment opportunites (for Unregesitred nursing) and prevailing culture. Further work will be undertaken via a deep dive to better understand these reasons.

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

The updated Managing Attendance Policy was ratified on 04 April 2022. The HR HUB site is currently being developed to reflect the changes to both the policy and toolkit incorporating training videos to support line managers to enable earlier intervention within sickness process and appropriate support.

The HR Team are currently rolling out the delivery of Managing Attendance training throughout May and June to all staff who have a line management responsibility to embed the changes, this is being delivered within the divisions. From July onwards this training will be accessible to book on via OLM on a monthly basis. The aim here is to enable managers to manage sickness processes more efficiently with a view to increase well-being support and enable a more positive experience for those experiencing difficulty. Earlier and more appropriate intervention will reduce length of sickness.

The team are currently focusing on any staff who have been absent on a long term basis due to long covid / covid restrictions to ensure adjustments are in place where necessary to facilitate a return to work, redeployment or to progress to a case review in line with the policy.



Apr 2022
79.0%

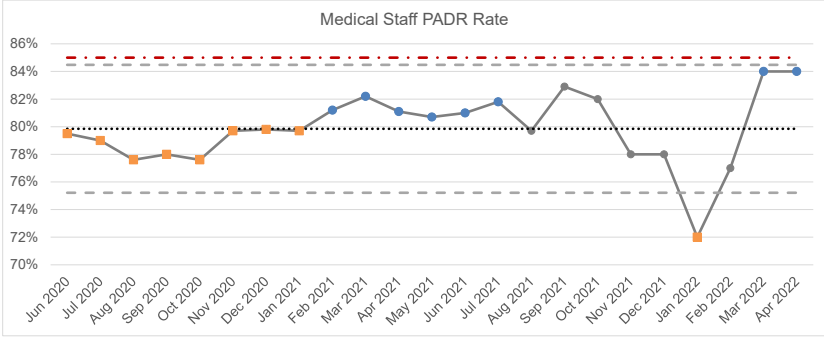
Target
85.0%

Variance

Common cause - no significant change

Assurance

Variation indicates consistently failing the target



Apr 2022
84.0%

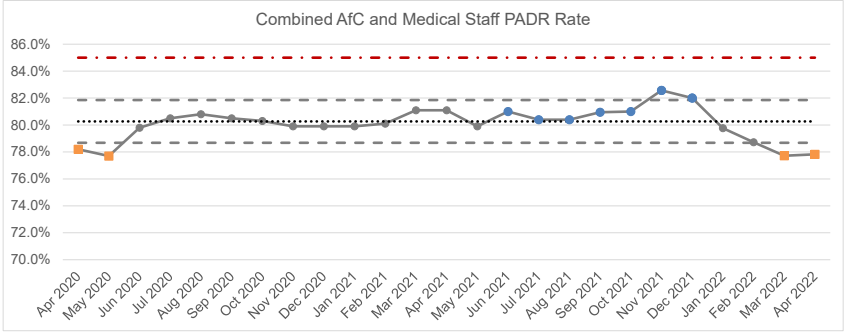
Target
85.0%

Variance

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

Assurance

Variation indicates consistently failing the target



Apr 2022
77.8%

Target
85.0%

Variance

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

Assurance

Variation indicates consistently failing the target

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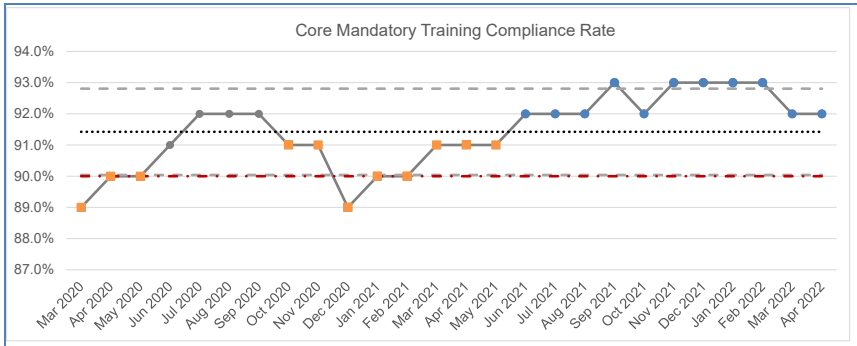
Data Analysis:
PADR Rate: Performance has been stable and is within the expected range.
Medical Staff PADR Rate: Performance has been predominantly within the expected range for the past two years with an improvement seen over recent months.
Combined AfC and Medical Staff PADR Rate: Following 18 months of stable or improving figures, performance has deteriorated in recent months and is now recording concern.

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 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 is at the final sign off stage.

Medical Staff PADR (RN): The omnicron surge played a signifcant role within the medical appraisal process. NLaG, via the Responsible Officer (Dr Kate Wood) received guidance and support from the GMC and NHSE/I which outlined how organisations can support doctors through appraial during the surge; i.e doctors who had apprasal due between December and February could delay their appraisal to a later date. The Trust adopted this approach to maintain the much needed flexibility within the process to ensure that the Trust is doing everything it can to balance the personal and professional wellbeing of its medical staff. Regarding medical appraisal delays, the Trust has adopted national policy (NHSE/I national policy on Medical Appraisal) which states that there can be up to 18 months between appraisals but doctors are supported by the revalidation assistant to ensure timely completion. There are now also operational changes to the process which is aimed at improving the process for medical staff. From April 2023, all doctors will have scheduled appraisals between the months April to December. No doctor will have a scheduled appraisal during the months January, February and March. This aim of this approach is to ensure that there is a balance of appraisal activity, as at the moment, one third of all medical staff have appraisals due in December, January, February and March. This balance will achieve personal and professional wellbeing balance for medical staff as well as a balance of appraisal activity for appraisers.



Apr 2022
92.0%

Target
90.0%

Variance

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

Assurance

Variation indicates consistently passing the target

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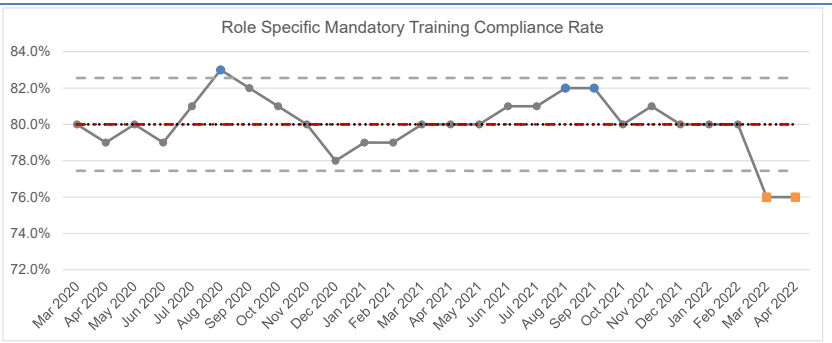

Apr 2022
76.0%

Target
80.0%

Variance

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

Assurance

Variation indicates 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 should reliably achieve the target.
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past two months and is now outside of the expected range. 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 is at the final sign off stage.

IPR Appendix A - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

Centiles from the Public View website have been provided where available (these are not available for all indicators in the IPR).
The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting 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 16/05/2022

* 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	Apr 2022	69.8%	92.0%	64	62/172	*Mar 22
	Planned	Number of Incomplete RTT pathways 52 weeks	Apr 2022	232	0	64	63/171	*Mar 22
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Apr 2022	23.9%	1.0%	56	71/159	*Mar 22
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Apr 2022	55.1%	85.0%	31	95/135	*Mar 22
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Apr 2022	58.9%	95.0%	16	112/133	*Mar 22
	Urgent Care	Number Of Emergency Department Attendances	Apr 2022	11,904	No target	47	79/147	*Mar 22
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Apr 2022	725	0	8	143/156	*Mar 22
	Flow	Bed Occupancy Rate (General & Acute)	Apr 2022	93.0%	92.0%	38	99/159	^Q3 21/22
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Apr 2022	6.5%	No target	23	131/169	*Feb 22
	COVID	Number of COVID patients in ICU beds (Weekly)	Apr 2022	6	No target	18	167/203	*Mar 22
	COVID	Number of COVID patients in other beds (Weekly)	Apr 2022	150	No target			

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Mar 2022	0	No target	100	1/138	*Feb 22
	Infection Control	Number of E Coli Infections	Mar 2022	2	No target	81	27/138	*Feb 22
	Infection Control	Number of Trust Attributed C-Difficile Infections	Mar 2022	1	No target	96	7/138	*Feb 22
	Infection Control	Number of MSSA Infections	Mar 2022	2	No target	42	81/138	*Feb 22
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Nov 2021	105.7	As expected	35	80/122	*Dec 21
	Safe Care	Number of Serious Incidents Raised in Month	Mar 2022	15	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Mar 2022	8.3	No target	48	99/188	*Feb 22
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Mar 2022	93.4%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Feb 2022	8.7	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Mar 2022	1124 out of 1190	No target	43	77/135	*Mar 22

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Mar 2022	6.9%	4.1%	42	125/214	*Nov 21

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

Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
* 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*	Apr 2022	69.8%	92.0%	Action Required		F	Board
	Number of Incomplete RTT pathways 52 weeks*	Apr 2022	232	0	Action Required	L	F	Board
	Total Inpatient Waiting List Size	Apr 2022	11,355	11,563	Action Required	H	P	Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Apr 2022	23.9%	1.0%	Action Required	L	F	Board
	Number of Incomplete RTT Pathways*	Apr 2022	32,085	No Target			n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Apr 2022	16,458	No Target		L	n/a	FPC
	% of Inpatient Waiting List Risk Stratified	Apr 2022	100.0%	99.0%		H	P	FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Apr 2022	28,869	9,000	Action Required		F	Board
	Outpatient Did Not Attend (DNA) Rate	Apr 2022	6.5%	No Target		L	n/a	Board
	% Outpatient Non Face To Face Attendances	Apr 2022	28.0%	No Target			n/a	Board
	% Outpatient summary letters with GPs within 7 days	Apr 2022	30.3%	50.0%	Action Required		F	FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Apr 2022	87.2%	99.0%		n/a	n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Apr 2022	55.1%	85.0%	Action Required	L	F	Board
	Cancer Waiting Times - 104+ Days Backlog*	Apr 2022	31	0	Action Required		F	Board
	Patients With Confirmed Diagnosis Transferred By Day 38*	Apr 2022	26.7%	75.0%	Action Required		F	Board
	Cancer Request To Test In 14 Days*	Apr 2022	80.2%	100.0%	Action Required		F	Board
	Cancer Waiting Times - 2 Week Wait*	Apr 2022	93.9%	93.0%	Action Required	L	?	FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Apr 2022	90.6%	93.0%	Action Required	L	?	FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Apr 2022	64.9%	75.0%			?	FPC
	Cancer Waiting Times - 31 Day First Treatment*	Apr 2022	96.4%	96.0%			?	FPC
	Cancer Waiting Times - 31 Day Surgery*	Apr 2022	94.7%	94.0%			?	FPC
	Cancer Waiting Times - 31 Day Drugs*	Apr 2022	97.9%	98.0%			?	FPC
	Cancer Waiting Times - 62 day Screening*	Apr 2022	100.0%	90.0%			?	FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Apr 2022	58.9%	95.0%	Action Required		F	Board
	Number Of Emergency Department Attendances	Apr 2022	11,904	No Target			n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Apr 2022	906	0	Action Required	H	F	Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Apr 2022	725	0	Action Required	H	F	Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Apr 2022	39.7%	40.0%	Action Required	H	F	Board
	% of Extended Stay Patients 21+ days	Apr 2022	13.1%	12.0%	Action Required	H	?	Board
	Inpatient Elective Average Length Of Stay	Apr 2022	2.1	2.5			?	Board
	Inpatient Non Elective Average Length Of Stay	Apr 2022	3.9	3.9		L	?	Board
	Number of Medical Patients Occupying Non-Medical Wards	Apr 2022	330	No Target	Action Required	H	n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Apr 2022	88.8%	90.0%			?	Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Apr 2022	17.7%	30.0%	Action Required		F	Board
	Bed Occupancy Rate (G&A)	Apr 2022	93.0%	92.0%			?	Board
	Percentage of patients re-admitted as an emergency within 30 days	Apr 2022	8.3%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Apr 2022	47.0%	No Target	Action Required	H	n/a	FPC
	% of Extended Stay Patients 14+ days	Apr 2022	25.4%	No Target	Action Required	H	n/a	FPC
COVID	Number of COVID patients in ICU beds (Weekly)	Apr 2022	6	No Target			n/a	Board
	Number of COVID patients in other beds (Weekly)	Apr 2022	150	No Target	Action Required	H	n/a	Board
	% COVID staff absences (Weekly)	Apr 2022	24.9%	No Target		H	n/a	Board

Appendix B - Scorecard - Quality and Safety

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Mar 2022	0.00	No target			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Mar 2022	0.10	No target			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Mar 2022	0.05	No target			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Mar 2022	0.10	No target			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Mar 2022	0.16	No target			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Feb 2022	100.1	As expected		L	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Nov 2021	105.7	As expected		L	As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Apr 2022	8	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Mar 2022	201	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Dec 2021	131.9	110.0	**Action Required**		F	Q&S
	Structured Judgement Reviews - Rate Completed of those required	Mar 2022	29.0%	100.0%	**Action Required**	L	?	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Mar 2022	100.0%	No target		H	n/a	Board
	Number of Serious Incidents raised in month	Mar 2022	15	No target			n/a	Board
	Occurrence of 'Never Events' (Number)	Mar 2022	0	0		n/a	n/a	Board
	Duty of Candour Rate	Feb 2022	100.0%	No target			n/a	Board
	Falls on Inpatient Wards (Rate per 1000 bed days)	Mar 2022	4.9	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate per 1000 bed days)	Mar 2022	4.8	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Mar 2022	93.4%	95.0%	**Action Required**	H	F	Board
	Care Hours Per Patient Day (CHPPD)	Mar 2022	8.3	No target	**Action Required**	L	n/a	Board
	Mixed Sex Accommodation Breaches	Mar 2022	13.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Feb 2022	8.7	No target			n/a	Board
	Complaints Responded to on time	Feb 2022	71.0%	85.0%			?	Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Mar 2022	1124 out of 1190	No target		n/a	n/a	Board
	Number of Positive A&E Scores	Mar 2022	478 out of 750	No target		n/a	n/a	Board
	Number of Positive Community Scores	Mar 2022	182 out of 192	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	Mar 2022	38 out of 43	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Mar 2022	16 out of 18	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Mar 2022	104 out of 106	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Mar 2022	0 out of 2	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Mar 2022	36 out of 42	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Mar 2022	90.8%	90.0%			?	Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Apr 2022	75.0%	90.0%			?	Q&S
	Escalation of NEWS in line with Policy	Mar 2022	0.0%	No target		n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	Mar 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)	Mar 2022	57.0%	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)	Mar 2022	14.0%	90.0%		n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool (to be added)	Mar 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 (to be added)	Mar 2022	25.0%	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)	Mar 2022	66.3%	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)	Mar 2022	13.8%	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	Feb 2022	100.0%	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	Mar 2022	2.2%	No target		n/a	n/a	Q&S
	Antibiotic prescriptions have evidence of a review within 72 hours	Mar 2022	69.1%	70.0%		n/a	n/a	Q&S
Maternity	**Caesarean Section Indicator - Based on Robson Scores (to be added)**							**Q&S**

Appendix B - Scorecard - Workforce

Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Action Required' is stated when either Variation is showing special cause concern or Assurance indicates failing the target.
*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	Mar 2022	11.6%	2.0%	Action Required		F	Board
	Registered Nurse Vacancy Rate	Mar 2022	7.4%	8.0%		L	?	Board
	Medical Vacancy Rate	Mar 2022	12.1%	15.0%			?	Board
	Trustwide Vacancy Rate	Mar 2022	9.3%	7.0%	Action Required	H	F	Board
Staffing Levels	Turnover Rate	Apr 2022	12.1%	10.0%	Action Required	H	?	Board
	Sickness Rate	Mar 2022	6.9%	4.1%	Action Required	H	?	Board
Staff Development	PADR Rate	Apr 2022	79.0%	85.0%	Action Required		F	Board
	Medical Staff PADR Rate	Apr 2022	84.0%	85.0%	Action Required	H	F	Board
	Combined AfC and Medical Staff PADR Rate	Apr 2022	77.8%	85.0%	Action Required	L	F	Board
	Core Mandatory Training Compliance Rate	Apr 2022	92.0%	90.0%		H	P	Board
	Role Specific Mandatory Training Compliance Rate	Apr 2022	76.0%	80.0%	Action Required	L	?	Board
Disciplinary	Number of Disciplinary Cases Commenced	Apr 2022	0	No Target		L	n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Apr 2022	0	12		L	?	WFC
	Number of Suspensions Commenced	Apr 2022	0	No Target		L	n/a	WFC
	Average Length of Suspension (Weeks)	Apr 2022	0	No Target		L	n/a	WFC

NLG(22)081

Name of the Meeting	**Trust Board of Directors – Public Board**	
Date of the Meeting	Tuesday, 7 June 2022	
Director Lead	Michael Proctor NED and Chair of Quality and Safety Committee	
Contact Officer/Author	As above	
Title of the Report	**Quality and Safety Committee Highlight Report (April and May meetings)**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide the Board with a summary of discussion/decisions of the Quality and Safety Committee	
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)	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.
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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

Highlight Report to Trust Board

Report for Trust Board Meeting on:	7 June 2022
Report From:	Quality & Safety Committee 25 April and 25 May 2022

Highlight Report:

The Committee workplan was updated and will return to Committee for approval in June.

Family Services presented an update from maternity and paediatrics. This included updates on CNST, Saving Babies Lives and the first Ockenden report. The report had good assurance on 15 steps reviews of the ward based establishment for the division.

Community Services presented an update on risks and mitigations, including End of Life. The Committee discussed the roll out of the RESPECT proforma, with Executive support offered to strengthen progress, and it was agreed to bring further assurance on the good progress made through QI on pain relief.

A discussion on risk stratification and clinical harm from delays in treatment agreed to change to focus more on the quality and potential harms.

Assurances were received from a paper looking specifically at the colorectal cancer pathway, part of a series of deep dives the Committee is undertaking into the quality issues on cancer pathways.

Concern remained about staffing issues given the significant pressures on the Trust. The Committee acknowledged the difficult choices which had needed to be made on a shift by shift basis to maintain safety, noting this had seen some improvement in May.

Two significant improvements were noted in regards to VTE, and the Committee was assured by the improvement in performance recorded in the IPR.

The Serious Incident report noted two new maternity Serious Incidents, one of which sat with HSIB, while the other related to a birth injury.

The quarterly report on diabetes noted good progress. The Committee agreed that the ward audit could be robustly covered through other tools, and noted the consistent delivery of the standard on that audit, but asked for another 3 months of data on blood sugar in both adults and children in ED.

The PROMS report gave good assurance on knee replacements, but noted a decrease on the scores for hip replacements for which a deep dive into the data had been arranged.

Ongoing progress with the CQC actions were noted.

The intelligence from the quarterly report on integrated quality data (incidents, medico-legal, complaints, mortality) was considered and further assurances sought for the next iteration on processes to address limited assurance audits.

Ratifications:

- The Mental Health Strategy
- The Clinical Audit Forward Programme for 2022/23

Escalations were received in relation to emerging issues:

- A backlog of unacknowledged results post the roll out of results acknowledgement, where reassurances had been received that results were acted on but not acknowledged on the system – further work to clarify assurance on safety was requested.
- Delays in PEG tube insertion, noting that actions were being explored to address this at pace.

Confirm or Challenge of the Board Assurance Framework:

The BAF was reviewed and following a lengthy discussion, there was consensus that the risk rating of 15 on strategic risk 1.1 may require raising due to the concerns relating to nurse staffing exacerbated by the need to continue the use of additional, unestablished capacity to deal with significant operational pressures. Whilst the staffing position was not significantly deteriorating the cumulative impact of long term nature of the pressures might conceivably increase risk. A discussion took place in relation to the long term target for strategic risk 1.1 in relation to the risk appetite for patient safety.

Action Required by the Trust Board:

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

Mike Proctor
Non-Executive Director

NLG(22)082

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	7 June 2022
Director Lead	Mike Proctor, Non Executive Director
Contact Officer/Author	Angie Legge, Associate Director of Quality Governance
Title of the Report	**2021/22 Annual Quality Account**
Purpose of the Report and Executive Summary (to include recommendations)	Each year the Trust is required to publish an annual Quality Account by the national deadline of 30th June 2022. The attached paper is the draft Quality Account which provides an overview of the Trusts performance, particularly the progress made against the Quality Priorities for 2020/21 and sets out future priorities going into 2022/23. Given the significant impact of Covid-19 and operational pressures on progress against priorities, the document refers to this in a number of sections. The consultation period on the contents of the quality account with overview and scrutiny committees, CCGs and local Healthwatch ended on the 31st May 2022. At present a joint response from the CCGs is yet to be received, along with a revised statement from North Lincolnshire HOSC. As per national guidance no external audit is required for this year's publication. However, the narrative detailed within the report has been written in keeping with previous years requirements to maintain consistency. A request has been made for internal audit review, however this request has not yet been confirmed. Due to the impact of COVID-19 and national data collection halting, some charts have not been updated nationally. Consequently, to retain consistency the charts remain within the report with the narrative providing a local update. Approval is requested from Trust Management Board for the Quality Account to be released for publication once the final statements have been received for inclusion (following any amendments requested by the Board).
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Click here to enter text.
Which Trust Priority does this link to	☐ 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

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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.

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NHS
Northern Lincolnshire
and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2021/2022

CONTENTS

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

In many ways the challenge the Trust faced in 2021/22 was greater than that faced in the first year of the pandemic. One of the main reasons I say that is our staff started the year tired and stressed after having to deal with multiple issues and changes as a result of the spread of COVID-19 in 2020/21. In April 2021 we were planning to do everything we could to cope with whatever the pandemic threw at us next as well as trying to bring back to 'normal' as many services as we could, particularly undertaking as many elective cases as we could.

I have to report our staff responded superbly to all of the challenges put in front of them throughout the year. Throughout our hospital, community services and support functions our teams went above and beyond, again and again, to do everything they could to care for patients and provide services. We saw incessant and growing demands – for example from patients attending our Emergency Departments (EDs), in responding to changing guidance and to discharging patients from our wards and trying to tackle the backlog of patients needing outpatient, diagnostic and elective care which built up during the pandemic. Our staff coped admirably with all this – I want to thank them publicly and wholeheartedly for their dedication and enormous hard work.

We did everything we can to help them, including giving them all an extra day of annual leave for a token of appreciation for all their efforts fighting the pandemic. We identified staff health and wellbeing as a key priority for 21/22 – without staff available to do their jobs, we wouldn't be able to provide what we need to. Despite this our staff have struggled to maintain their morale and motivation, a point picked up in our disappointing results from the national staff survey which were published in March 2022. These results showed it is clear we need to continue our focus to create a better working environment for our staff. So in 2022/23 our priorities will include, alongside a continued focus on health and wellbeing, developing further how we attract and recruit new staff as well as addressing how we develop and care for the staff we do have.

Responding to the pandemic continued to affect all aspects of how we provided healthcare. We have continuously had to make risk-based decisions to keep our patients safe, which resulted in services being segregated and reducing the scale of some of the services we could offer due to the consequent reduced capacity. This has been complicated further by some of the Trust's ageing estate, although we did make good progress in the year to build our new EDs at Grimsby and Scunthorpe which will open in 2022/23. These restrictions impacted on our improvement ambitions for the year with regards to patient flow through our hospitals. As a consequence I'm sad to report the number of patients waiting more than 12 hours was more than we would want, as was the number of ambulances waiting to hand over patients to the department. I would like to apologise to all patients who waited longer than they expected. In terms of patients attending the departments with minor ailments we did improve how quickly we saw and treated these through the year. This was due to the introduction of an Urgent Care Service, first at Scunthorpe in October 2021 and then at Grimsby in January 2022.

Our planned care (which means operations or other procedures) numbers continued to grow, mainly as a result of the national decision to cancel all planned activity for much of 2021/22. However, we did continue to undertake operations throughout the winter, prioritising those patients with the most urgent needs and those who had been waiting the longest times.

Despite the challenges we faced, this annual Quality Account is also an opportunity to reflect on what the Trust has achieved and its progress against quality goals and to the best of my knowledge the information contained within this report is accurate. We recognise further improvement is required to meet the targets initially set at the beginning of the year, therefore several quality priority indicators have been carried over to 2022/23. Work has also continued throughout the year to achieve the actions identified by the Care Quality Commission (CQC) in

their report published in February 2020, following their inspection in September 2019. At the time of writing, we had 83 open actions with significant progress being made.

The Trust has seen a sustained decrease in hospital mortality over the course of the year and has remained within the 'as expected' rating. This is an excellent achievement especially given the Trust's previous position. Work continues with system wide partners to further improve on the progress that has been made. The following report will provide greater details on this and other achievements.

In many ways our challenge for 2022/23 remains the same as it was in 2021/22: to make sure our staff are able to offer the best possible patient care, by looking after them (our staff) and supporting them as they recover from such an intense year, whilst at the same time doing everything we can to bring down our waiting lists and managing the increased demand we are experiencing for urgent care. As I reported in last year's Quality Account, this is no easy task and will require dedication, relentless effort and high levels of resilience. At the same time we will be asking our teams to take on other challenges too – as we move into new buildings, create and embed new digital systems, and deliver more new ways of working. If anyone can manage to do this, our staff can; they are remarkable. Once again, very many thanks to them all.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 20 April 2022

About Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'the Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire and therapy services at all our sites. In summary these services are:

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

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

Figure 1: 2021/22 - A year in numbers

Executive summary of key points

5 Quality Priorities for 2021/22:

As part of the Trust's annual setting of priorities, the Trust had set 5 quality priorities:

(1) Reduce mortality rates and strengthen end of life care
(Patient Experience and Clinical Effectiveness)

(2) Improve the management of deteriorating Patients & Sepsis
(Clinical Effectiveness and Patient Safety)

(3) Increasing medication safety
(Patient Experience & Patient Safety)

(4) Safety of Discharge:
(Patient Safety, Experience & Clinical Effectiveness)

(5) Improve the management of Diabetes
(Clinical Effectiveness and Patient Safety)

The executive summary outlines key performance against these quality priorities. For a more detailed narrative and explanation of performance, see part 2.1 of this report.

Covid-19 Pandemic Response:

The Trust's priorities for 2021/22 were set during the Covid-19 pandemic which had a significant impact on the Trust and the wider NHS. As such it should be noted:

(1) Responding to the pandemic pressures and the associated impacts on staff, waiting lists, facilities, etc. were handled as additional pressure.

(2) The pandemic significantly affected Trust performance against some objectives where key personnel/organisational focus needed to be diverted to support the pandemic response and system-wide operational pressures.

Priority 1 - Patient Experience & Clinical Effectiveness	**Outcome**
Reduce mortality rates and strengthen end of life care	**Progress made**

1a) The Trust has sustained a statistically significant improvement with regards to the overall Summary-Hospital Level Mortality Indicator (SHMI) with a score of 106.4 in March 2022, which remains within the 'as expected' range. The intended target of reducing the out of hospital (OOH) element of the SHMI to 110 was not achieved as the current figure for November 2021 (the most recent release of data) is 131.9, and therefore remains above the intended target.

1b) Despite the pandemic and pressures across the healthcare system, data demonstrates an improvement with an average of 17 patients dying within 24 hours compared to an average of 21 in 2020/21.

1c) The same also applies where no statistically significant change has been achieved with regards to reducing the number of emergency admissions for people in the last 3 months of life. Although, data shows positive progress with an average monthly reduction of 7 admissions per month compared to 2020/21.

Priority 2 - Clinical Effectiveness and Patient Safety	Outcome
Improve the management of deteriorating Patients & Sepsis	**Progress made**

2a) Recording of patient observations using NEWS and OEWS in line with timescales was achieved against a target of 90%. This is a significant achievement given the operational and pandemic pressures. However, for paediatrics, whilst the performance is within the expected range of variation, it has regularly passed and failed the target during 2021/22.

2b) The audit data has identified that the Trust is not able to demonstrate compliance in response to escalation in line with the NEWS policy due to the current systems and documentation in place to provide retrospective evidence. This coupled with persistent operational pressures and staffing shortages has made it challenging to make sustained improvement. Work is underway to look at system changes to better support this area of improvement.

2c) The audit data has also demonstrated that further improvement work is required in relation to screening patients for sepsis and meeting the desired 90% target. Whilst the target has not been reached, significant improvement has been observed with an increase to 80% in January 2022 from 34% in May 2021.

Priority 3 - Patient Experience and Patient Safety	Outcome
Increasing medication safety	**Partially achieved**

3a) Operational pressures and staffing shortages within Acute Care services has impacted on the Trust's priority to sustain any improvement in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU). Audit data has demonstrated further improvement work is required and therefore, this priority is being carried over into 2022/23.

3b) Performance for administering insulin on time in wards using EPMA was consistently above the intended target of 85%, therefore the Trust achieved this indicator.

3c) The Trust also achieved its target in reducing the number of medication omissions without a valid reason for ward areas using EPMA from 13.7% in April 2021 to 2% in February 2022.

Priority 4 - Patient Safety, Experience and Clinical Effectiveness	Outcome
Safety of Discharge	**Not achieved**

Performance against the discharge indicators has been significantly affected by the Covid-19 pandemic and continued system wide pressures. The closure of several residential and nursing homes within the region resulted in the Trust having delayed discharges and being unable to discharge patients safely due to social care constraints. In March 2022 the Trust achieved a 16.4% performance rate against the 30% target in discharging patients home before 12 noon, 66% of patients by 5pm and had 55 patients in hospital for more than 21 days.

The Trust has implemented a discharge improvement plan to drive progress and move towards the intended targets, therefore, this quality priority is being carried over into 2022/23.

Priority 5 - Clinical Effectiveness and Patient Safety	Outcome
Diabetes Management	**Partially achieved**

5a) The Trust continues to face challenges in releasing staff to undertake diabetes mandatory training due to persistent operational pressure and staff sickness levels. Compliance has remained above 85%, thus demonstrating continued long-term improvement despite the challenges.

5b) Performance for the Diabetes Audit on inpatient ward areas has been consistently on par with the intended target of 80%, therefore the Trust achieved this indicator.

5c) Clinical Audit results for the recording of children's blood glucose in the Emergency Department demonstrate an improvement in compliance; however, this fluctuates and has not yet provided sustained assurance. Therefore, the audit will continue to be undertaken as part of the 2022/23 Trust's Quality & Audit Forward Programme to embed improvements.

Quality Priorities for 2022/23:

Setting quality priorities:
During 2019/20, the Trust reviewed and aligned its five-year quality strategy. The strategy, based upon the National Quality Board's (NQB) *'Shared Commitment to Quality',* sets long term quality objectives linked to the Trust's strategic objectives, the Trust will continue to review and set annual quality priorities.

Priorities for 2021/22 were set in accordance with the Trust's quality strategy The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and social media channels.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2022/23. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

Quality priorities for 2022/23:
Six priorities have been agreed for 2022/23 and relate to several areas/priorities where progress has been made during the period covered by this quality account:

(1) Mortality improvement (n=3)
Indicators within this area remain the same and aim to build on the progress made with mortality performance so far. They seek to support further improvement with advanced care planning for patients who are at end of life and require individualised and holistic plans to ensure care is provided at the right time and in the right place.

(2) Deteriorating Patient (n=3)
These indicators build on the improvements already made in connection with patient observations, but aims to continue focusing on improving the processes and systems around escalation. A new indicator has been added to measure the timeliness of clinical assessment in Emergency Care Centres for both adults and children.

(3) Sepsis (n=2)
These indicators build on the improvements already made in connection with sepsis screening in adults but also continue to focus on the delivery of the sepsis six standards within agreed timeframes. During 2022/23 sepsis management for children will also be measured and reported.

(4) Increasing medication safety (n=3)
These indicators build on the improvements already made in connection to medication omissions and safety around prescribing for drugs that require a 'weight for dosing'. New indicators have also been added to support the further improvement in the reduction / appropriateness of antibiotic prescribing across the Trust.

(5) Friends and Family Test and PALS (n=2)
These are new indicators that focus on patient experience measures which aim to support improvement in responding to PALS complaints within set timescales and improving patient and family feedback rates to enable direct patient driven improvements.

(6) Safety of Discharge (n=5)
These measures continue to focus on the Discharge to Assess project and will enable the Trust to monitor progress with continued improvements in patient flow through the Trust's hospitals. They also focus on performance with issuing discharge communications to the patient's GP Practice within defined timescales.

How progress against 2022/23 quality priorities will be monitored and measured:
Progress will be monitored through the Trust's Quality and Safety section of the Integrated Performance Report. This is a monthly report considered by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes.

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

Some of the above quality priorities and the underpinning measures link to Trust performance indicators. In these instances, the Trust's Finance and Performance Committee will primarily oversee progress, with the Quality & Safety Committee seeking assurance on quality outcome measures.

There are close links established between these oversight arrangements and monthly performance meetings held with divisions, where divisions are held to account for performance.

Interpreting the data presented within this report:
The Trust's monthly quality performance report makes use of Statistical Process Control (SPC) charts to support an understanding of what data trends show and what assurance can be gained.

The annual quality account aims to provide an easy to digest summary of this performance during the 2021/22 period. To achieve this aim the measures used to focus on the Trust's quality priorities are presented in a table that summarises what the data trends show. This presentation will use the following icons to support interpretation of key points.

To further help the reader, a rating is provided within each summary table to demonstrate if the Trust has met the quality priority stated. Supportive narrative will further aid the reader gain a sense of the key points.

Variation - Using SPC methodology, data since April-2017 (or as early as currently available) is fed into SPC charts. If the variation is showing as special cause in the reported month, this is flagged. Orange being negative, and blue being positive.

Assurance – As per above, if the variation in the performance is consistently showing above the target, it will be blue. If orange, it will not meet target without system change. Grey indicates that the target is within the limits of variation.

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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

2.1 Priorities for improvement: overview of the quality of care against 2021/22 quality priorities & quality priorities planning for 2022/23

2.1a: Priority 1: Patient Experience & Clinical Effectiveness: End of Life and Related Mortality Indicators

Summary table: Performance during 2021/22:

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:							
QP1: Reduce mortality rates and strengthen end of life care	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
1a) Reduction in the number of patients dying within 24 hours of admission to hospital.	**15**	14	17	**16**		No target	G
1b) Reduction in the number of emergency admissions for people in the last 3 months of life.	**193**	172	212	**199**		No target	G
1c) Reduction in the out of hospital SHMI to 110, by March 2022.	**131.9**	132.6	135	**137**			R

Progress made (April 2021 – March 2022):
During the 2021/22 period, Trust performance has not met the target set in reducing the out of hospital SHMI. No numerical targets were agreed for reducing the number of patients dying within 24 hours of admission to hospital and reducing the number of emergency admissions in the last 3 months of life, however a reduction in both indicators has been observed on average throughout the year.

1a) Reduction in the number of patients dying within 24 hours
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. Despite the significant operational pressures associated with the COVID-19 pandemic, the number of patients who died within 24 hours of admission has remained stable and continues within the expected range of variation. Trust data demonstrates an improvement, with a reduction from an average of 21 patients dying within 24 hours of admission during 2020/21 to an average of 17 patients during 2021/22.

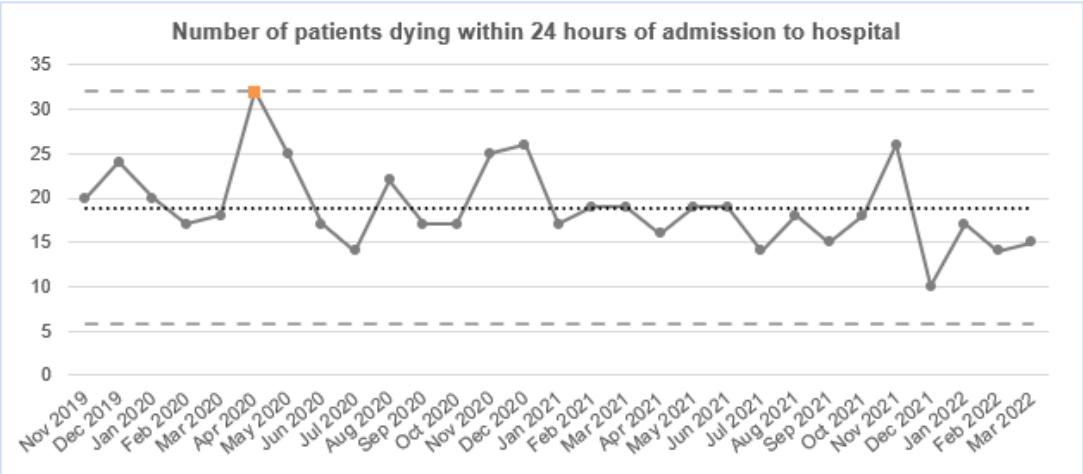


Figure 2: Number of patients dying within 24 hours of admission to hospital

1b) Reduction of emergency admissions for people in the last 3 months of life

Emergency admission to hospital during the end-of-life phase may also represent a failure in advanced care plans and negatively impact the patient's experience. Despite the impact of the COVID-19 pandemic the number of admissions remained stable. Positive progress is demonstrated as data shows an average reduction of 7 admissions per month during 2021/22 compared to 2020/21.

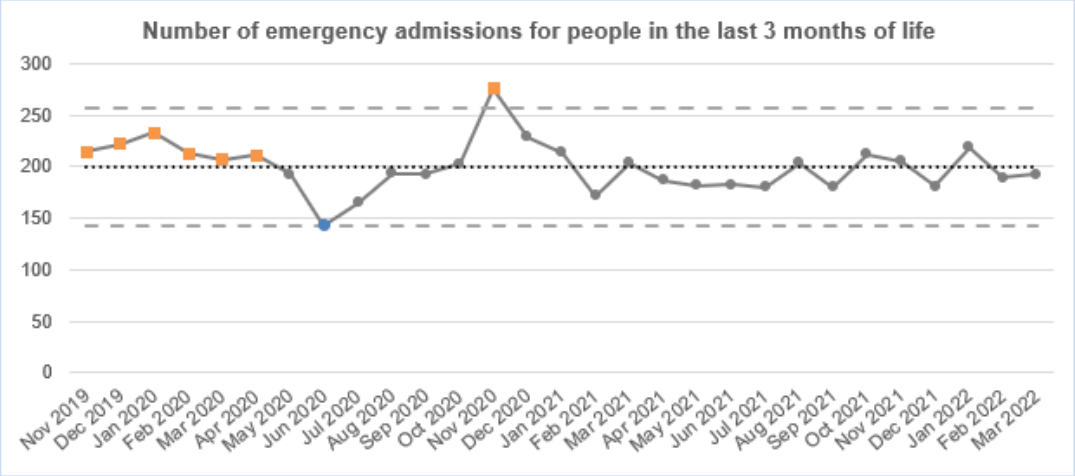


Figure 3: Number of emergency admissions for people in the last 3 months of life

1c) Reduction in out of hospital SHMI to 110 by March 2022

The Trust has sustained a statistically significant improvement with regards to the overall Summary-Hospital Level Mortality Indicator (SHMI) with a score of 106.4 in March 2022, which remains within the 'as expected' range. The Trust aimed to work with partners to reduce the out of hospital (OOH) element of the SHMI to 110 during 2021/22. Based on the most recent published data (November 2021) the Trust has not achieved the target as the current figure is 131.9, and therefore remains above the intended target. However, the figure has reduced from 140 in March 2021, the Trust continues to work with partners to try to bring this down further to fall in line with the agreed target.

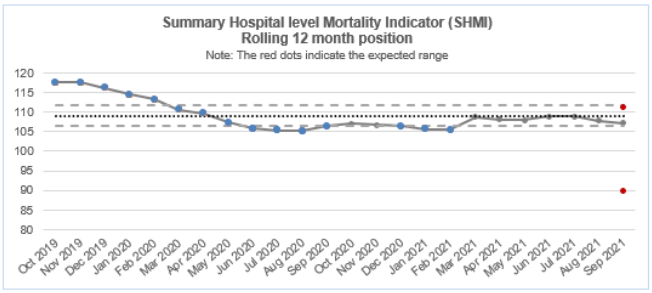


Figure 4: Overall SHMI – 12 month position

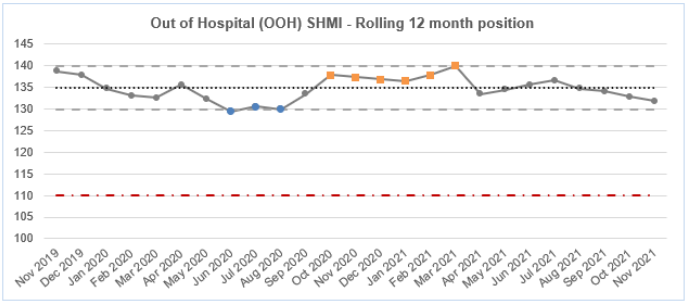


Figure 5: Out of Hospital SHMI – 12 month position

Figure 4: demonstrates the improvement in the Trust's overall SHMI position.

Figure 5: shows the improvements made in the last quarter and from the position in October 2019 despite the operational pressures the Trust has encountered linked to the COVID-19 pandemic.

Milestones achieved during 2021/22:

- Introduction of new national mortality reporting mechanisms to provide the Trust with improved oversight of high-level mortality information and learning from structured judgement reviews.

- Introduction of consultant led screening process to allow investigation into collaborative system processes and identify learning to prevent potential avoidable admissions to hospital.

- Introduction of Medical Examiner to oversee and scrutinise the quality of care for patients who die during admission or within 30 days of discharge.

- A selection of patients who die within 24 hours of admission are reviewed to ascertain further understanding of patient pathways. Findings are discussed at collaborative morbidity and mortality meetings alongside commissioners and other system partners. Cases for learning are shared at specialty specific Quality & Safety Meetings.

- A selection of patients who were admitted to hospital in the last 3 months of life are reviewed by a General Practitioner to identify learning and ascertain further understanding of patient pathways. Review outcomes are discussed at collaborative morbidity and mortality meetings alongside commissioners and other System partners. Cases for learning are shared at specialty specific Quality & Safety Meetings.

- Review of patients identified within certain SHMI diagnosis groups where 'higher than expected' mortality rates have been identified, alongside system partners at collaborative morbidity and mortality meetings.

- Review of system wide medical and nursing palliative care provision in collaboration with local commissioners.

The Trust has listed this as a priority to take forward into 2022/23 recognising that a greater depth of understanding of the factors influencing the out of hospital SHMI rates at both North Lincolnshire and North East Lincolnshire is required. Therefore, the Trust is committed to working alongside local CCGs to improve this position and move towards the intended target.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality & Safety Committee and the Trust Board. Progress is also monitored at the Trust's Mortality Improvement Group (MIG).

Relationship to 2022/23 Quality Improvement Priorities: This quality priority will continue into 2022/23. Focus will be placed on the recognition of the dying patient to allow earlier initiation of end of life and advanced care planning and in gaining a greater understanding of the out of hospital deaths within 30 days of discharge.

2.1b: Priority 2: Clinical Effectiveness and Patient Safety: Deteriorating Patient and Sepsis

Summary table: Performance during 2021/22:

CLINICAL EFFECTIVENESS & PATIENT SAFETY:								
QP2: Deteriorating Patient & Sepsis	**Mar-22**	**Jan-22**	**Nov-21**	**Sep-21**	**May-21**	**SPC Variation**	**SPC Assurance**	**RAG**
2a) ADULTS: 90% of patient observations recorded on time.	**91%**	90%	91%	91%	**91%**			G
2a) CHILDREN: 90% of patient observations recorded on time.	**90%**	100%	80%	95%	**90%**			A
2b) Escalation of NEWS in line with policy *(Audit data available bi-monthly)*	No data	0%	9%	3%	**5%**			R
2c) Sepsis screen in 90% of patients with a sepsis six indicator.	No data	80%	47%	39%	**34%**			R

Progress made (April 2021 – March 2022):
During the 2021/22 period, Trust performance has partially met the target set in recording patient observations in accordance with agreed timescales. Significant improvement has been made in

increasing the number of patients having a sepsis screen (where required), but the Trust was unable to make any positive progress in meeting the target around escalation for deteriorating patients in line with Trust policy.

2a) Timeliness of observations

During the 2021/22 period, the Trust has continued to achieve the target in recording patient observations utilising National Early Warning Score (NEWS) and Obstetric Early Warning Scores (OEWS) in line with agreed timescales. This is a significant achievement given the operational pressures. Audit data also shows that performance for undertaking observations in children is regularly above the target but there were occasions where compliance dropped below the target, suggesting further embedding is required.

The charts below summarise compliance over the year for adults and children compared to the 90% target.

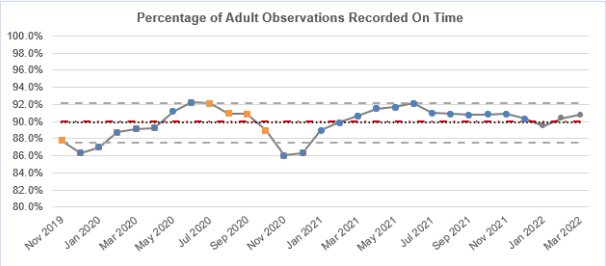


Figure 6: Percentage of adult observations recorded on time

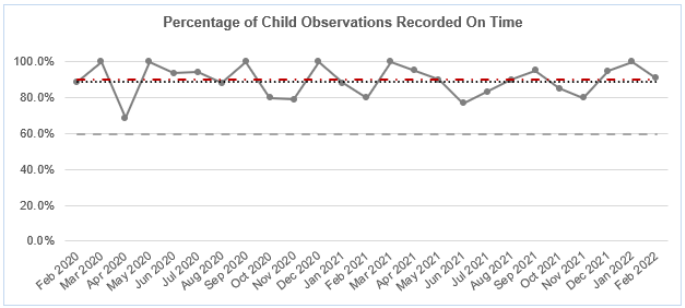


Figure 7: Percentage of adult observations recorded on time

2b) Escalation of NEWS in line with policy

The Trust is not able to demonstrate improvement with regards to escalating patients in line with the NEWS policy to meet the agreed target. The pressures associated with the COVID-19 pandemic has impacted progress being made, however, the audit identified that figures may reflect poorer compliance in recording, than that in actual practice. This is due to the lack of systems to retrospectively capture clinical review times in accordance with the timeframes (which are often not documented until the patient has been treated).

2c) Sepsis screening

Improvement plans linked to sepsis screening and appropriate treatment were not achieved, although positive progress has been observed with the most recent audit data showing an increase from 34% in May 2021 to 80% in January 2022.

Milestones achieved during 2021/22:

- Introduction of electronic systems to record sepsis screening that reports ward-based compliance rates.

- Introduction of a Clinical Nurse Educator and Sepsis Nurse Specialist to provide targeted support to adult ward areas (where data indicates this is required).

- Individual case review (where learning associated with sepsis has been identified) are shared at the Deteriorating Patient and Sepsis Group.

- Introduction of Clinical Nurse Educator within Paediatrics who undertakes regular Paediatric Early Warning Scores (PEWS)/Sepsis audits.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality & Safety Committee and the Trust Board.

Relationship to 2022/23 Quality Improvement Priorities: This quality priority has remained the same throughout 2021/22. Sepsis and the deteriorating patient will remain a priority for 2022/23 with a focus on improving processes around evidencing escalation and treatment for deteriorating patients and patients with identified flags for sepsis. The Trust will also assess sepsis management for children in 2022/23.

2.1c: Priority 3: Patient Safety and Experience: Increasing Medication Safety

Summary table: Performance during 2021/22:

PATIENT SAFETY & PATIENT EXPERIENCE:							
QP3: Increasing medication safety	Feb-22	Jan-22	Dec-21	Jul-21	SPC Variation	SPC Assurance	RAG
3a) Improvements in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU).	64%	68%	63%	64%		Insufficient data	R
3b) Insulin administered on time in 85% within wards using EPMA.	100%	80%	95%	90%		Insufficient data	G
3c) Reduction in medication omissions without a valid reason for ward areas using EPMA.	2%	2%	2%	14%		Insufficient data	G

N.B. There is insufficient data points to allow assurance to be calculated from SPC calculations. RAG rating has been provided based on data collected during 2021/22 to date.

Progress made (April 2021 – March 2022):

During the 2021/22 period, the Trust has made significant improvement and met the targets regarding insulin administration and in reducing medication omissions without a valid reason, on ward areas. Further improvement is required in recording patient weights to reach the target. This priority is being carried over into 2022/23.

3a) Recording of patient weights

A monthly audit commenced in July 2021, this has helped to get an understanding of the issues associated with weighing patients during acute admission and prescribing 'weight for dosing drugs' on ward areas. From this the results indicate there is additional work still to be done to attain and embed the standards.

3b) Administration of Insulin on Ward Areas

Performance for administering insulin on time in wards using EPMA was consistently above the intended target of 85%, therefore the Trust achieved this indicator. The chart below demonstrates the sustained high compliance throughout 2021/22.

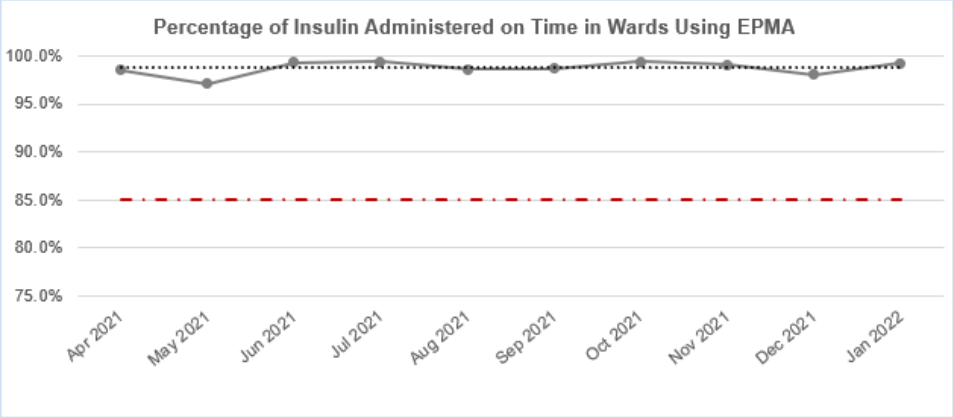


Figure 8: Percentage of Insulin Administered on Time in Wards using EPMA

3c) Reducing the number of medication omissions

The Trust also achieved its target in reducing the number of medication omissions without a valid reason for ward areas using EPMA from 13.7% in April 2021 to 2% in February 2022.

The chart below demonstrates the progress made throughout the year.

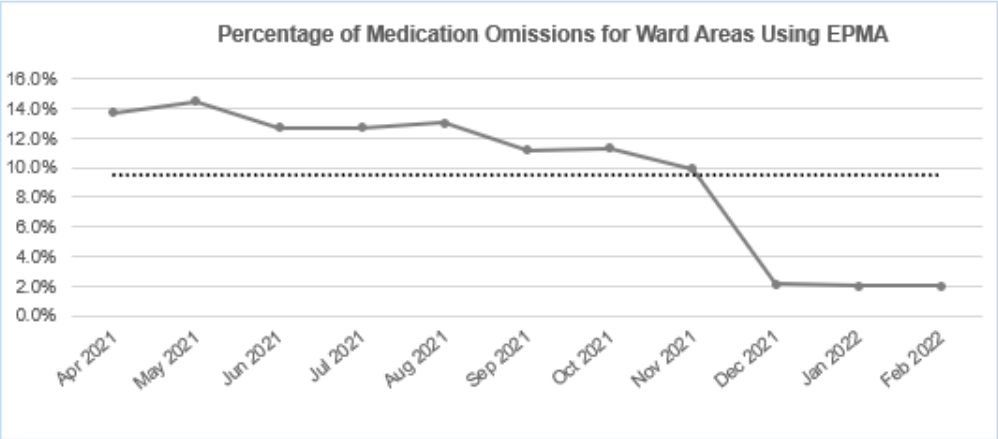


Figure 9: Percentage of Medication Omissions for Wards using EPMA

Milestones achieved during 2021/22:

- Weighing patients - aide memoire added to EPMA in quarter three to remind ward areas to weigh patients to obtain an actual weight. Also, to remind prescribing limits for paracetamol in patients under 50kg.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality Governance Group, Quality & Safety Committee and the Trust Board. Progress against the Weighing and Prescribing Audit standards is also monitored at the Safer Medication Group and has been raised with divisional Governance Groups.

Relationship to 2022/23 Quality Improvement Priorities: An indicator within this quality priority has remained the same throughout 2021/22. Focus on medication safety will be included as a quality priority during 2022/23 and will also focus on antibiotic prescribing practices within the Trust.

2.1d: Priority 4: Patient Experience, Patient Safety & Clinical Effectiveness: Improve the safety of discharge

Summary table: Performance during 2021/22:

PATIENT SAFETY, CLINICAL EFFECTIVENESS & PATIENT EXPERIENCE:							
QP4: Safety of Discharge	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
4a) Improve the proportion of patients discharged before 12 noon.	16.4%	15.2%	16.3%	**16.9%**			R
4b) Improve the proportion of patients discharged before 5pm.	66.3%	66.0%	67.1%	**69.9%**		No target	R
4c) Improving trend showing a reduction in length of hospital stay above 21 days.	55	71	62	**0**			R

Progress made (April 2021 – March 2022):
During the 2021/22 period, Trust performance has not been able to achieve the target, and as such has been unable to make any positive progress in improving the proportion of patients discharged before 12 noon and before 5pm. The Trust has also been unable to meet the target in reducing the number of patients having a hospital stay greater than 21 days. Progress against this priority has been negatively affected by the persistent system-wide operational and pandemic related pressures during this period, and although the Discharge to Assess process is fully embedded within the Trust, further improvement work is required to review system-wide discharge pathways.

4a) Proportion of patients discharged before 12 noon
Performance for discharging patients before 5pm has been consistently below the 30% target, therefore the Trust has not achieved this indicator. Performance in March 2022 was 16.4%, this reflects the difficulties experienced with flow throughout the hospital and in the community over the last several months. Shortages in available workforce to meet service needs has also contributed to delays in patient pathways. The chart below shows performance in this area.

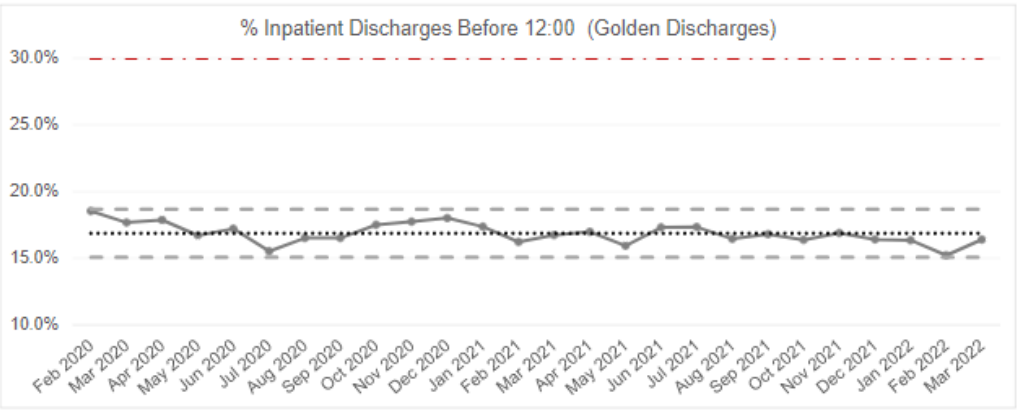


Figure 10: Percentage of Discharges before 12:00

4b) Patients discharged before 5pm
Performance for discharging patients before 5pm reflects the difficulties experienced with flow throughout the hospital and in the community over the last several months. Shortages in available workforce to meet service needs has also contributed to delays in patient pathways and timely discharge. Performance in March 2022 shows that 66% of patients were discharged before 5pm.

4c) Reduction in the length of stay above 21 days
The Trust has made significant improvements in this area over the last year and is now the third best performing Trust in the whole of the north region (Out of 52 Trusts). However, since the new year, the Trust has seen a slight increase, this is because although lots of improvement work has been undertaken, for example, discharge rounds, board rounds and implementation of the hospital discharge policy (D2A), our system partners (particularly in north Lincolnshire and Lincolnshire) experienced significant pressures within their services, with closed care homes and limited packages of care available due to staff shortages. At the time of writing the Trust had 70 patients ready for discharge by the acute team, however there is a delay in their discharge as our social care partners are unable to meet their needs, therefore creating a longer stay in hospital for these patients. The Trust is working with system partners to manage this on a daily basis.

The following chart highlights the impact of the improvement work which commenced in March 2021, it also shows the impact of the system wide pressures from October 2021 to date.

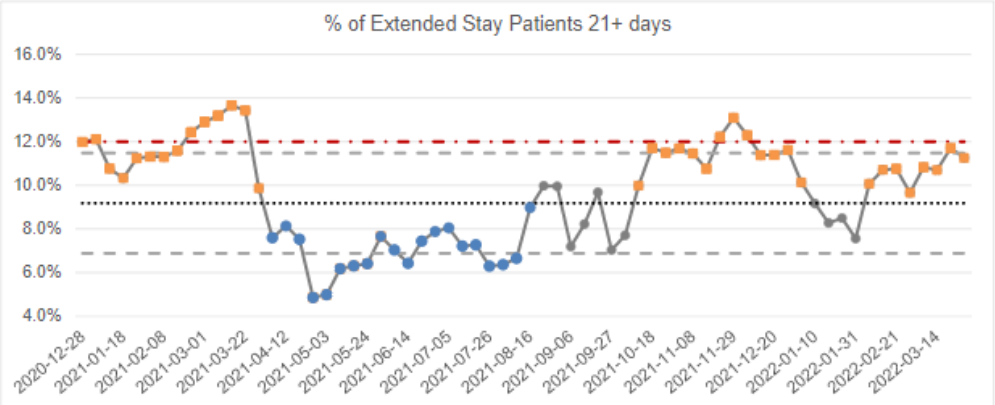


Figure 11: Percentage of patients with a hospital stay of 21+ days

Milestones achieved during 2021/22:

- Daily board rounds are undertaken on inpatient wards.
- Discharge rounds are undertaken at weekends to support patient flow and discharge.
- Long length of stay reviews take place twice weekly in medicine division – led by the senior triumvirate.
- Introduction of a Matron within the site team to support flow and progress on discharge.
- Daily 12 noon meetings take place seven days per week led by the site senior team allowing oversight of delayed discharges.
- The Trust are in the process of developing a discharge improvement plan which triangulates all aspects impacting discharge pathways including board rounds, transport, checklist and the discharge lounge.
- The Trust plans to implement a six-day provision for acute Speech and Language Therapy.
- Work is underway to expand the Trust's virtual wards, particularly around palliative care, frailty and acute respiratory infection.
- Discharge improvement meetings introduced on a fortnightly basis to discuss themes.
- Introduction of a seven-day service for the provision of equipment at North and North East Lincolnshire.
- Introduction of a respiratory on call seven-day service.
- In December the Same Day Emergency Care (SDEC) hours increased and is now open between 8am to 10pm at both hospital sites. This allows extra time to turn the patients round and home rather than admitting into a hospital bed.

Progress monitored, measured and reported: Progress with these indicators are monitored within the access and flow section of the integrated performance report and is reported to the Finance and Performance Committee and the Trust Board.

Relationship to 2022/23 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2021/22. Access and flow will feature as a priority for the Trust during 2022/23 as part of the pandemic recovery work. There are also links to the discharge to assess project and the timeliness of discharge letters as part of the Trust's 22/23 quality priorities.

2.1e: Priority 5: Clinical Effectiveness & Patient Safety: Improve diabetes management

Summary table: Performance during 2021/22:

CLINICAL EFFECTIVENESS & PATIENT SAFETY:							
QP5: Diabetes Management	Feb-22	Jan-22	Dec-21	Apr-21	SPC Variation	SPC Assurance	RAG
5a) Diabetes Audit findings.	85%	77%	80%	**80%**			G
5b) 100% of BM taken in ECC in adults when NEWS of >1	100%	95%	90%	**93%**			A
5b) 100% of BM taken in ECC in children when PEWS of >1	88%	83%	83%	**75%**			A
5c) 90% relevant staff have completed mandatory diabetes training.	88%	87%	85%	**85%**			A

Progress made (April 2021 – March 2022):
During the 2021/22 period, the Trust has achieved the target in accordance with diabetes audit standards, but due to operational and staffing pressures has just fallen short of achieving the 90% target of staff completing mandatory diabetes training. Improvement has been observed in carrying out BM testing in the Emergency Departments, however, further embedding is required to reach the 100% target. For both adults and children BM measurements were undertaken on average in 88% of patients throughout the year.

5a) Diabetes Audit Findings
A monthly audit has been designed and implemented. This has helped to get an understanding of the management of diabetes across ward areas, and for most part of the year the audit data shows the Trust are achieving the 80% target. The Chart below demonstrates this sustained improvement.

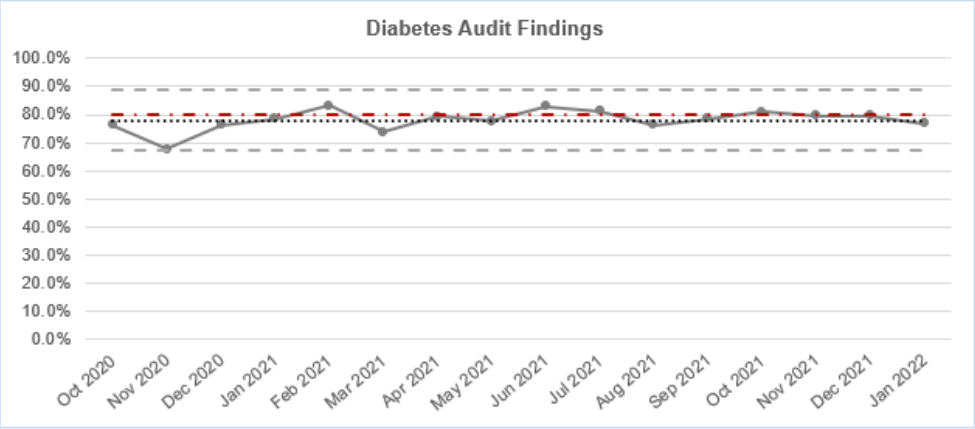


Figure 12: Diabetes Audit Findings

5b) BM Testing in Emergency Care Centres with NEWS/PEWS >1
The Trust's Emergency Departments continue to face significant operational and pandemic related pressures, which has impacted on positive progress being made in embedding BM testing during 2021/22. As a result, performance against this indicator has fluctuated, particularly for children. Throughout the year performance for adults has been 94% against the 100% target and for children an average of 82% has been achieved against the target. Performance may be lower for paediatric patients as the Paediatric Emergency Nursing remain within the Emergency Department which allows expert oversight and often negates the need for blood glucose recording in some instances.

The charts below provide an overview of performance over the last two years.

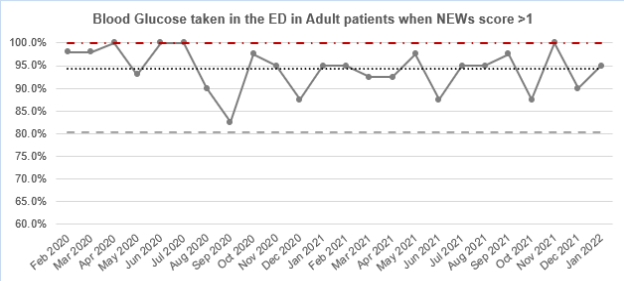


Figure 13: Percentage of patients with a blood glucose taken in ED in adult patients when NEWS score is >1

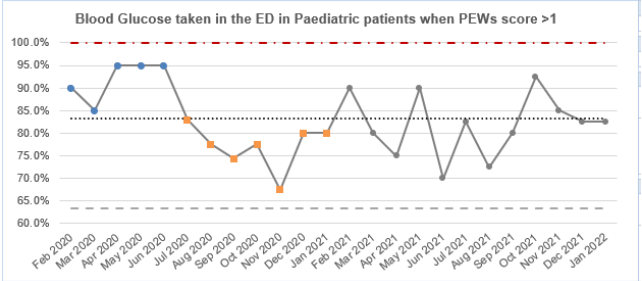


Figure 14: Percentage of patients with a blood glucose taken in ED in paediatric patients when NEWS score is >1

5c) Diabetes mandatory training

The Trust continues to face challenges in releasing staff to undertake mandatory training due to persistent operational pressure and staff sickness levels. Whilst these pressures are reflected in the performance during this period, the Trust continues to demonstrate long term improvement and remains within the control limits and above the Trust's mean average. The chart below demonstrates this performance.

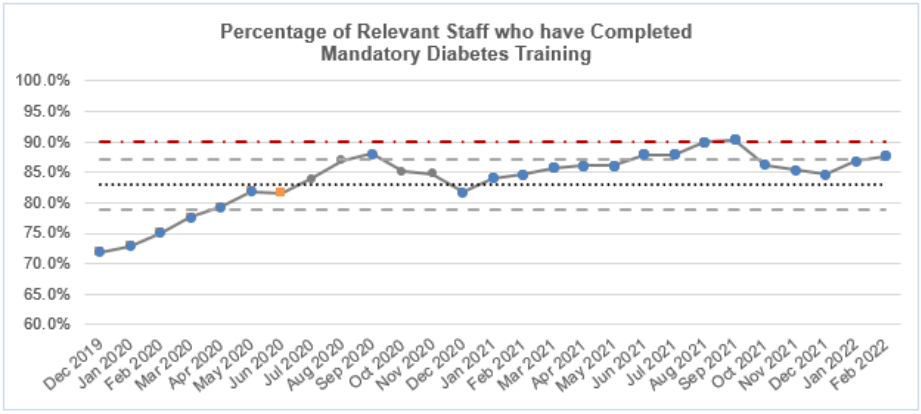


Figure 15: Percentage of relevant staff who have completed mandatory diabetes training

Milestones achieved during 2021/22:

- The trust placed particular focus on providing educational support to the wards to highlight the need for Glucose monitoring.

- Diabetes Specialist Nurses provided supportive feedback to wards on an on-going basis on BM management (particularly BM testing throughout the night).

- Diabetes Specialist Nurses have supported specific case discussions on wards where incidents were reported.

- Clinical Nurse Educators reviewed non-compliant cases where children, with abnormal vital signs, have not had BM testing whilst in the Emergency Department. Findings from the reviews have been fed back to the Emergency Department team for learning lessons.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality Governance Group, Quality & Safety Committee and the Trust Board.

Relationship to 2022/23 Quality Improvement Priorities: This quality priority has remained the same throughout 2021/22. Paediatric performance of BM testing in the Emergency Department will be audited in 2022/23 as part of the Trust's Quality & Audit Programme to gain assurance and ensure practice becomes embedded.

2.1f: Quality Priority planning for 2022/23

The Trust has agreed 6 quality priority areas for 2022/23:

1. Mortality Improvement
   (Clinical Effectiveness & Patient Experience)

2. Deteriorating Patient
   (Clinical Effectiveness & Patient Safety)

3. Sepsis
   (Patient Safety)

4. Increasing Medication Safety
   (Clinical Effectiveness, Patient Safety & Patient Experience)

5. Friends & Family Test and PALS
   (Patient Experience)

6. Safety of Discharge
   (Clinical Effectiveness, Patient Safety & Patient Experience)

How these priorities were set:

The quality priorities for 2022/23 were set in accordance with the Trust's quality strategy longer term objectives. The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and patient experience teams as well as CCG partners.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2022/23. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

How progress against 2022/23 quality priorities will be monitored and measured:

Progress against these quality priorities will be monitored through the Trust's quality section of the Integrated Performance Report. This is a monthly report considered by the Executive-led Quality Governance Group for the oversight of management of actions and also by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes. Assurance and performance against the Quality Priorities will also be monitored via the Trust Management Board, Quality & Safety Committee, Quality Governance Group and Operations Directorate performance.

Some of the above quality priorities and the underpinning measures link to the Trust's performance indicators. In these instances, the Trust's Finance and Performance Committee will primarily oversee progress, with the Quality & Safety Committee seeking assurance on quality outcome measures related to Trust performance.

There are close links established between these oversight arrangements and the monthly performance meetings held with divisions, where divisions will be held to account for their performance.

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

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2021/22 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services.

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

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health and care services for 2021/22.

2.2b Information on participation in clinical audits and national confidential enquires

During 2021/22, 48 national clinical audits and 2 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

Due to Covid-19, in March 2020 all Trusts received the following communication:

> *"All national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, can be suspended. Analysis and preparation of current reports can continue at the discretion of the audit provider, where it does not impact front line clinical capacity. Data collection for the child death database and MBRRACE-UK-perinatal surveillance data will continue as this is important in understanding the impact of COVID-19. Participation in NCAPOP and data entry should not impact on front line clinical Covid care".*

This guidance was changed in May 2021 when all Trusts received the following communication:

> *"In order to support the National Clinical Audit Patient Outcome Programme (NCAPOP) with monitoring and improving patient care, please accept this letter as notice that NHS England and Improvement is mandating a restart to data collection in England for the NCAPOP.".*

The Trust participated in 48 or 100% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2021/22 and those in which it participated in are as follows:

NB: *The table which follows lists:*

- The name of the national clinical audits and national confidential enquiries listed in HQIP's quality account resource,
- Which ones the Trust were eligible to participate in,
- The number of cases submitted for each audit against the number required, also expressed as a percentage (%),
- If action planning is taking place or has been completed to improve processes and practice following publication of findings.

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
BAUS Urology Audit – Cytoreductive Radical Nephrectomy	No	N/A	N/a	N/a	BAUS stated this should have been removed from Quality Accounts
BAUS Urology Audit – Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Yes	Yes	22	100%	Awaiting publication of national report
British Spine Registry	No	N/A	N/A	N/A	N/A
Case Mix Programme (CMP)	Yes	Yes	1287	100%	Awaiting publication of results
Cleft Registry and Audit Network (CRANE)	No	N/A	N/A	N/A	N/A
Elective Surgery - National PROMs Programme	Yes	Yes	378	86.1%	Report writing/Action planning
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database (submitted for all)	Yes	Yes	531	100%	Awaiting National Report
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	669	On-going	Yes
Falls and Fragility Fractures Audit programme (FFFAP) National Falls Audit	Yes	Yes	12	Ongoing	Project still underway
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	442 (Cumulative)	100%	Yes
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	10	100%	Yes
Mandatory Surveillance of HCAI	Yes	Yes	461	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal morbidity & mortality confidential enquiries	Yes	Yes	21	100%	Report writing/Action planning
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry	Yes	Yes	1 Maternal death	100%	Report writing/Action planning
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult COPD**	Yes	Yes	727	On-going	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult Asthma**	Yes	Yes	149	On-going	Yes
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Children and Young People Asthma**	Yes	Yes	48	ongoing	Project still underway
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	310	100%	Awaiting Publication of Results for 2021
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	812	100%	Report writing/action planning
National Audit of Care at the End of Life (NACEL)	Yes	*Yes*	80 cases 254 Quality Survey letters	100%	Awaiting Publication of Results
National Audit of Dementia	Yes	Yes	50	100%	Report writing/action planning
National Audit of Pulmonary Hypertension (NAPH)	No	N/A	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	166 (Cohort 3)	100%	Awaiting Publication of Results
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	103	100%	Project still underway
National Cardiac Audit Programme (NCAP) – Heart Failure	Yes	Yes	625	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – MINAP	Yes	Yes	292	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	377	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	Yes	Yes	290	Ongoing	Project still underway

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Cardiac Audit Programme (NCAP) – Adult Cardiac Surgery	No	N/A	N/A	N/A	N/A
National Cardiac Audit Programme (NCAP) – Congenital Heart Disease	No	N/A	N/A	N/A	N/A
National Child Mortality Database	No	N/A	N/A	N/A	N/A
National Clinical Audit of Anxiety and Depression	No	N/A	N/A	N/A	N/A
National Clinical Audit of Psychosis	No	N/A	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion Programme *2021 Audit of Patient Blood Management & NICE Guidelines*	Yes	Yes	73	100%	Report writing/action planning
National Comparative Audit of Blood Transfusion Programme *2021 Audit of the perioperative Management of Anaemia in children undergoing elective surgery*	N/A	N/A	N/A	N/A	Project was postponed due to Covid
National Diabetes Audit – Core Audit	Yes	Yes	1220	100%	Yes
National Diabetes Audit – Inpatient HARMS	Yes	Yes	20	Ongoing	Yes
National Diabetes Audit – Foot Care	Yes	Yes	105	84%	Project still underway
National Pregnancy in Diabetes (NPID) Audit	Yes	Yes	42	100%	Action planning
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	26	Ongoing	Project still underway
National Emergency Laparotomy Audit (NELA)	Yes	Yes	196	82%	Awaiting Publication of Results
National Gastro-intestinal Cancer Programme Bowel Cancer (NBOCAP)	Yes	Yes	252	100%	Report writing/action planning
National Gastro-intestinal Cancer Programme Oesophago-gastric cancer (NOGCA)	Yes	Yes	83	100%	Report writing/action planning
National Joint Registry (NJR)	Yes	Yes	929	97%	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes	391	100%	Yes
National Maternity and Perinatal Audit (NMPA)	Yes	*Yes*	3273	*97.1%*	Report writing/action planning

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	652 All babies admitted. NNAP extract numbers based on eligibility	100%	Awaiting Publication of Results
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	160	ongoing	Project still underway
National Prostate Cancer Audit	Yes	Yes	242	100%	Report Writing / Action Planning
National Vascular Registry	No	N/A	N/A	N/A	N/A
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	No	N/A	N/A	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)	No	N/A	N/A	N/A	N/A
Perinatal Mortality Review Tool	Yes	Yes	21	100%	Action Planning
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A	N/A
RCEM QIP: Consultant Sign Off	Project postponed to April 2022		N/A	N/A	N/A
RCEM QIP: Infection Control	Yes	Yes	240	Ongoing	Yes
RCEM QIP: Pain in Children	Yes	Yes	25	Ongoing	Project still underway
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	666	100%	Project still underway
Sentinel Stroke National Audit Programme (SSNAP) Early Supported Discharge Data	Yes	Yes	203	100%	Report writing/Action planning
Serious Hazards of Transfusion	Yes	Yes	17	Ongoing	Project still underway
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	67	100%	Yes
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes	0	Ongoing	Project still underway
The Trauma Audit & Research Network (TARN)	Yes	Yes	494	Ongoing	Yes
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
UK Renal Registry National Acute Kidney Injury programme	No	N/A	N/A	N/A	N/A

National confidential enquires 2021/22

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Physical Health Care of inpatients in Mental Health Hospitals	No	N/A	N/A	N/A	N/A	N/A
Dysphagia in People with Parkinson's	Yes	Yes	Yes	4	100%	Yes
Transition from child to adult health services	Yes	Yes	Ongoing			

A number of published **national** clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

Increased information to patients/carers – Summary of some actions taken:

- National Neonatal Audit Programme:
  - Posters are displayed on all nursery doors to ensure parents are aware that they are to be involved and updated in the care of their baby.
- MBRRACE Perinatal Mortality Review Tool:
  - The parent engagement material from MBRRACE has been reviewed. The templates and leaflets are in use to improve the engagement of parents
- National Paediatric Diabetes Audit, PREMS:
  - A Ketone card is distributed to all new and existing patients who are on an Insulin Pen & Pump with the relevant contact details for the service.
  - Ketone monitoring & illness management is discussed as part of the annual education checklist during the patient's annual review.

Increased awareness and education of staff – Summary of some actions taken:

- National Neonatal Audit programme:
  - Raise the importance of using the Jitsi Meet App and alternative communication methods to involve parents and update them on their baby within 24 hours of admission by discussion in ward huddles and medical training meetings.
  - Badger is to be included within the Doctor induction training day to ensure awareness of the NNAP measures.
  - The Quarterly dashboards published by NNAP are presented at the Trust wide Children's service clinical audit meeting to ensure staff are aware of the NNAP standards and any shortfalls in compliance are identified.
- National Hip Fracture Database:
  - NHFD charts showing the improvement in mortality and time to theatre to be displayed in SGH Theatres to boost staff morale.
  - SGH Project Lead to raise issues around the lack of a dedicated Orthopaedic ward at SGH with senior management.
  - National Hip Fracture Database: To clarify with NHFD what is the definition of a pressure ulcer occurring during the acute admission, and to then ensure staff at both sites follow this definition when collecting data.
- National Bowel Cancer Audit: To email all colorectal consultants and stoma nurses with information of the 3 major concerns (90-day mortality rate, 18 month unclosed diverting ileostomy rate, and permanent stoma procedure rate) to raise awareness of the issues.

- National Emergency Laparotomy Audit: NELA have introduced Early Warning Reports for various criteria – to send copies of the Early Warning Mortality Report and Early Warning Admitted to Critical Care Report to the Critical Care delivery Group for information/discussion.
- National Joint Registry: To discuss how to better embed the NJR Consent process into the existing consent process for emergency cases with Trauma coordinators, Day Surgery Unit Manager and relevant Matrons.
- Trust wide Intensive Care National Audit and Research Centre Case Mix Programme: The team made aware to escalate any significant issues to matrons with regard to achieving 4-hour discharge from time of decision.
- National Baus Renal Colic Audit:
  - Mr Khan to contact A&E about NSAIDS needing to be given out to renal colic patients as per the pathway.
  - Mr Khan to email urology clinicians to reiterate the importance of accurate documentation of stone prevention advice.
- NACAP Asthma & COPD Audits: Clinical standards and performance shared with Emergency department teams to highlight need for early intervention to improve patient care.
- National Heart Failure Audit: Clinical lead raised awareness of the clinical need and pathway for referring patients with Heart Failure.
- NACAP Children's & Young People Asthma audit:
  Targeted sessions for medical staff are to be implemented to ensure the PEF is completed before discharge.
- Fracture Liaison Service Database:
  - Completed a review into Vertebral Fractures to influence referrals to the service going forward and ensure various teams and departments within the Trust understand the importance of referring to the Fracture Liaison Service

Further evaluation/patient surveys – Summary of some actions taken:

- Trust wide Intensive Care National Audit and Research Centre Case Mix Programme: Review patients who have been discharged out of hours and create a summary of the data relating to the patients and their diagnosis, with regard to the discharge home, to produce a narrative why it was delayed and send to the group.
- Fracture Liaison Service Database: Engage with patients in clinics asking how service can be improved gathering some qualitative data as evidence.
- NABCOP: Design and introduce a 3 monthly feedback pro-forma to ascertain if patients have sufficient information about their care & treatment.

Changes to service/process – Summary of some actions taken:

- EIA: One stop clinic set up to aid diagnosis in single visit and commencement of treatment regime.
- Children's & Young People Asthma (NACAP)
  - The BTS discharge care bundle has been added to WEBV. This is to ensure the patients have all the relevant information of their care when discharged.
- SSNAP:
  - The handover to the community team is to take place at time of the patient's discharge to allow longer term needs to be identified and reduce the length of stay.
- NABCOP:
  - To introduce the Fitness assessment form for older patients and ensure this is uploaded to the Somerset system
  - Ensure patients have sufficient information about their care and treatment and are engaged in a shared decision-making process by introducing a patient feedback pro-forma.

- National Neonatal Audit Programme:
  - Explore the feasibility of recruiting a data clerk to ensure the data is cleansed regularly on BadgerNet
  - Purchase of a ward trolley to enable the ward laptop to be present when seeing patients and parents to allow medical team to be input information into Badger at point of care
  - Ward round templates updated to ensure that it is documented that parents are present or have been contacted by telephone to update them on their baby
- National Paediatric Diabetes Audit Prems:
  - Dietician availability is to be reviewed and explore the feasibility of being available in all clinics.
- National Hip Fracture Database: New hip fracture pathway to be amended at the first opportunity, in order to allow any nerve block given in A&E or on the ward to be easily documented.
- National Joint Registry:
  - Data validation for the audit to be undertaken via webtool data review system on an ongoing basis, rather than prior to the end of the deadline period.
  - To assess whether a process can be put in place to identify patients who did not document consent for their details to go on the NJR and contact them via telephone for permission, so their details can be submitted.
- National Prostate Cancer Audit: Performance status to be put on two week wait referral form for GP to fill in.
- MBRRACE – Perinatal Mortality Review Tool:
  - An external member is now included as part of the PMRT review team to improve the process of PMRT.
- Fracture Liaison Service Database:
  - Undertake a review to evidence case ascertainment estimations are hugely overestimated using the Hip Fracture methodology and feedback to audit supplier.

A number of **local** clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

Increased awareness and education of staff – Summary of some actions taken

- Paediatric Pews & Sepsis audit
  - An addition to the Monthly dashboard has been implemented to monitor the use of the Sepsis pathway in children who are admitted, and the results are presented at the Clinical Audit meeting to raise the importance of adhering to policy.
- Audit of Paediatric Discharge Summaries
  - A Poster has been designed to raise awareness of areas of low compliance. This is displayed on the wards to highlight the importance of accuracy when completing the discharge summary.
  - The monthly rapid cycle documentation audit is discussed at the Clinical Audit meeting to highlight the importance of documenting patient height, weight, head circumference and centiles.
- Trust wide Outpatient Medical Documentation Audit 20/21: Share Outpatient Documentation Audit results at OPD staff meetings at all sites, at Clinical Sciences Governance Meeting and at Patient Access Business Meeting to raise awareness.

Changes to service/process – Summary of some actions taken:

- Trust wide Outpatient Medical Documentation Audit: To raise the benefits of moving to digital documentation for outpatient clinics with the management team, as this would mean date/time and name, grade etc would be recorded 100% of the time automatically.
- Documentation Audit: To recommend the Trust implements the documentation of Ward Rounds on WebV as soon as possible to improve documentation by raising it at the Surgery and Critical Care Governance meeting.

- Paediatric Documentation: Electronic documentation has been piloted and is to be re-introduced during 2022 to ensure mandatory fields are completed.
- Maternity Documentation: A new data collection form has been designed and implemented to streamline the collection of data.
- Emergency Department Documentation: ED clerking document underwent revision to ensure a consistent approach across both hospitals. Prior to 2021 the emergency departments used different clerking forms.
- Audit of Weighing Prescribing:
  - Undertake continuous monthly audit on patients admitted to acute care to improve obtaining actual weight of patients, specifically those who appear to have estimated weights of around 50KG to ensure best practice in prescribing is followed
  - Add aide/memoir to the trusts Electronic Prescribing System to encourage obtaining the actual weight of patients and warn regarding prescribing of drugs that require a weight for dosing
- Audit of Blood Glucose Management on Ward Areas:
  - Undertake continuous monthly audit on patients who are prescribed insulin and/or sulphonylureas who are out of target range (below 4 (Hypo) or above 11 (Hyper)
  - Undertake “Diabetes Days” on wards to raise awareness with Diabetes Specialist Nurses feeding back best practice and standards of care for Diabetic patients

2.2c Information on participation in clinical research

The research team priorities for 2021/22 have been urgent Public Health studies and the restarting of other research trials.

The Trust’s research recruitment target has been exceeded with a balanced mixture of both COVID-19 and non COVID-19 clinical research studies. Clinical Characterisation Protocol for Severe Emerging Infection (CCP) and SIREN (staff research) studies were both high recruiters. In addition, a collaborative research study called FASTer was run within our ECC’s at both Grimsby and Scunthorpe Hospitals saw high recruitment over July and August 2021.

Again, this year clinical research has allowed the world’s population to gain knowledge and develop treatments during the pandemic and the Trust has played its part in supporting this.

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 2082, an increase of 1,095 from last year.

2.2d Information on the Trust’s use of the CQUIN framework

Due to the on-going pandemic NHS England continued to suspend CQUINs for 2021/2022. Payments continued to be made on a block arrangement, and included the element identified for CQUINs.

2.2e Information relating to the Trust’s registration with the Care Quality Commission

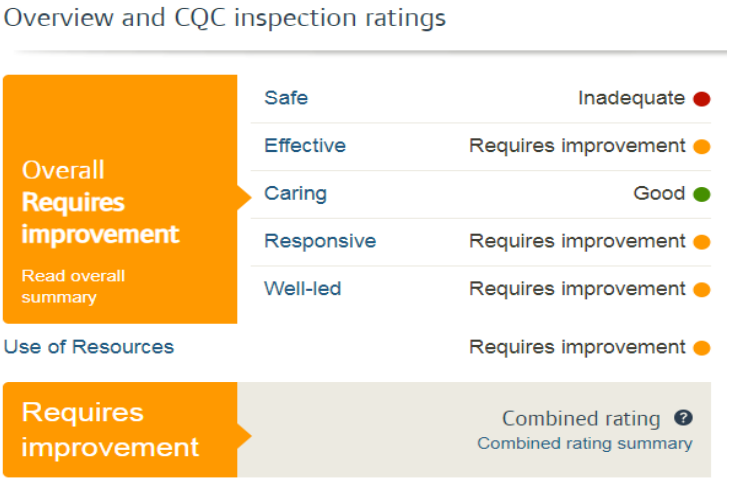
Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

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

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

From their last visit of the Trust in September and October 2019 (of which the report was published on the 7 February 2020) the outcome was as follows:



The Care Quality Commission (CQC) last inspected the Trust formally in 2019. Due to the Covid-19 pandemic routine inspections from CQC had been put on hold during the peak of the pandemic. A Transitional Monitoring Approach (TMA) was used by the CQC to support providers during the pandemic and using a more 'desktop' style approach, assess if there were risks to patient safety that required further regulatory action.

The Trust was involved in two such instances with CQC to review provision of services, in line with the CQC key lines of enquiry, for infection prevention and control and its provision of Emergency Department services. As a result no further action was required by CQC.

CQC's Transitional Monitoring Approach was not designed to replicate an inspection and has no impact on a providers rating. The Trust therefore has had no ratings review since the 2019 inspection.

Despite the pandemic, the Trust has continued to progress with the CQC improvement programme of work following the last inspection. A monthly report provides detail and assurance on progress. At the time of writing, the Trust had 83 open CQC actions, of those, 56 are green and on target, 21 are amber (with significant mitigation in place) and 3 actions are red.

Some risks arise from this in relation to the effects of the pandemic, these are around:

- Staff compliance with mandatory training which has been impacted by significant difficulties in releasing staff from direct front line care and due to some forms of training requiring practical delivery which was not possible to deliver virtually due to the pandemic.
- Personal Appraisal Development Reviews again impacted upon by staffing challenges linked to the pandemic.
- Capacity within diagnostics remains a challenge as part of social distancing, increased cleaning and infection prevention and control measures.

The Trust continues to have regular engagement meetings with the CQC and supplies them with regular updates on progress with the plan along with supporting evidence.

2.2f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS Number was:

- 99.9 per cent for admitted patient care
- 99.9 per cent for outpatient care
- 99.6 per cent for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100.0 per cent for admitted patient care
- 100.0 per cent for outpatient care
- 100.0 per cent for accident and emergency care.

2.2g Information governance assessment report

Throughout 2020/21 and 2021/22 there have been several changes to the reporting of the data and Security Protection Toolkit (DSPT). NHSX recognised that organisations would find it difficult to fully complete the toolkit without impacting on their Covid-19 response. The date for the finial submission for 2020/2021 was moved to the 30 June 2020 from the usual 31st March and continues to remain the 30th June for the 2021/2022 submission. It is proposed that this final submission date will remain for future toolkit returns.

The status of the final submission for 2020/21 was 'Approaching Standards'.

The 2020/2021 improvement plan has been updated and reviewed a number of times by NHS Digital throughout 2021, however it was announced by NHS Digital that the final submission of the 2020/2021 improvement plan which was due to take plane in December 2021 would no longer be required due to the increasing impact COVID 19 and the Log4J cyber incident was having on organisations and would allow organisations to focus their efforts on responding to both these areas.

The 2021/22 Version of the DSPT was released on the 20th July 2021, with an initial baseline assessment date of the 28 February 2022 followed by the final submission of the 30 June 2022. At the time of compiling this report the Trust has still yet to submit its final response and is therefore not in a position to provide a submission statement for 2021/22.

2.2h Information on payment by results clinical coding audit

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

Northern Lincolnshire & Goole NHS Foundation Trust will re-commence an internal audit programme in April 2022. This will include a trust-wide random sample audit of 200 FCEs and speciality specific audits. Additionally, a rolling programme of individual coder audits will commence in 22/23 to ensure data quality and identify any training requirements.

2.2i Learning from Deaths

During 2021/22, 1,475 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 319 in the first quarter
- 369 in the second quarter
- 402 in the third quarter
- 385 in the fourth quarter

As at the 31st March 2022, 1,392 case record reviews and 49 investigations have been carried out in relation to 1,475 deaths. In 36 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 302 in the first quarter
- 339 in the second quarter
- 388 in the third quarter
- 363 in the fourth quarter

1 representing 0.06% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. [Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].

In relation to each quarter, this consisted of:

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

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

Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust's Serious Incident process. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care. The denominator used in the calculation is the total number of deaths during 2021/22.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2021/22

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2021/22

And,

An assessment of the impact of the actions taken by the Trust during 2021/22:

The Trust has not found from the mortality reviews completed, evidence of systematic failings in care delivery leading to 'Avoidable' deaths. The Trust views mortality reviews as an opportunity

to review the quality of care provided to these patients. From these mortality case reviews, the following quality improvement themes and learning have been identified:

Patient flow has been affected across the wider healthcare system, both by normal winter pressures and additional pressures associated with the COVID-19 pandemic. This has placed a strain on services and the Trust's ability to see and treat patients in the Emergency Department within normal timeframes. Several structured judgement reviews identified long ambulance waits in the community and delayed admission to hospital due to the lack of bed availability for patients requiring admission and infection control measures. During 2021/22 the Trust have:

- Introduced the Urgent Care Service along with new patient pathways with streamlined access to clinician review.
- Second senior reviews introduced in the Emergency Department where long stay patients are identified.
- Support has also been secured from the Community Response Team GP which allows certain ambulance calls to be transferred to North Lincolnshire Single Point of Access.
- The Trust continues to embed the Discharge to Assess programme to support effective management of flow to reduce bed occupancy and mitigate delays in discharge.

Due to the unprecedented pressures across the healthcare system the actions remain ongoing with activity and flow monitored on a daily by the Trust's multidisciplinary senior management teams.

Clinical monitoring has been identified as requiring improvement. Reviewers identified occasions where clinical observations indicated patients were deteriorating but at time of retrospectively reviewing the patient's records, there was a lack of evidence to support that the appropriate escalation and reviews had taken place. During 2021/22 the Trust have:

- Refreshed the Deteriorating Patient Policy and amended pathways for escalation.
- Completed a selection of case note reviews for patients admitted to Critical Care Units to assess the quality of care prior to admission. Findings are reported to the Deteriorating Patients and Sepsis Group.
- Introduction of WEB V ward based monitoring which has allowed targeted support to be provided by the Clinical Nurse Educator.
- Provision of ongoing education to clinical teams.

The Trust is working towards introducing escalation via WEB V systems, this action remains ongoing at the time of writing.

The quality of **documentation and record keeping** remains an area requiring further improvement. During 2021/22 the Trust have:

- Introduced the Trust Learning Group – record keeping was identified as a theme to raise awareness of the expectations of basic record keeping standards.
- The Trust has undertaken specialty specific documentation audits throughout the year and fed back the findings to the clinical teams.

This is an area that will remain a focus for improvement for 2022/23.

Advanced care planning also remains an area requiring further improvement. This was a common theme identified from screening reviews and structured judgement reviews (SJR) where reviewers identified opportunities in the patient's pathway where greater consideration and planning could have potentially prevented hospital admission, and supported patients to die at home with the appropriate community support in place. During 2021/22 the Trust have:

- Undertaken in depth reviews alongside community and primary care partners to discuss the quality of care provided, identify gaps in provision of services or pathways that could have enabled patients to die in their preferred place. Identified findings are shared with the CCGs and has supported the development of the refreshed Out of Hospital Mortality Strategy. The key actions being taken or planned relate the following areas:

  - The RESPECT (Recommendations Summary Plan for Emergency Care and Treatment) document has now been rolled out within the acute Trust and in the community, an audit is currently underway to assess the quality of the forms completed and identify areas where further improvement is identified. Findings will then be fed into education provided by a dedicated trainer/lead facilitator supporting.

  - Electronic Palliative Care Coordination System or (EPaCCs) has been rolled out across the wider Humber Coast and Vale Integrated Care System and therefore covers Northern Lincolnshire. Work is ongoing to ensure this is accessible to hospital based clinicians.

  - Review of palliative care provision (nursing and medical) to focus on advanced planning in the community.

  - The Trust have undertaken a pain assessment audit and triangulated the findings with other available intelligence. As a result, the Trust are currently reviewing the pain assessment tool, policy and staff training to ensure patients have the necessary pain assessment undertaken to enable the appropriate anticipatory medication prescribing in hospital and in the community.

Recognition of the end of life (EOL) is essential in ensuring patients have the appropriate end of life care, however, in addition to other feedback mechanisms, screening reviews and structured judgement reviews continue to highlight that further improvement is required. This relates to; earlier recognition of dying patients to enable discussions with patients and families, involvement of the palliative care team and earlier initiation of the EOL pathway/RESPECT documentation. The Trust have an EOL improvement plan in place, the following key actions being taken or planned relate the following areas:

- The Trust collaborates with local community CCG, primary care and ambulance service partners to undertake end to end mortality reviews based on SJR/screening reviews to discussed potential 'missed opportunities' around earlier recognition. Cases where learning is identified are fed back to GP practices and shared with the acute care teams where applicable. The quality of reviews undertaken have been impacted by the lack of access to the patient's complete healthcare record due to the governance surrounding accessing patient records. This remains a priority for the Trust and across the ICS.

- Training of the completion of RESPECT forms continues within the Trust to encourage earlier discussions around EOL care and initiation.

- Work has commenced with Primary care to pilot the EARLY tool within 2 practices across Northern Lincolnshire.

- The Trust participated in the National Audit of Care at the End of Life for 2021/22. Data collection allowed immediate lessons to be learnt that were weaved into EOL training and education sessions. Early feedback from the national audit provider, focusing on high level

themes, and patient/family feedback, suggests further work is required to improve communication. Results also highlight the impact of the COVID-19 pandemic on EOL experiences.

- The use of Family Voices Diaries was implemented to improve listening and communication with both patients and their carers/relatives.

- The Trust have introduced the BLUEBELL model on several acute ward areas. The Model encourages the discussions and earlier identification of EOL and provides staff with the skills and confidents to identify and discuss patients end of life care needs. The positive impact of implementing this model is demonstrated in staff feedback and via early feedback from families using the Family Voices Diary.

- The EOL pathway documentation is currently under review and will be carried forward as an action into 2022/23.

The Trust completed 116 case record reviews and 19 investigations after 1st April 2021 which related to deaths which took place before the start of the reporting period.

Four of the patient deaths, representing 0.22% before the reporting period (2020/21), are judged to be more likely than not to have been due to problems in the care provided to the patient. Each case was reviewed using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from Score 6: “Definitely Not Avoidable” to Score 1: “Definitely Avoidable”. The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer’s evaluation from the retrospective analysis of the medical record. Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust’s Serious Incident Framework. It should be stressed that this data is not a measure of deaths that were avoidable, rather it is designed as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

For further information relating to mortality improvement work, please see part 2.3a.

2.2j Details of ways in which staff can speak up

Annual Update on Speaking Up:

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

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

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:

    - Through the Trust’s nominated Freedom to Speak Up Guardian
    - Via the Human Resources Department, a part of the Trust’s People Directorate
    - Using ‘Shout Out Wednesday’ in Family Services to raise any concerns.
    - Logging an incident on the Trust’s incident reporting tool hosted on Ulysses

- Contacting ‘Ask Peter’ which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian:

The Trust’s Freedom to Speak Up Guardian, their role, contact details and the principles of Freedom to Speak Up process is communicated to all new starters within the Trust as part of the corporate induction programme. The Trust’s appointment of a substantive guardian in 2020 has led to a significant increase in the number of concerns raised and the role of the Guardian is now being widely publicised to all.

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events (including a highly publicised campaign for the NGO Speak Up month in October), and additional magazine features. The Guardian is active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email address and a dedicated mobile telephone number. Staff can also raise concerns using the Staff App, which gives another portal to access Guardian support.

The Trust’s Freedom to Speak Up Policy and Process and associated procedures supports staff to raise concerns safely without suffering any form of detriment. The Freedom to Speak Up Guardian responds to all concerns raised under this process and follows through each case according to the individual requirements providing regular communications and feedback until the case is concluded. Evaluation feedback from staff raising concerns has shown confidence in the Guardian and the overall process.

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

During 2020/21 there was a significant increase in concerns raised with 143 cases brought to the Guardian, and 2021/22 has seen a further increase with 157 cases being raised through the Guardian route. The latest staff survey indicates increased confidence in staff being able to raise concerns about unsafe clinical practice but a decline in confidence that the organisation will address concerns. There is also a decrease in staff perception feeling safe to raise concerns about other issues so further work is required to improve this. These findings reflect a national trend.

2.2k Annual report on rota gaps and plan for improvement

The Trust has made significant progress with management of Medical and Dental rotas. The latest data for February 2022 showed a vacancy rate of 13.05%, compared with 15.40% in April 2021. This vacancy rate includes an increase in establishment of 54.75 whole time equivalent staff for 2021/22. For trainees, the latest data available is for August 2021, this demonstrated a fill rate of 80.10% which was a decrease of 11.02% in comparison to the previous year. The overall fill for all medical staff grades has been affected by COVID-19 absence and risk assessments that have limited the duties that some doctors are able to conduct.

Workforce and Recruitment meetings now take place regularly, monthly for Surgery & Critical Care and Medicine and fortnightly for Family Services division. Temporary Staffing attend as part of the development of the Resource Centre (RC) and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. Staffing levels continue to give cause for concern and more is needed to be done to develop alternatives such as Physician's Associates (PA) and Advanced Clinical Practitioners (ACP). Workforce objectives, as part of the Trust objectives, are monitored by the Workforce Committee which is a sub committee of the Trust board. The Trust has an established ACP program with planned annual cohorts supported by Health Education England.

Rota Co-ordination has improved in 2021, the Trust is in the process of transitioning to an electronic rostering system for greater visibility to identify the workforce needs and but there is still work to be done. Both A&E departments are fully implemented onto e-Rostering and the Rota Co-Ordinator team is now fully established. The Trust is continuing its efforts to diversify the clinical workforce and thereby reduce sole reliance on medical staff.

2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS Foundation Trust's indicators should be compared with:

a) **The national average for the same and;**

b) **Those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.**

This information should be presented in a table or graph (as seems most appropriate).

For each indicator, the Trust will also make an assurance statement in the following form:

> The Trust considers that this data is as described for the following reasons *[insert reasons]*.
>
> The Trust *[intends to take or has taken]* the following actions to improve the *[indicator / percentage / score / data / rate / number]*, and so the quality of its services, by *[insert descriptions of actions]*.

Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore the following indicators reported on are only those relevant to the Trust.

2.3a Summary Hospital-Level Mortality Indicator (SHMI)

The data made available to the Trust by NHS Digital with regard to:

a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period;

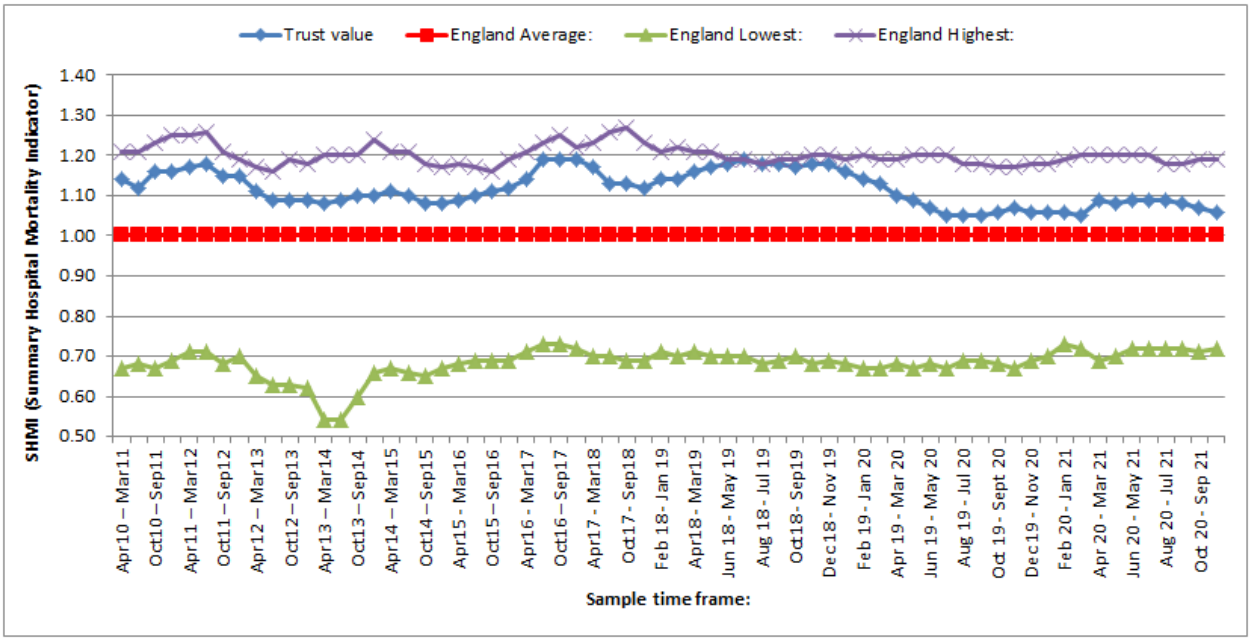


Figure 16: Trust's SHMI score, trended over time

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

NB: It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases.

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

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

- The Trust, as demonstrated in the chart above, has demonstrated statistically significant improvement in the SHMI resulting in the Trust being categorised as having mortality that is 'as expected'.

b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

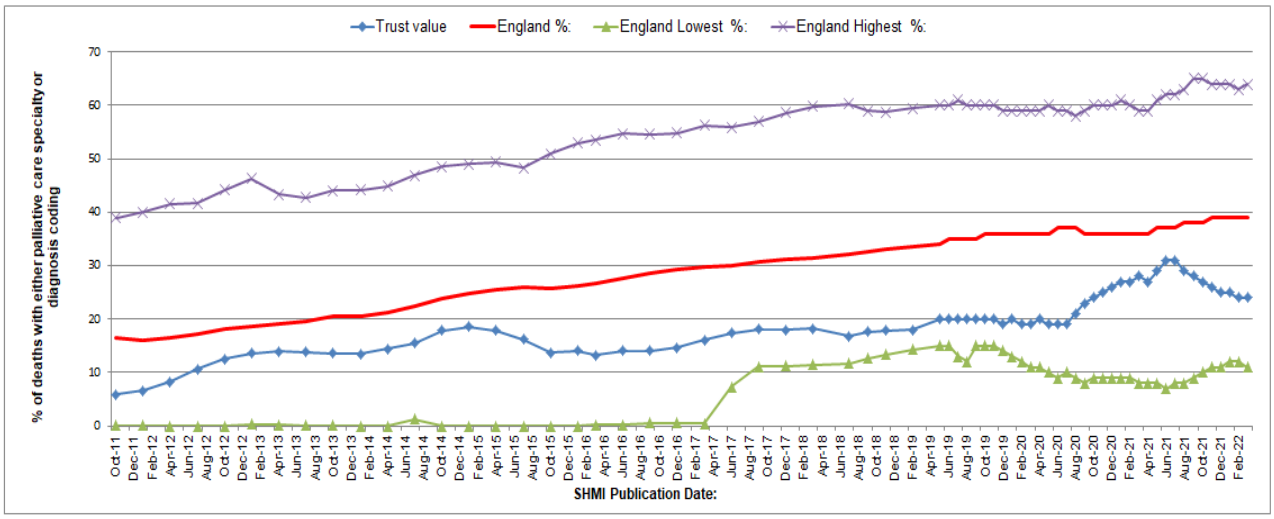


Figure 17: Percentage of patients with a coded palliative care code, compared with other UK Trusts

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

NB: It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases.

- The above chart illustrates the percentage of patients with a palliative care code used at either diagnosis or specialty level. Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

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

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

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

- The palliative care level information captured has decreased during 2021/22. This may be a result of the normal higher rates of activity resuming within the hospital following reduced activity during the height of the COVID-19 pandemic. Data continues to highlight a difference between hospital sites with SGH having higher levels of palliative care coding than DPOW. This reflects the disparity of consultant-led Palliative care provision between both hospitals and related Clinical Commissioning Groups and is likely to impact palliative care coding. This forms part of the end of life improvement plan and is being addressed collaboratively between primary and secondary care. Funding has now been secured and recruitment of a Palliative Care Consultant at Grimsby is underway to address the disparity.

  Clinical record keeping has been identified within the Trust as an area where further improvement is required. The quality of documentation can vary across the Trust which may have impacted on the accuracy of the coding and contributed to the dip identified.

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

- Despite the impact of the pressures associated with COVID-19, clinician led coding validation sessions and mortality screening reviews have continued throughout 2021/22. As at the end of February 2022 the target of reviewing more than 85% of all hospital deaths has been achieved, thus supporting the accuracy of Trust data recording, and helps the Trust better understand specific areas requiring Trust and wider system focus. As a result, a reduction in the number of related alerts with 'higher than expected' deaths has been observed.

- As the SHMI includes out-of-hospital deaths (within 30 days of discharge), it can be broken down into in-hospital and out-of-hospital mortality indices. The in-hospital SHMI performance is 'as expected', however, the out-of-hospital SHMI remains higher with Trust average difference of 36 points. The Trust's mortality reviews continue to identify a theme of patients being admitted to hospital at end of life to provide symptom control, often where the acute hospital is not the chosen place of death. This highlights the need of having advanced care plans and RESPECT forms in place which may then prevent hospital admission. The system-wide pressures associated with the COVID-19 pandemic has hampered progress being made in this area. However, the Trust are working closely with CCG colleagues to gain further understanding of the issues. During 2022/23 the Out of Hospital Group and the Trust's Mortality Improvement Group plan to meet to agree a way forward.

- The Trust have worked collaboratively with NHS England/Improvement 'Better Tomorrow: Learning from Deaths, Learning for Lives' team to pilot the national Mortality Reporting Dashboard (after being identified as a 'flagship Trust'). This includes the roll out electronic mortality reviews to allow greater oversight of available SHMI, Medical Examiner and learning from deaths data. Continued focus will be placed on this area throughout 2022/23 to embed the new reporting measures.

- During 2021/22 the Trust continued to be outliers for SHMI indicators relating to secondary malignancies and lung cancer. During this period the Trust has worked with community partners to review these outlying areas in greater detail and understand contributing factors. At the time of writing the Trust is no longer identified as an outlier for lung cancer related SHMI rates and are in the process of undertaking specific case reviews for secondary malignancies to identify gaps in service provision.

- The Trust identified improvement opportunities for patients dying with alcohol related liver disease and for patients with a heart valve disorder. Processes and services for these areas of care were reviewed which resulted in improved pathways for heart valve clinic referrals being implemented, and funding being provided by Public Health to support the services around alcohol prevention and the introduction of an alcohol support team.

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

2.3b Patient Reported Outcome Measures (PROMS)

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

a) Hip replacement surgery
b) Knee replacement surgery
c) Varicose vein surgery (no longer performed by this Trust)

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Hip replacement (Primary)	April 2011 – March 2012	0.405	0.416	0.532	0.306
	April 2012 – March 2013	0.461	0.438	0.538	0.369
	April 2013 – March 2014	0.426	0.436	0.545	0.342
	April 2014 – March 2015	0.436	0.437	0.524	0.331
	April 2015 – March 2016	0.485	0.438	No data available	No data available
	April 2016 – March 2017	0.501	0.445	No data available	No data available
	April 2017 – March 2018	0.453	0.468	0.56	0.376
	April 2018 – March 2019	0.483	0.469	0.55	0.33
	April 2019 – March 2020	0.447	0.459	0.54	0.35
	April 2020 – March 2021	0.410	0.472	0.574	0.393
Knee replacement (Primary)	April 2011 – March 2012	0.317	0.302	0.385	0.180
	April 2012 – March 2013	0.357	0.319	0.409	0.195
	April 2013 – March 2014	0.332	0.323	0.416	0.215
	April 2014 – March 2015	0.339	0.315	0.204	0.418
	April 2015 – March 2016	0.349	0.320	No data available	No data available
	April 2016 – March 2017	0.361	0.324	No data available	No data available
	April 2017 – March 2018	0.323	0.338	0.416	0.233
	April 2018 – March 2019	0.305	0.341	0.410	0.253
	April 2019 – March 2020	0.335	0.335	0.19	0.215
	April 2020 – March 2021	0.334	0.315	0.399	0.181

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

Comment:

The Patient Reported Outcome Measure (PROMs) is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The three areas listed above are nationally selected procedures. Varicose vein surgery is not performed by the Trust, therefore no data is available.

- The above tables show the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery.
- EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value.
- The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health).

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

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

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

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

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

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

- Previously when data concerns have been identified, this has been discussed with Trauma and Orthopaedic Surgeons who have identified areas of improvement and implemented change to address this. Discussion of the most recent results (published in February 2022) will take place at the next Orthopaedics Clinical Audit Meeting in May 2022 alongside an investigation into the data to identify any contributing factors.

2.3c Readmissions to hospital

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

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

Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital during the reporting period.

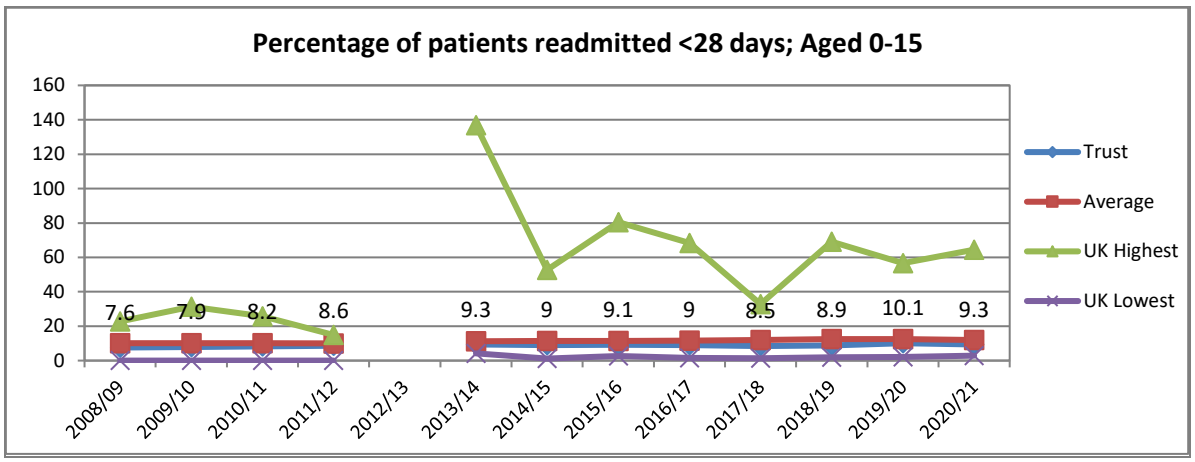


Figure 18: Chart demonstrating % of patients aged 0-15 readmitted within 30 days

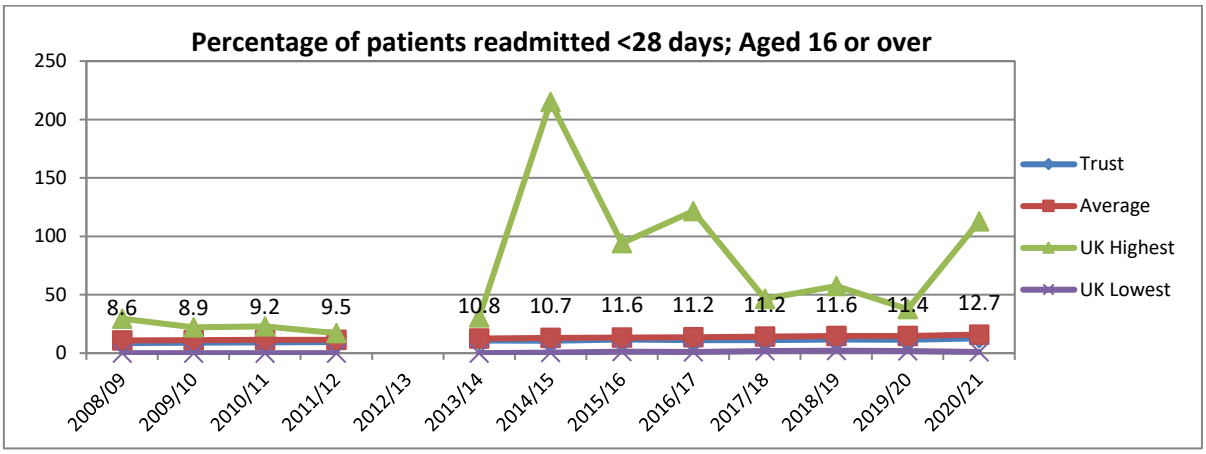


Figure 19: Chart demonstrating % of patients aged 16 or over readmitted within 30 days

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts) [NB: No data is available for the 2012/13 year, hence the gap; the UK highest data should be interpreted with caution as some Trusts with >100% data carry health warnings]

Comment:

The 2012/13 data was not available hence the gap in the above charts.

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

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

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

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

2.3d Responsiveness to the Personal needs of patients

The data made available to the Trust by NHS Digital with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.

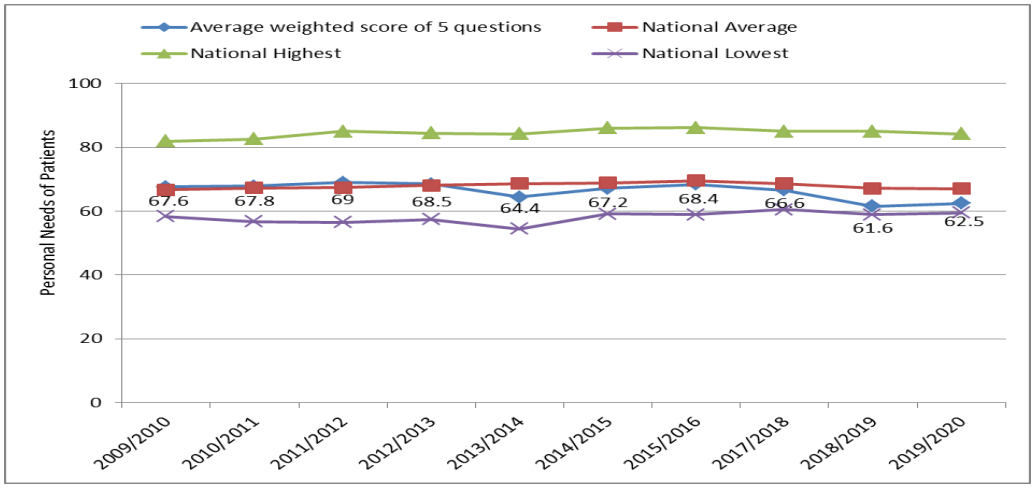


Figure 20: Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services

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

Comment:

The table above highlights the average weighted score for five specific questions. This information is presented in a way that allows comparison to the national average and the highest and lowest performers within the NHS.

The above figures are based on the adult inpatient survey, which is completed by a sample of patients aged 16 and over who have been discharged from an acute or specialist trust, with at least one overnight stay. The indicator is a composite, calculated as the average of five survey questions from the inpatient survey. Each question describes a different element of the overarching theme:

"*Responsiveness to patients' personal needs".*

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

Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

Due to the Covid-19 pandemic, the adult inpatient surveys were halted during 2020. These have now resumed, but no further data is yet available, the data presented above therefore is the same referenced to in last year's edition of the Quality Account at the end of 2020.

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

Due to Covid-19, the surveys that provide this data were halted, and therefore no more recent data is available. The data presented here is the same as reported in the 2020/21 quality account.

Northern Lincolnshire and Goole NHS Foundation Trust is committed to involving patients, carers and families in their care, treatment and relevant decision making. The COVID 19 pandemic has resulted in unprecedented challenges which resulted in prioritising clinical activity. This means that whilst progress is being made consideration has to be given to the local and national picture which has definitely affected the pace to achieve respective outcomes.

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

The local rolling inpatient survey, INSIGHTs, has been utilised to map key elements from the national surveys. Ensuring patient views are captured throughout every month enabling oversight, discussions and actions.

Introduction of the Family Liaison Assistant role across key areas, which focused on communication and patient wellbeing. The role has provided patients with the opportunity to discuss issues and have general support for their wellbeing. This has been further supported by the Patient Experience Officers who have provided support on all wards and departments, ensuring patients and families are connected. They have worked to resolve issues and provided a pivotal conduit between patients and staff to create a better involvement.
The Trust is delivering two discharge projects that are working in collaboration. The processes and quality of discharge are central to ensuring safety of medication post discharge alongside safety netting advice which is appropriate for patients and families.

2.3e Staff recommending Trust as a provider to friends and family

The data made available to the Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

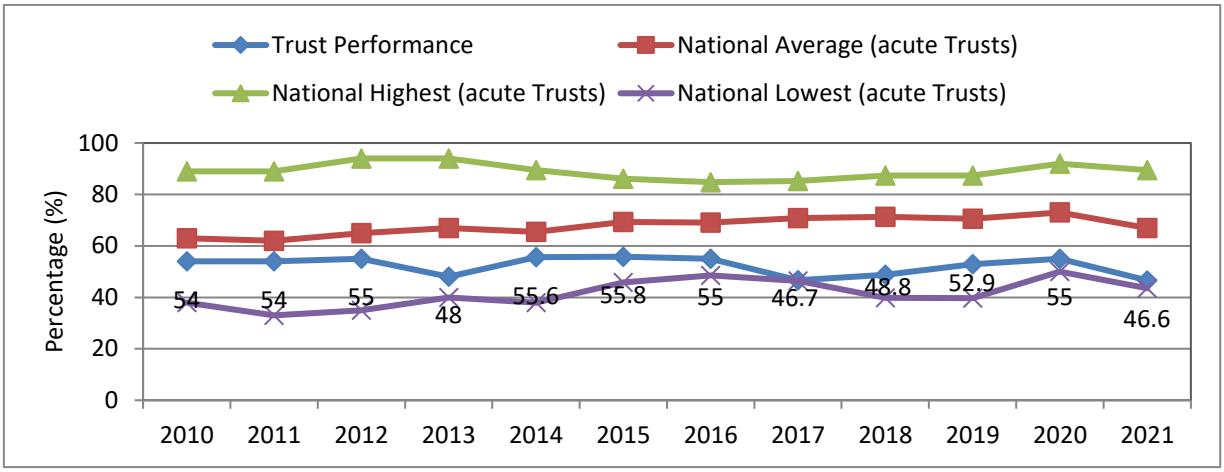


Figure 21: Trust reported performance for staff recommending the Trust as a provider to family and friends

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

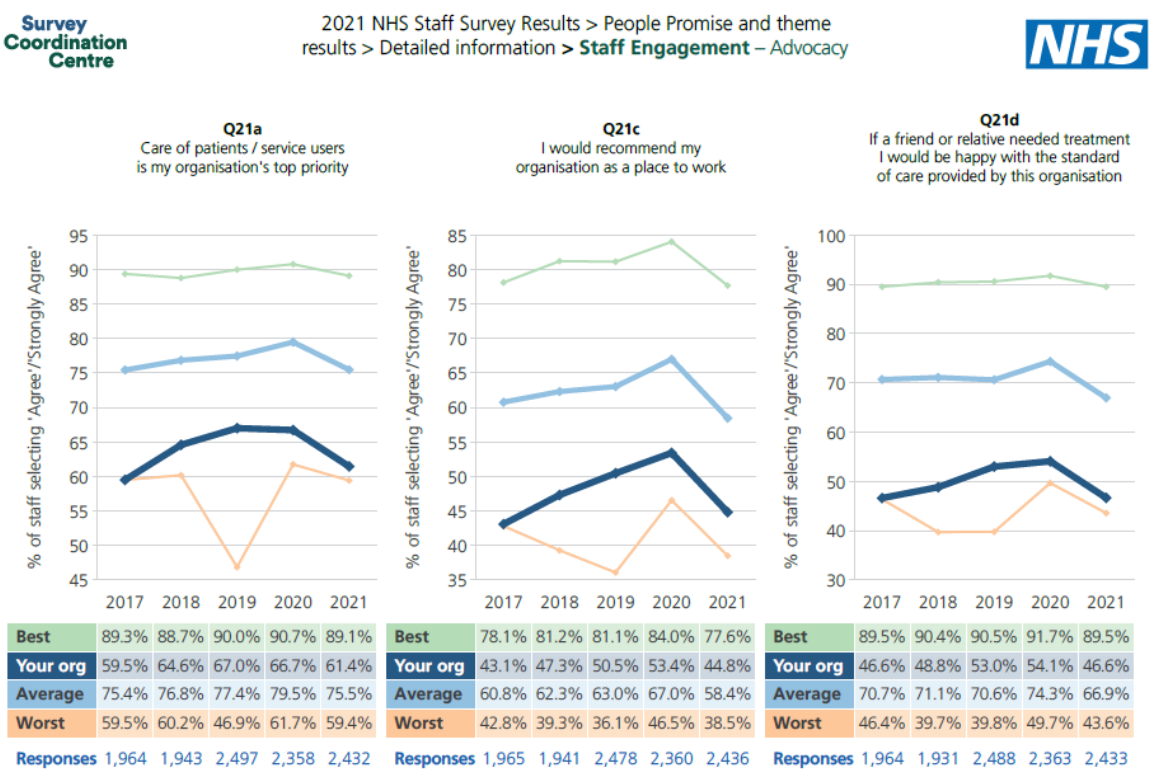


Figure 22: Trust reported performance for staff recommending the Trust as a provider to family and friends

Source: NHS Staff Survey Results

Comments:

The above table illustrates the percentage of staff answering that they "Agreed" or "strongly agreed" with the question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust".

46.6% of staff surveyed would recommend the Trust; as you can see this trend is system wide across the whole NHS and is likely as a response to the pressures presented by the pandemic.

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

The unprecedented pressures the COVID-19 pandemic continued to impact on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2021 compared to 2020. The Trust notes that there is much work to do across all staff survey themes.

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

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

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

- The launch of a two year culture transformation programme collaborating with our staff on what actions we need to take to improve employee experience.

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

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

- A two year Equality, Diversity and Inclusion action plan to strengthen our inclusion, diversity and equity.

- A two year health and wellbeing plan designed to build on progress made to date and embed effective leadership of our staff's health and wellbeing.

2.3f Risk assessed for venous thromboembolism

The data made available to the Trust by NHS Digital regarding the percentage of patients admitted to hospital and were risk assessed for venous thromboembolism during the reporting period are shown in the table below.

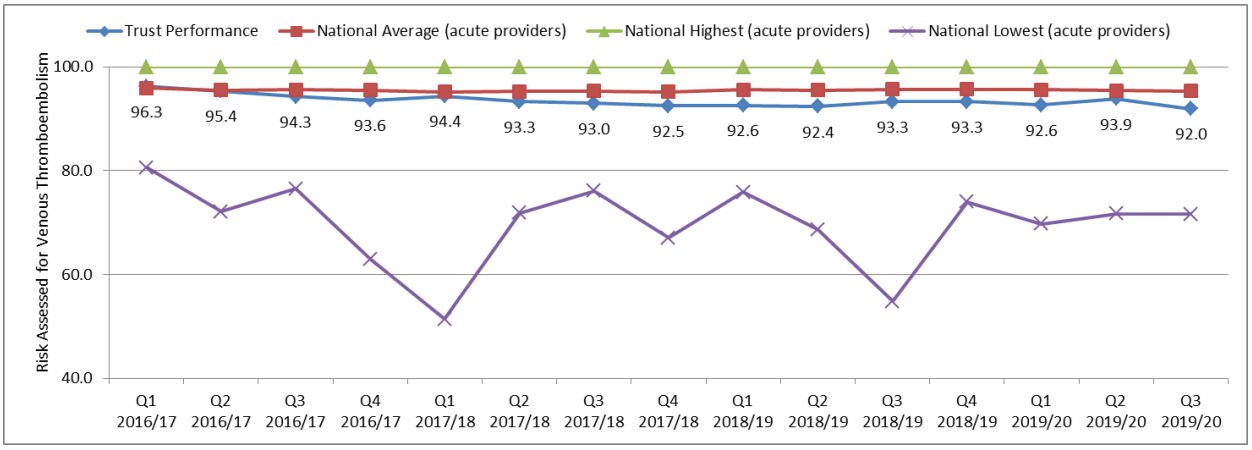


Figure 23: Trust performance for patients risk assessed for venous thromboembolism (VTE)

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

Comment:

- The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter one, 2016/17.

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

- Due to Covid-19, the surveys that provide this data were halted, and therefore no recent data is available. The data presented is the same as reported in the 2020/21 quality account.

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

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

- The Trust completed the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system in November 2021. The system is having the desired effect

in improving patient safety as built in controls prompt doctors to undertake full VTE risk assessments in a timely manner, prior to prescribing or administering medications. Reporting for March 2022 demonstrated an improvement to 90% compliance.

- The Trust appointed two clinical leads to support further improvement and to provide ongoing education and support to clinical staff to understand and overcome identified barriers.

- Trust policy and patient information leaflets are currently being reviewed to fall in line with the latest NICE guidance and to reflect delivery of VTE risk assessment through EPMA. Progress has been slower than anticipated due to the persistent operational pressures impacting on acute care services.

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

2.3g Clostridium Difficile infection reported within the Trust

The data made available to the Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of *Clostridium difficile* infection reported within the Trust (hospital onset) amongst patients aged 2 or over during the reporting period.

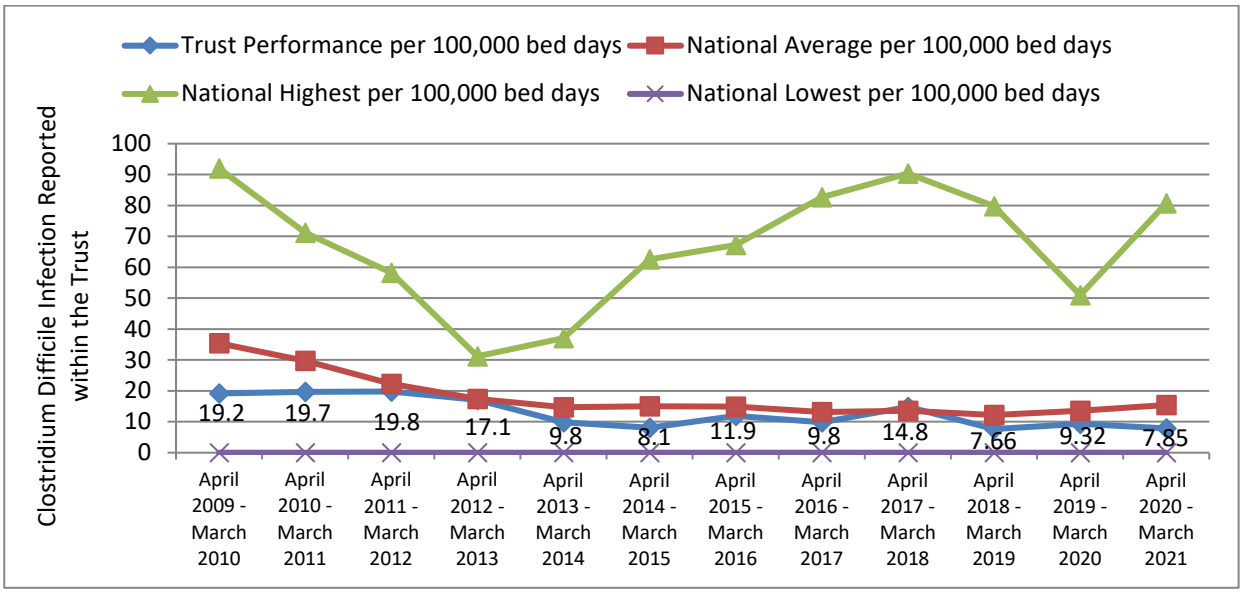


Figure 24: Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

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

Comment:

The above table illustrates the rate of *C. difficile* per 100,000 bed days ending 20/21, for the Trust (Hospital onset only), for specimens taken from patients aged two years and over.

The data shows that the Trust, for the latest reporting period, is beneath the UK average and one of the best performing acute hospitals in the UK which is a major achievement.

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

The Trust reported 20 healthcare acquired cases for the year ending March 2022 compared to 28 last year. The definitions for reporting *C. difficile* cases changed in April 2019 meaning cases

detected after 2 days would be attributed as Hospital onset (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Hospital related (COHA) if the patient was an in-patient within the previous 4 weeks.

	HOHA	COHA
Diana, Princess of Wales Hospital (DPoW)	5	3
Scunthorpe General Hospital (SGH)	7	3
Goole District Hospital (GDH)	2	0

The Trust has detected no significant lapses in practice/care contributing to the development of the infection.

The Trust has taken significant actions to maintain low rates of infection and maintain the quality of its services by:

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

2.3h Patient safety incidents

The data made available to the Trust by NHS Digital regarding:

a) The number and, where available, rate of patient safety incidents per 1,000 bed days reported within the Trust during the reporting period

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days	Acute – Non-specialist highest rate per 1,000 bed days	Acute – Non-specialist lowest rate per 1,000 bed days
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2016 – September 2016	5,953	49.5	40.8	71.8	21.1
October 2016 – March 2017	6,536	52.3	41.1	69.0	23.1
April 2017 – September 2017	6,347	52.4	42.8	111.7	23.5
October 2017 – March 2018	5,897	48.0	42.6	124.0	24.2
April 2018 – September 2018	5,806	48.3	44.5	107.4	13.1
October 2018 – March 2019	6,176	50.0	46.6	95.9	16.9
April 2019 – September 2019	7,275	59.2	49.8	103.8	26.3
October 2019 – March 2020	8,105	65.5	50.7	110.2	15.7
April 2020 – September 2020	7,570	79.9	Data not available	Data not available	Data not available
October 2020 – March 2021	7,547	69.7	Data not available	Data not available	Data not available
April 2021 – September 2021	7,889	69.0	Data not available	Data not available	Data not available

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

NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate 'per 100 admissions'. The classification of Trusts also changed from 'large acute', 'medium acute', 'small acute' and 'acute teaching' to simply 'Acute non-specialist' and 'Acute specialist'. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

- The data published for all Trusts is now annual and is not available 6 monthly. Data for 2021 is not yet available by organisation.

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

b) And the number and rate of such patient safety incidents that resulted in severe harm or death.

Time frame	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2016 – September 2016	7	0.06	0.16	0.60	0.01
October 2016 – March 2017	21	0.17	0.16	0.53	0.01
April 2017 – September 2017	24	0.20	0.15	0.64	0.00
October 2017 – March 2018	21	0.17	0.15	0.55	0.00
April 2018 – September 2018	21	0.17	0.16	0.54	0.00
October 2018 – March 2019	15	0.13	0.15	0.49	0.01
April 2019 – September 2019	31	0.25	0.16	0.67	0.00
October 2019 – March 2020	20	0.2	0.16	0.5	0.00
April 2020 – September 2020	49	0.51	Data not available	Data not available	Data not available
October 2020 – March 2021	94	0.86	Data not available	Data not available	Data not available
April 2021 – September 2021	21	0.18	Data not available	Data not available	Data not available

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

NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate 'per 100 admissions'. The classification of Trusts also changed from 'large acute', 'medium acute', 'small acute' and 'acute teaching' to simply 'Acute non-specialist' and 'Acute specialist'. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

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

- Due to Covid-19 and the lack of available data, the national indicators were not updated with new data periods. Therefore, the table has been populated with local data updates only from April 2020 onwards from Ulysses Risk Management software system.

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

- The increase in numbers during October 2020 – March 2021 was due to incidents added retrospectively as severe harm/death for each patient who may have acquired COVID in hospital and then required treatment in ITU or who subsequently died with Covid-19. Letters of apology were sent to each patient's family.

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

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

Part 3: Other information

An overview of the quality of care based on performance in 2021/22 against indicators

3.1 Overview of the quality of care offered 2021/22

The Trust set out 5 key quality priorities for focus on within 2021/22, which were:

As part of the Trust's annual setting of priorities, the Trust had set 5 quality priorities:

1. Reduce mortality rates and strengthen end of life care
   (Patient Experience and Clinical Effectiveness)

2. Improve the management of deteriorating Patients & Sepsis
   (Clinical Effectiveness and Patient Safety)

3. Increasing medication safety
   (Patient Experience & Patient Safety)

4. Safety of Discharge:
   (Patient Safety, Experience & Clinical Effectiveness)

5. Improve the management of Diabetes
   (Clinical Effectiveness and Patient Safety)

Priority 1 – Reduce mortality rates and strengthen end of life care

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:							
QP1: Reduce mortality rates and strengthen end of life care	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
1a) Reduction in the number of patients dying within 24 hours of admission to hospital.	**15**	14	17	**16**		No target	G
1b) Reduction in the number of emergency admissions for people in the last 3 months of life.	**193**	172	212	**199**		No target	G
1c) Reduction in the out of hospital SHMI to 110, by March 2022.	**131.9**	132.6	135	**137**			R

Comment:
The Trust has made positive progress in moving towards the target, however, the system-wide effect of Covid-19 has impacted on full delivery of these quality priorities. This will remain as a quality priority for 2022/23 to ensure further improvement is made in collaboration with community partners.

Priority 2 – Deteriorating patients and sepsis

CLINICAL EFFECTIVENESS & PATIENT SAFETY:								
QP2: Deteriorating Patient & Sepsis	Mar-22	Jan-22	Nov-21	Sep-21	May-21	SPC Variation	SPC Assurance	RAG
2a) ADULTS: 90% of patient observations recorded on time.	**91%**	90%	91%	91%	**91%**			G
2a) CHILDREN: 90% of patient observations recorded on time.	**90%**	100%	80%	95%	**90%**			A
2b) Escalation of NEWS in line with policy *(Audit data available bi-monthly)*	No data	0%	9%	3%	**5%**			R
2c) Sepsis screen in 90% of patients with a sepsis six indicator.	No data	80%	47%	39%	**34%**			R

Comment:
The Trust has sustained good practice in ensuring patients have the required observations recorded within set timescales, however, further work is required to improve processes and documentation for recording the escalation of deteriorating patients and sepsis six pathways. These areas will remain as a quality priority for 2022/23 to ensure further improvement is made.

Priority 3 – Increasing medication safety

PATIENT SAFETY & PATIENT EXPERIENCE:							
QP3: Increasing medication safety	Feb-22	Jan-22	Dec-21	Jul-21	SPC Variation	SPC Assurance	RAG
3a) Improvements in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU).	64%	68%	63%	**64%**		Insufficient data	R
3b) Insulin administered on time in 85% within wards using EPMA.	100%	80%	95%	**90%**		Insufficient data	G
3c) Reduction in medication omissions without a valid reason for ward areas using EPMA.	2%	2%	2%	**14%**		Insufficient data	G

Comment:
The Trust have achieved the targets for administering insulin on time and reducing medication errors on ward areas. However, further work is required to improve the recording of patient's weight during admission. This will remain as a quality priority for 2022/23 to drive improvement.

Priority 4 – Improve the Safety of Discharge

PATIENT SAFETY, CLINICAL EFFECTIVENESS & PATIENT EXPERIENCE:							
QP4: Safety of Discharge	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
4a) Improve the proportion of patients discharged before 12 noon.	16.4%	15.2%	16.3%	16.9%			R
4b) Improve the proportion of patients discharged before 5pm.	66.3%	66.0%	67.1%	69.9%		No target	R
4c) Improving trend showing a reduction in length of hospital stay above 21 days.	55	71	62	0			R

Comments:
Progress against these priorities have been significantly impacted upon by the Covid-19 pandemic and system-wide operational pressures. These areas are remaining as key Trust priorities to support recovery actions.

Priority 5 – Improve diabetes management

CLINICAL EFFECTIVENESS & PATIENT SAFETY:							
QP5: Diabetes Management	Feb-22	Jan-22	Dec-21	Apr-21	SPC Variation	SPC Assurance	RAG
5a) Diabetes Audit findings.	No data	77%	80%	80%			G
5b) 100% of BM taken in ECC in adults when NEWS of >1	No data	95%	90%	93%			A
5b) 100% of BM taken in ECC in children when PEWS of >1	No data	83%	83%	75%			A
5c) 90% relevant staff have completed mandatory diabetes training.	88%	87%	85%	85%			A

Comments:
Good progress has been made with a number of these areas. Whilst diabetes care will not be carried over into 2022/23 as a quality priority, achievement of BM testing in the Emergency Departments will be measured as part of the annual Quality & Audit Forward Programme for 2022/23.

3.2 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Single Oversight Framework (SOF) are shown as follows for 2021/22.

Indicator	Quarter 1 21/22			Quarter 2 21/22			Quarter 3 21/22			Quarter 4 21/22		
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	66.3%	68.2%	69.0%	68.4%	68.9%	68.1%	67.9%	69.1%	68.7%	70.0%	70.7%	*Not yet available*
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	72.3%	72.7%	74.6%	63.9%	59.8%	53.2%	52.9%	58.2%	58.9%	62.4%	63.4%	61.9%
All cancers: 62-day wait for first treatment from referral/screening	67.1%	61.5%	65.8%	70.7%	62.4%	66.3%	60.9%	63.5%	65.5%	58.8%	63.1%	*Not yet available*
C.difficile: variance from plan [lapses in care] (target 21)	0	0	0	0	0	0	0	0	0	0	0	0
Maximum 6-week wait for diagnostic procedures	39.8%	39.7%	33.3%	32.4%	36.1%	31.5%	34.4%	30.9%	31.0%	27.1%	18.3%	*16.6%*
Venous Thromboembolism (VTE) risk assessment	79.3%	77.7%	80.4%	76.5%	76.1%	87.6%	92.8%	93.7%	92.3%	93.1%	92.4%	93.4%
Summary Hospital-level Mortality Indicator	108	N/A	109	109	108	107	106	106	*Not yet available*	*Not yet available*	*Not yet available*	*Not yet available*

3.3 Information on staff survey report

Summary of performance – NHS staff survey

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

Timeline

Survey Window: 4th October to 26th November 2021
Embargoed Findings: Received – 24th February 2022
NHSEI Publication: 30th March 2022

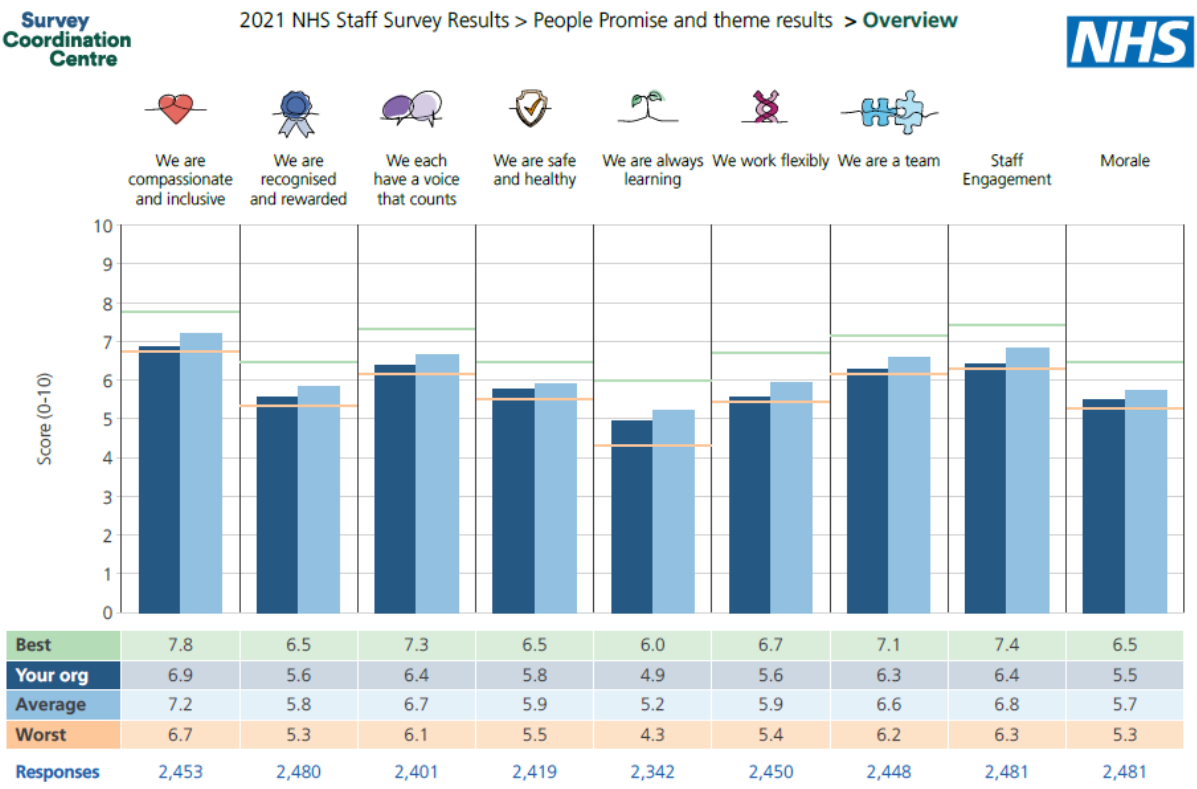
Key Facts

Benchmark Comparators: 126 Acute & Acute Community Trusts
Benchmark Response Rate: 46% (+2% on 2020 survey)
NLaG Response Rate: 38% (+2% on 2020 survey)
NLaG Survey Mode: Paper and Online (2,542 completed)

Staff Survey 2021 findings

The 2021 survey questions are aligned to the seven themes of the People Promise. Staff Engagement and Morale remain included as in previous years.

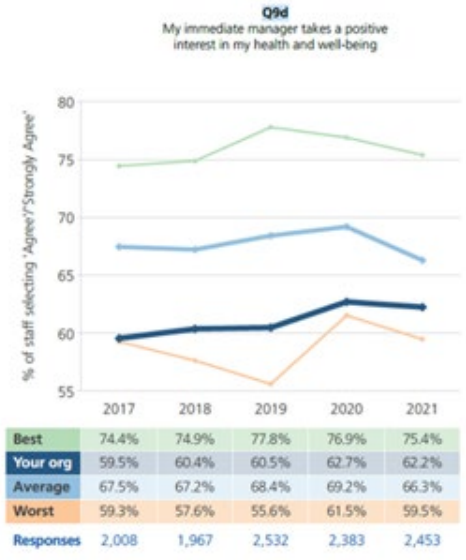
The chart below demonstrates Trust results in comparison to peer organisations.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	6.9	5.6	6.4	5.8	4.9	5.6	6.3	6.4	5.5
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,453	2,480	2,401	2,419	2,342	2,450	2,448	2,481	2,481

Figure 25: Key reported in the national staff survey

Health and Well-Being



	2017	2018	2019	2020	2021
Best	74.4%	74.9%	77.8%	76.9%	75.4%
Your org	59.5%	60.4%	60.5%	62.7%	62.2%
Average	67.5%	67.2%	68.4%	69.2%	66.3%
Worst	59.3%	57.6%	55.6%	61.5%	59.5%
Responses	2,008	1,967	2,532	2,383	2,453

From the pandemic the Trust can evidence:

- Increased positive action being felt regarding health and wellbeing support
- Note: further evidence Q8f with Managers recognised as taking interest in the health and wellbeing of staff
- The uptake of staff working agilely can be evidenced.

Figure 26: Focus on: Health and Well-being

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

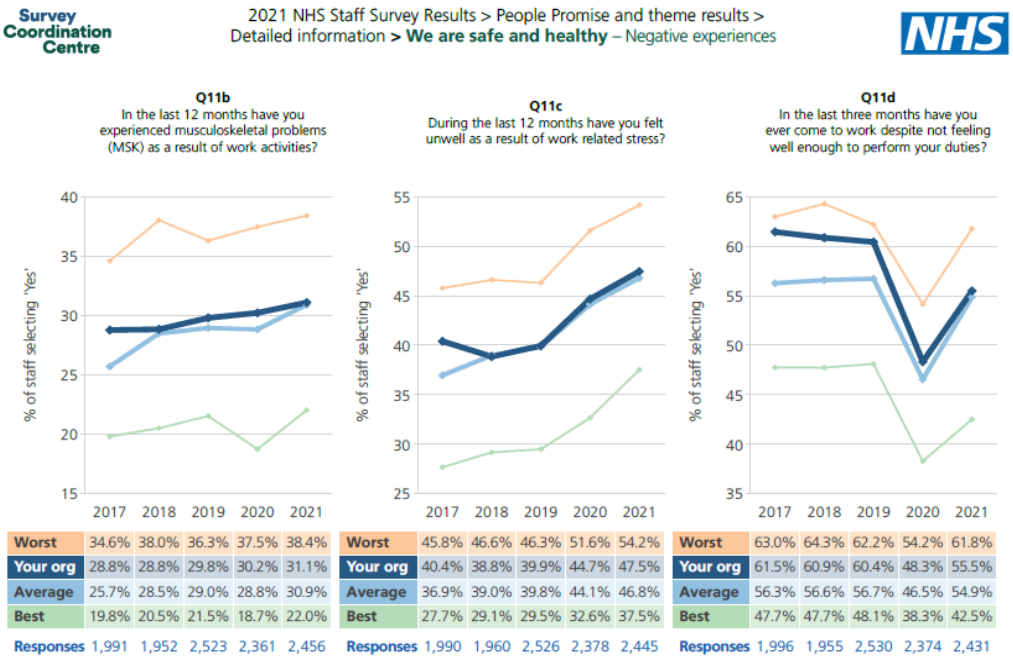


Figure 27: Focus on: Health and Well-being

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

- The support of staff psychological wellbeing with skills training and sessions in CISM training, further funding of clinical psychologists, the introduction of Schwartz Rounds and a series of pop up wellbeing Hubs planned for 2022/3.

- Consideration given to supporting staff burnout is required given Q11d and staff continuing to work when unwell (despite c.12% in-year reduction reporting for work while unwell).

Safety Culture

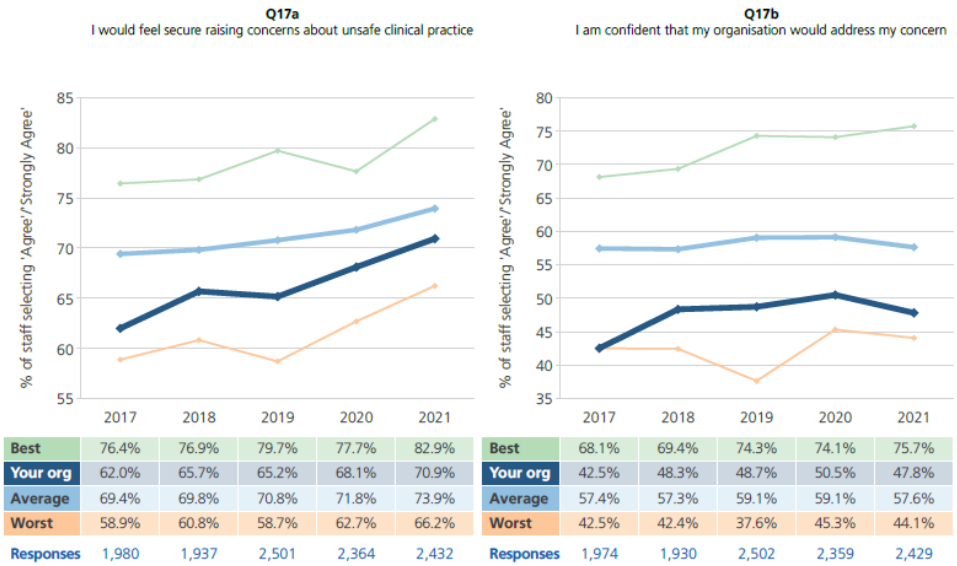
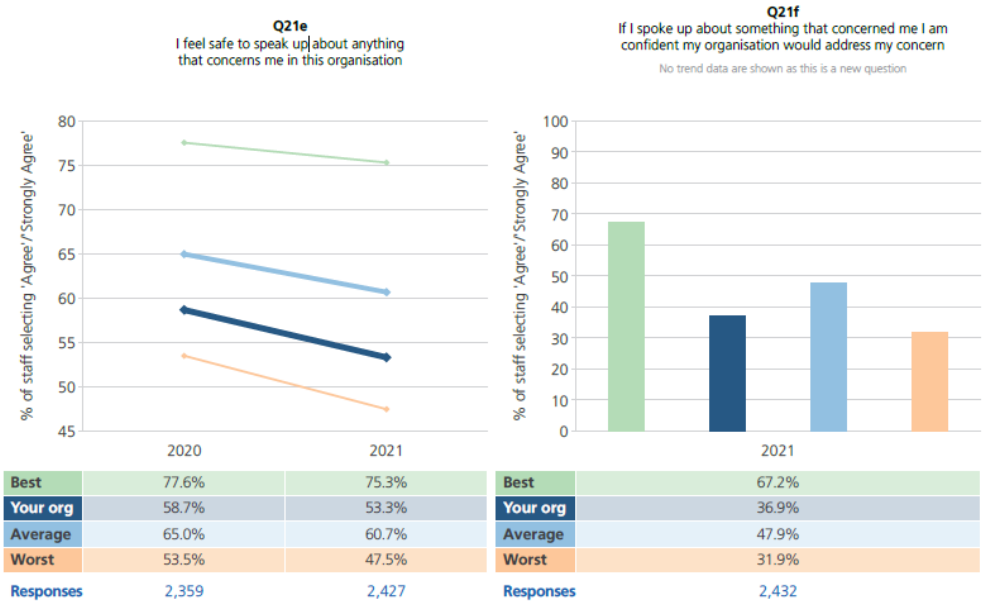


Figure 28: Focus on: Safety culture

Since 2017 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017).



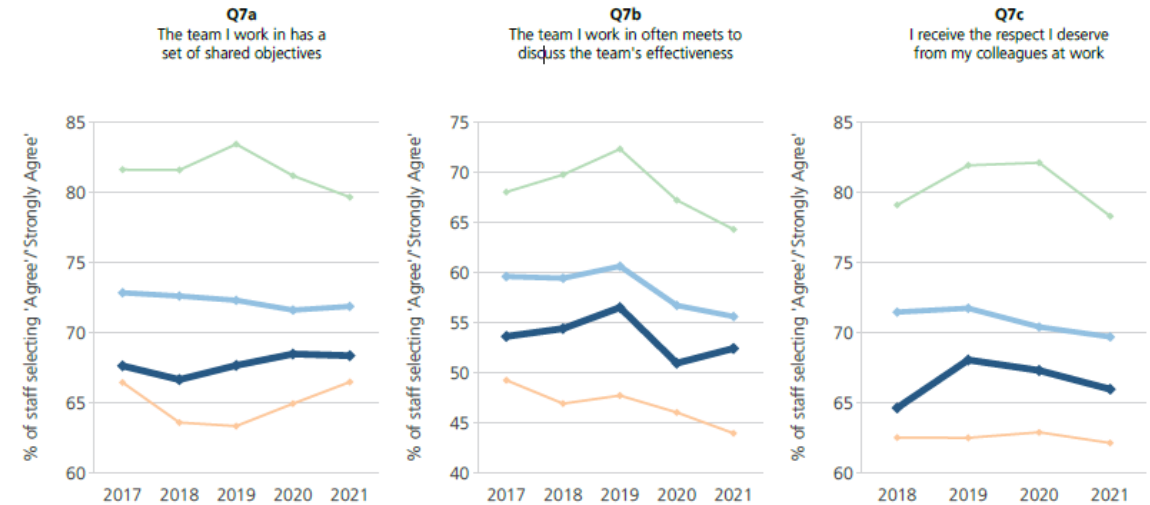
	2020	2021
Best	77.6%	75.3%
Your org	58.7%	53.3%
Average	65.0%	60.7%
Worst	53.5%	47.5%
Responses	2,359	2,427

	2021
Best	67.2%
Your org	36.9%
Average	47.9%
Worst	31.9%
Responses	2,432

Figure 29: Focus on: Safety Culture

There has been a decrease of 5% from 2020 to 2021 in staff feeling they are able to speak up about anything that concerns them in the organisation. The Trust have a proactive programme of work in place to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

Team Working



	2017	2018	2019	2020	2021
Best	81.6%	81.6%	83.4%	81.2%	79.6%
Your org	67.6%	66.6%	67.7%	68.5%	68.3%
Average	72.8%	72.6%	72.3%	71.6%	71.9%
Worst	66.4%	63.6%	63.3%	64.9%	66.5%
Responses	2,033	1,978	2,526	2,369	2,464

	2017	2018	2019	2020	2021
Best	68.0%	69.8%	72.3%	67.2%	64.3%
Your org	53.6%	54.4%	56.5%	50.9%	52.4%
Average	59.6%	59.4%	60.6%	56.7%	55.6%
Worst	49.2%	46.9%	47.7%	46.0%	43.9%
Responses	2,035	1,974	2,544	2,386	2,464

	2018	2019	2020	2021
Best	79.1%	81.9%	82.1%	78.3%
Your org	64.6%	68.0%	67.3%	66.0%
Average	71.5%	71.7%	70.4%	69.7%
Worst	62.5%	62.5%	62.9%	62.1%
Responses	1,989	2,548	2,388	2,467

Figure 30: Focus on: Team Working

As you can see from Q7a-c, there has been no significant change to our scores.

The Trusts recently approved Leadership Development Strategy, consisting of 3 strands of work, includes the strengthening of competence and confidence in our leadership community to build, lead and manage effective teams. Teamworking and Line management are central to high levels of staff engagement. Our forthcoming core leadership skills programme of work will support improvement in this theme.

Next Steps:

Following the recent refresh of the People Directorate's Trust priorities and the ratification of the Leadership Development Strategy and the inception of both a Culture Transformation Board and Working Group, the key deliverables are:

We will further develop how we seek to **attract and recruit new** staff by:

- Developing an overall Recruitment Plan
- Reviewing our recruitment practices
- Developing new roles (including nurse apprenticeships) to attract staff and support existing workforce shortages
- Increasing flexible and hybrid working opportunities clinically and non-clinically for our new starters.

We will **develop and care for our own staff** by:

- Implementing a nursing career pathway
- Exploring opportunities with partners, to introduce new clinical roles
- Reviewing our approach to flexible and hybrid working, and retire and return
- Continuing to raise awareness of and expand access to health and wellbeing services for staff.

We will continue to **improve our culture and staff engagement** within the Trust by:

- Conducting a culture diagnostic exercise to understand better what matters to staff, and build actions to address these needs, overseen and monitored through the introduction of a Culture Transformation Board
- Further embedding Just and Learning Culture practices
- Designing and implementing a 3-strand Leadership Development Strategy
- Strengthening our efforts to increase and celebrate the diversity of our workforce

3.4 Information on patient survey report

Due to Covid-19 the National Inpatient Survey was not undertaken in 2021. The National Inpatient Survey for 2020 contributes to the Trust understanding where to align patient experience priorities in conjunction with the other patient experience intelligence received by the Trust.

The survey response rates were in line with previous years, as seen below:

1250 Invited to complete the survey	1195 Eligible at the end of survey	**44%** Completed the survey (528)	45% Average response rate for similar organisations	45% Your previous response rate

The survey detailed aspects of the respondents stay where they reported a better experience than the other Trusts surveyed or internal improvement since the last survey results, such as how good the food was. The year on year improvement views helps the Trust understand how quality

improvement measures taken from previous survey actions or projects have impacted on patient's experience.

The areas for development, relating to the survey, are taken from the lower scores as seen in the red section of the table below:

Top 5 scores vs Picker Average	Trust	Picker Avg
Q12. Food was very good or fairly good	79%	70%
Q2. Did not mind waiting as long as did for admission	69%	68%

Most improved scores	Trust 2020	Trust 2019
Q12. Food was very good or fairly good	79%	63%
Q10. Able to take own medication when needed to	83%	77%
Q38. Given written/printed information about what they should or should not do after leaving hospital	64%	59%
Q21. Always or sometimes enough nurses on duty	89%	85%
Q36. Staff discussed need for additional equipment or home adaptation after discharge	79%	76%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
Q3. Did not have to wait long time to get to bed on ward	66%	82%
Q5. Not prevented from sleeping at night	38%	49%
Q41. Told who to contact if worried after discharge	69%	78%
Q38. Given written/printed information about what they should or should not do after leaving hospital	64%	73%
Q42. Staff discussed need for further health or social care services after discharge	75%	82%

Most declined scores	Trust 2020	Trust 2019
Q24. Right amount of information given on condition or treatment	75%	80%
Q42. Staff discussed need for further health or social care services after discharge	75%	79%
Q47. Asked to give views on quality of care during stay	7%	11%
Q41. Told who to contact if worried after discharge	69%	73%
Q40. Knew what would happen next with care after leaving hospital	79%	81%

The actions to be addressed were matched against those aspects of care deemed most important to patients, through Picker's relational aspects of care mapping processes.

Divisional teams are taking their own actions and reporting progress through a single combined central monitored improvement plan. This allows for improved triangulation of opportunities, sharing of quality improvement successes and increased oversight through quarterly support and challenge conversations at the Patient Experience Group. The four areas for development are:

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

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

Annex 1.1: Statements from Commissioners

Feedback from:
North East Lincolnshire CCG

North Lincolnshire CCG

Lincolnshire CCG

East Riding of Yorkshire CCG

Delayed response from lead CCG. Expected to be received by 07/06/22

Annex 1.2: Statement from Healthwatch organisations

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

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

The three local Healthwatch organisations recognise that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. The following is the joint response from Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire and Healthwatch East Riding of Yorkshire.

The summary clearly sets out what you have achieved during 2021/22 against your 5 priority areas and what still needs working on, in the forth coming year. Here at Healthwatch we are aware that the COVID-19 Pandemic has had a major impact on the NHS and what you hoped to achieve, this is the reason why some of your priority areas are being carried forward into 2022/23. The National Inpatient Survey was put on hold due to COVID-19, here at Healthwatch we are glad to see this has now resumed and that the Friends and family Test and PALS are targets set for the forthcoming year. This will ensure that patients and their families' feedback can drive change throughout the Trust.

During 2021/22 the Covid-19 pandemic was still having an impact and this has been demonstrated from the Out of Hospital SHMI figures, which are still above where you wanted them to be. This needs a collaborative approach between Adult Social Care, Ambulance Services and Care Homes, to name a few. Partnership working is key to enable patients to be treated in a timely manner and to ensure that there is minimal attendances at hospital, if patients can be treated in a different way. As a Trust you are aware of the progress you still need to make and have identified it as a priority to continue monitoring into 2022/23.

Discharge from hospital before 12pm has also been difficult to maintain. Procedures have been put in place by yourselves to improve your position, however, you are reliant upon services outside your control to assist with this. Discharge from hospital relies on collaboration with Adult Social Care and Care Homes to ensure the flow of patients is carried out in a timely manner and improvements need to be made in this area. Indeed the report mentions that at the time of publication there were 70 patients waiting to be discharged who could not be due to pressures elsewhere. In your Quality Accounts you are committed to working alongside your CCGs to improve this and move to the intended target. Healthwatch will continue to monitor this priority and will offer support to the Trust to ensure this cohort of patients are discharged quickly to the most appropriate place, with the support packages in place they need to enable them to recover quickly.

The trusts work and future plans around advanced care planning is welcomed. Particularly as this is an area which the trust has recognised as requiring further improvement; especially around preventing unnecessary admission and supporting people to die at home.

We would like to thank all of your staff for the hard work they have put in during these unprecedented times, Healthwatch is aware that staff morale is low currently and the steps the Trust has put in place to improve this situation have an impact on staff well-being.

Healthwatch recognises it has been a difficult year for Secondary Care Providers, however, the Trust has continued to recognise the areas that need improving and put action plans in place to improve the situation.

Feedback from:
Healthwatch Lincolnshire

Healthwatch Lincolnshire acknowledges Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) as one of the major providers of services to Lincolnshire people due to the significant number of patient referrals into NLAG services to both Grimsby and Scunthorpe hospitals.

Healthwatch Lincolnshire welcomes the opportunity for better joint working and integration across borders as we all move towards an Integrated Care System (ICS), where the public and patients experience should be integral. We have received very little patient feedback relating to NLAG services this year but are pleased to see public and patient feedback has been used to produce the areas of quality priority chosen for 2022/23 which if achieved will lead to better health outcomes and experiences for patients.

Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

Feedback from:
North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel:

No feedback was received for inclusion in the Trust's quality account.

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel:

Feedback challenged by NLAG. Revised statement being drafted, not yet received.

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire:

The Health Scrutiny Committee for Lincolnshire is grateful to Northern Lincolnshire and Goole NHS Foundation Trust for sharing its draft quality account for 2021/22 and recognises the Trust's continued provision of acute hospital services to residents in the north of the administrative county of Lincolnshire, in particular to those residents in Louth, Mablethorpe and the surrounding areas.

While the Committee is focusing on the detail of the quality accounts of three other local NHS trusts for 2021/22, it is pleased to note the Trust's priorities for improvement for 2021/22 and the Trust's arrangements for monitoring progress with these priorities.

The Committee recognises that engagement between the Trust and the Committee is likely in the coming year, as proposals are brought forward as part of the Humber Acute Services Programme.

Feedback from:
East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee:

No formal statement was received for inclusion in the Trust's quality account. However, three priority points were sent for inclusion.

1. Waiting lists for mental health care in general
2. Staffing and vacancy rates
3. Use of community hospitals and the impact of the centralisation of services
4. Digital inclusion

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is pleased to have the opportunity to comment on the 2021/22 Quality Account which demonstrates that significant quality improvements have been achieved despite the extraordinary challenges the coronavirus pandemic has continued to pose. Again this year, governors would like to place on record our appreciation of the incredible commitment made by Trust staff to the delivery of high quality patient care in the most difficult of circumstances.

Throughout the year governors have continued to prioritise seeking robust assurance regarding the quality and safety of services provided to patients, specifically in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We receive regular reports at Council of Governors meetings on progress against the Trust's quality priorities. We are represented in an observer capacity at meetings of the Quality & Safety Committee the NED chair of which makes himself available to brief Governor Assurance Group meetings on committee highlights and to answer often searching questions.

Although the Trust remains in quality special measures, governors are greatly encouraged by all the hard work that has been undertaken to successfully deliver the vast majority of the 'must do' and 'should do' actions recommended by the Care Quality Commission (CQC) in its 2019 inspection report. Despite coronavirus constraints it is good to see that progress has also been made against many of the Trust's 2021/22 quality priorities. Perhaps most pleasing has been the consistent downward in-hospital mortality trajectory. In the coming year governors hope that improved partnership working at 'place' level across the new integrated care system will drive concomitant reductions in out of hospital mortality. Governors have also been impressed by the impact the roll-out of electronic prescribing and medicines administration (EPMA) across all three hospital sites has had on the medication safety priority. On the negative side governors are frustrated that little progress has been made in improving performance on the safety of discharge priority, although it is appreciated that this has largely been due to system-wide Covid related pressures.

The Council of Governors supports the six quality priorities agreed for 2022/23. Governors were pleased that feedback was sought from Trust members and service users in identifying potential quality improvement areas. The recognition that Governors need to be more fully consulted in future years on the shortlist of quality priorities is welcome. Governors will continue to support the Trust as 'critical friends' in delivering quality improvements over the coming year. We hope that the tremendous efforts of Trust staff will be rewarded in 2022 by the CQC lifting quality special measures following its imminently expected reinspection.

Annex 1.5: Response from the Trust to stakeholder comments

Response to be provided following Trust Board approval

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

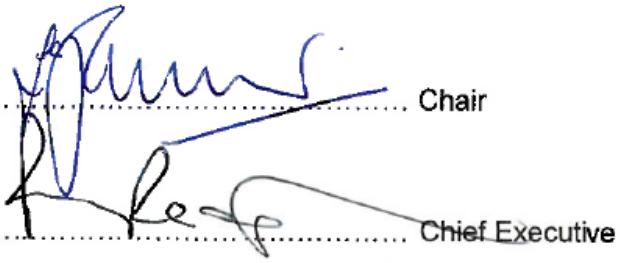
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2021 to March 2022
    - Papers relating to quality reported to the board over the period April 2021 to March 2022
    - Feedback from commissioners dated……
    - Feedback from governors dated 09 May 2022
    - Feedback from Local Healthwatch organisations dated 24 May 2022 and 31 May 2022
    - Feedback from Overview and Scrutiny Committees dated…….
    - The trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2022
    - Latest national inpatient survey 2020
    - Latest national staff survey 2022
    - CQC inspection report dated 7 February 2020.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is routinely quality checked to ensure it is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

20/07/2021 Date ..... Chair

2.8.21 Date ..... Chief Executive



Updated signatures required when approved by TMB

Annex 3: Independent auditor's report to the Board of Governors on the Annual Quality Report

No independent auditor's report has been required as part of the 2021/22 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

Glossary

CQUIN or Commissioning for Quality & Innovation Framework: The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Mortality Data: - How is it measured?

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

NEWS stands for the National Early Warning Score which is a nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 5: Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2021/22 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

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Name of the Meeting	**Trust Board**	
Date of the Meeting	Tuesday 7 June 2022	
Director Lead	Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Jo Loughborough, Senior Nurse Patient Experience	
Title of the Report	**Volunteer Strategy**	
Purpose of the Report and Executive Summary (to include recommendations)	Volunteer Strategy 2021 – 2024 approved at the Quality & Safety Committee on 26 April 2022	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ 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)	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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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
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VOLUNTEER STRATEGY

2021-2024

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

At NLAG the aim of our volunteer strategy is to change the perception of volunteering, create new and interesting opportunities which will attract members of our communities who wish to support and learn about the NHS across our local hospitals and community settings.
We aim to provide pathways which will enable volunteers to not only support and be involved in the development our services; but also to share their skills with our staff and/or learn new skills while they are giving us their time.

Priority One: Increase the diversity and number of active volunteers volunteering in NLAG, to support key services and enhance overall patient experience.

Priority Two: To work with Departmental Managers to identify opportunities where volunteers can have the greatest impact.

Priority Three: To support, train, engage and retain volunteers so they have a positive experience of volunteering at Northern Lincolnshire and Goole NHS Foundation Trust

Priority Four: Improve good practice in volunteer management by growing the volunteer co-ordination and support team.

Objectives

Robust management systems in place to support NHS Volunteering

Recognise and clebrate the contribution and comitment of volunteers

Deliver a high quality personnalised volunteer journey that maximises reciprocal benefits for the hosptial and volunteers

To be able to demonstrate the value of volunteering to staff, patients and the wider community

Kindness • Courage • Respect

How we will get there?	Year 1	Year 2	Year 3
Priority One: **Increase the diversity and number of active volunteers volunteering in NLAG, to support key services and enhance overall patient experience.**	• We will work collaboratively with local educational facilities to increase number of young people, 17 to 25 • We will develop role descriptions for generic and specific roles • We will make it easy to access volunteering and promote our commitment to equality and diversity throughout our processes • We will attend recruitment events to engage with public • We will provide staff awareness and engagement about volunteering and its benefits for patients and staff • We will further explore opportunities with partners to increase opportunities for volunteers	• We will actively promote volunteering via all media platforms, including social media and publicise the launch of the strategy • Develop relationship with community teams to promote volunteering opportunities • Develop a promotional video showcasing volunteer stories	• We will develop a structure of volunteers who will support patient partners to develop in their roles • We will continue to expand the number of younger volunteers, through collaborative working with local educational facilities
Priority Two: **To work with Departmental Managers to identify opportunities where volunteers can have the greatest impact**	• We will provide opportunities for clinical and senior teams to feedback and evaluate volunteers roles • We will work with patient experience team to identify areas which will benefit from focused support • We will evidence and celebrate the impact volunteers have made to the experience of care across the Trust • Continue to be proactive with NHS Futures engagement platform	• We will engage with divisions to promote volunteering and identify their requirements • We will embed audit as part of our processes to drive quality improvement • We will incorporate the role of volunteers into the staff corporate induction programme	• Seek to further develop partnerships and links with voluntary services teams from other areas • We will develop a pipeline of volunteers to support new service developments
Priority Three: **To support, train, engage and retain volunteers so they have a positive experience of volunteering at NLAG.**	• We will develop a quarterly newsletter to promote and celebrate volunteering • We will develop mechanisms to ensure feedback is obtained from volunteers and their areas of work • We will standardised our induction sessions for all volunteers • We will develop our volunteers through opportunities on the Health Education England platform – Learning for Volunteering • We will seek funding for a volunteer uniform to make volunteers a part of the NHS Team • We will ensure we have a Volunteer reward and recognition programme • We will actively look at volunteering opportunities to support patients and carers at the End of Life experience • We will recruit and train volunteers to patient experience roles • We will form strong links with local third sector organisations to share good practice	• We will review volunteer handbook with high quality information • We will create opportunities for volunteer peer support • We will aspire to preserve national accreditation	• We will undertake an annual survey to obtain volunteer feedback • We will plan and deliver E-learning to ensure we provide flexible training opportunities, ensuring there is no digital isolation
Priority Four: **Improve good practice in volunteer management by growing the volunteer co-ordination and support team.**	• We will provide support for areas to ensure a good volunteering experience • We will develop a programme of celebrating success • We will act on volunteer feedback to improve volunteering experience and share this through the quarterly update • We will establish Key Performance Indicators to monitor progress	• We will develop the Volunteering Strategy Task and Finish Group to monitor progress • Review KPI's and develop them further	• We will share stories of successful volunteering which have transformed patient experiences • We will explore funding for volunteer software management support

NLG(22)084

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7th June 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.	
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:	7th June 2022
Report From:	Finance & Performance Committee – 20 04 22 and 25 05 22

Highlight Report:

Trusts Ambulance handover position challenge remains. 4-hour emergency care standard performance continued to deteriorate, linked to the flow and volume of patients attending ED who require admission to hospital. Urgent Care Service performed at 98%. 12hr DTA breaches continued. We are developing a change to D2A, earlier management of patients with no right to reside. We continue in the top quartile for D2A and discussions are ongoing with our partners about further development to sustain this. Improvement to ambulance handover standard expected from opening the new emergency department at DPoW in June.

M1 reviewed by the Committee showed that elective activity had missed the trajectory and the Committee noted that there was a potential risk to the tight margins of error on the 2022/23 operational plan. Actions were in place to mitigate the underperformance in M1.

The Committee expressed concern that cancer still hadn't moved, with heightened concern over patients waiting over 62 and 104 days. Actions were being taken with specialties to reduce the risks around 104 days, however performance on cancer treatment was noted by the Committee.

Levelling up of waiting lists was ongoing and we have received our first 300 patients from HUTH. It was important for the board to be aware that our elective waiting list will grow as we take patients from HUTH onto our waiting list, lengthening the waits for NLAG patients.

Diagnostic performance was debated following a deep dive paper into the DM01, the Committee generally felt good improvement was shown across all modalities. The community diagnostic provisions were discussed and the positive impact this was having on performance.

Business continuity, including EPRR, was discussed alongside some specific risks to the trust, but the Committee noted that the Trust had achieved substantial compliance against the NHS annual core standards.

During 21/22, £5.7m was spent on Backlog maintenance but the budget was smaller in 22/23. Premises Assurance Model 2021/22 was debated alongside the costed action plans that were in place. The Committee was shown the summary of findings which highlighted the known water and ventilation issues.

A deep dive on Ventilation and air conditionings took place, highlighted was the new Health Technical Memorandum (HTM) released on 22nd June '21. It was confirmed that ventilation upgrades would only occur as a full refurb happens due to availability of Capital funding.

Theatres 7 and 8 at DPoW and Theatre A at SGH have had funding approved for refurbishment. The aim was to complete in this financial year, but it was unlikely to change the risk score of estates but may change the risk score of other strategic objectives.

Confirm or Challenge of the Board Assurance Framework:

SO1-1.2 – the Committee was happy with the risk score but suggested some additions to the gaps in control and Gaps in Assurance.

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)085

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	07 June 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 Highlight Report and Board Challenge**

Purpose of the Report and Executive Summary (to include recommendations)	The Committee recommended highlighting the following matters of concern to the Board, namely:
	• The Trust People Strategy was reviewed
	  ○ An end of year review of 2021/22 delivery was undertaken, and the excellent progress made was commended by the Committee
	  ○ The 2022/23 annual delivery plan was endorsed by the Committee
	• A Health and Wellbeing assurance deep dive was undertaken.
	• The Director of People and Chief Executive are to review the BAF strategic objective 2 "To be a Good Employer" to see if there is opportunity to sub-divide the overall risk rating between workforce, safety, and financial risk.
	• The Annual Freedom to Speak Up report was approved.

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	☐ 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.

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BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	07 June 2022
Report From:	Michael Whitworth, NED & Chair of Workforce Committee

Highlight Report: Workforce Committee – 31 May 2022

1 Introduction

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

2 Items Highlighted by the Committee for the Attention of the Board

- The Committee undertook an end of year review of the 2021/22 People Strategy achievements. The improvements in policies, the people directorate structure, recruitment, and leadership development were particularly noted. The People Strategy delivery plan for 2022/23 was endorsed by the Committee.
- A Health and Wellbeing deep dive was undertaken, and the 2-year wellbeing plan endorsed by the Committee.
- New recruitment metrics data was reviewed by the Committee

3 Items for Committee Ratification and Assurance

3.1 The Committee approved the Freedom to Speak Up Annual Report

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)086

Name of the Meeting	**Trust Board**	
Date of the Meeting	7th June 2022	
Director Lead	Christine Brereton – Director of People	
Contact Officer/Author	Liz Houchin – Freedom To Speak Up (FTSU) Guardian	
Title of the Report	**FTSU Q4 & Annual Report for 2021-22**	
Purpose of the Report and Executive Summary (to include recommendations)	Report is the Q4 and annual report and gives an update from last board, an overview of number of concerns raised, national and regional updates and 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	☐ 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
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Financial implication(s) (if applicable)	N/A	
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Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q4 – Jan–March 2022 & Annual report for 2021-2022

Liz Houchin 5th May 2022

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q4 2021-22 (which covers the period January to March 2022) and also the annual report for the year 2021-2022. 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 (updated July 2019). The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

4. Assessment of FTSU Concerns Raised

4.1 In Q4 2021-22 the number of concerns received were 38. There were no concerns reported anonymously in Q4. The main theme in Q4 was 'process'.

- The total number of concerns in 2021-22 was 157. Of these 4 concerns were raised anonymously which is lower than the national average (from 2020-21 data) and indicates that staff feel safe to raise concerns openly or confidentially. The Guardian has also introduced a new section on the hub site 'You said, we did', this will enable those that have raised concerns anonymously to access an outcome and feedback from raising the concern.

- National figures show that the average number of quarterly concerns per 1000 WTE for an NHS Trust was 3.71. The Trust's figure of 8.28 puts it in the highest quarter nationally. Model hospital data provided relates to Q3 2021/22, annual data has not been published to date.

- The quarterly average figure for concerns per 1000 WTE which involved an element of patient safety is 2.34 which places the Trust in the top quartile nationally, with the national figure being 0.54.

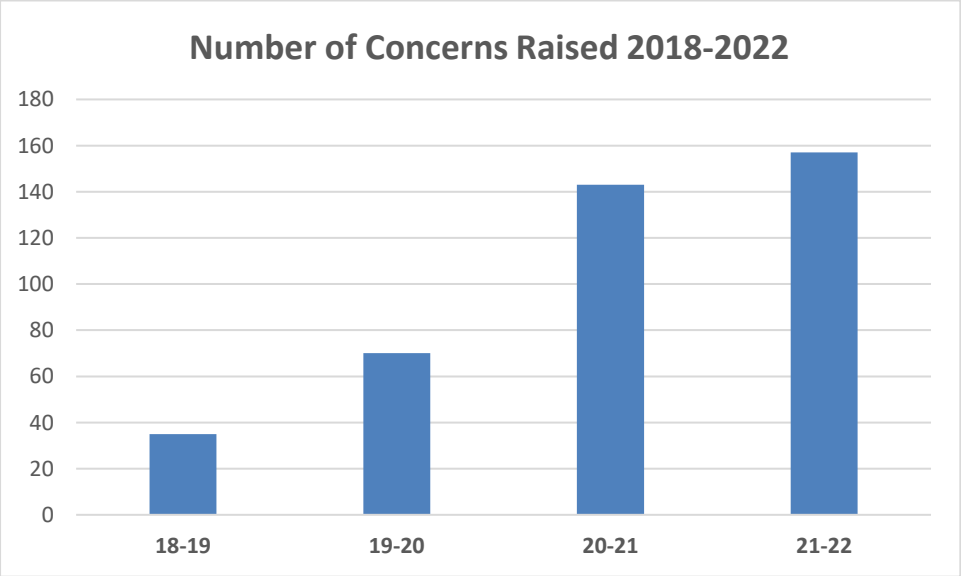
- The quarterly average figure for concerns which involved an element of bullying and harassment was 0.36, which puts the Trust in the middle quartile nationally, the national figure was 0.90 and indicates an improvement for the Trust from previous years.

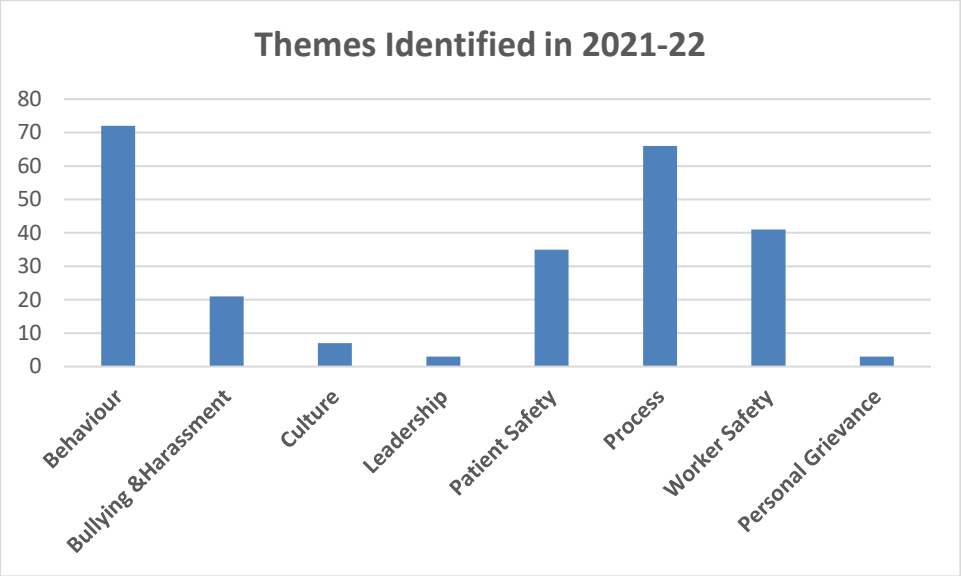
4.2 The number of concerns coming to the Guardian has risen for the past four years and may be due to a number of factors, the appointment of a permanent and dedicated Guardian, and the increased confidence of staff feeling able to raise concerns. In addition, there has been considerable promotion through the year including Freedom to Speak up Month and social media presence.

4.3 The main themes raised were around behaviours, process, worker safety and patient safety. The high number of concerns relating to behaviours may be an indication of staff being exhausted and burnt out. It also indicates the need for the cultural transformation work.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and most concerns were managed and closed within 8 weeks. Any outstanding concerns are discussed monthly with the DOP /CEO for awareness and support if required.

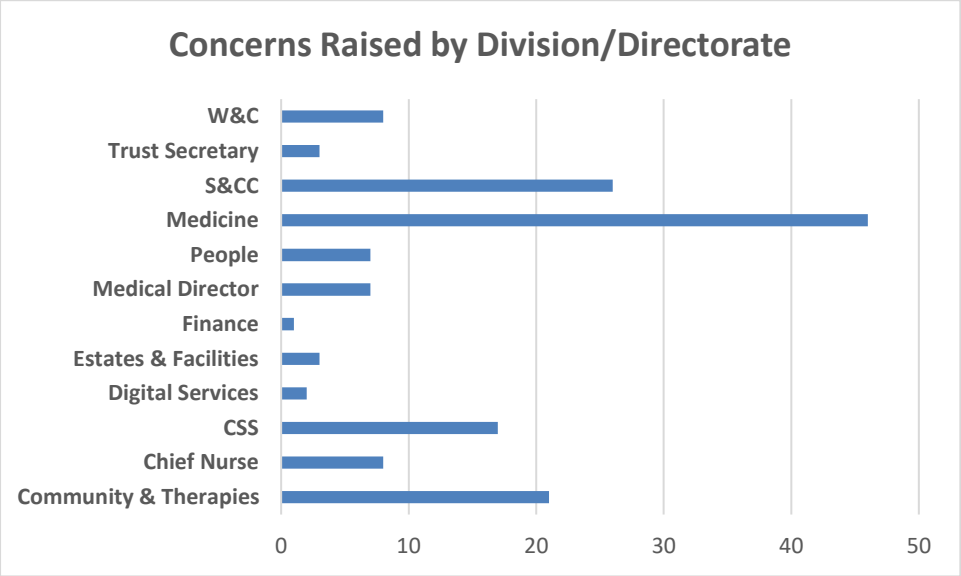
4.5 FTSU Guardian continues to produce quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data ie HR information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified and interventions put in place where needed.

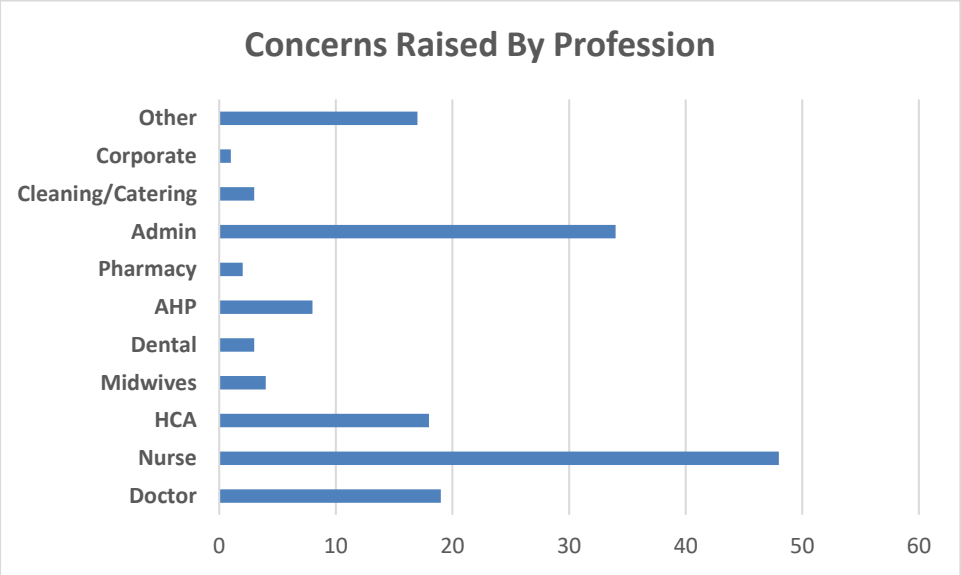




Please note that each concern may have more than 1 element.

Area of Concern	No.	Themes and Lessons Learnt
Behaviour	72	Most of these relate to behaviours that are not in line with Trust values or behaviour that is unprofessional. The increase in reporting may be related to an increase in awareness of the Guardian role and the impact of working during the pandemic. Each Division has access to FTSU data which can be used in conjunction with other HR data to identify areas of concern.
Process	66	These are cases where staff were either unsure of how to proceed with a concern and needed help signposting/support to the appropriate services or around Trust policies and procedures not being followed.
Worker Safety	40	Various issues including staff levels, training, redeployment and rota issues. Each concern looked into individually and escalated as appropriate





The diversity of different professions contacting the FTSU Guardian, demonstrates an increased awareness of the Guardian role amongst staff in the Trust.

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. The number of evaluations returned has also increased.

2021-2022	Feedback received	Would you speak up again? Yes	Suffering Detriment (staff perception)
Total	36	34	1

Within the feedback received, the following are extracts of qualitative feedback received:

'I was made to feel at ease, Liz did not rush me in any way, listened intently, waited when I was tearful. This has been a hard thing to do but I also felt if no one speaks up then nothing will change. When people are not showing respect or supporting the service, it is the team that suffer.'

'Without your guidance and help I wouldn't have had the confidence to challenge the initial reply so thank you so much. Your help and empathy are so appreciated.'

4.7 Case Study

The inclusion of a case study in the report illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The FTSU Guardian received a phone call from a distressed staff member citing that since arriving at the Trust, they were being treated differently to others. Staff member had tried to speak to line manager but felt that the situation had not improved. After discussing options with the FTSUG, staff member decided that they would like Guardian support to raise their concerns.

The concerns included (staff member's own words used)

- A feeling of not being welcomed into the department or 'belonging'
- Staff member cited that they felt that their views and feelings were not taken into consideration, they were being constantly criticised and felt 'unworthy'
- They were terrified of making a mistake and asking for help
- Felt that they were always having to justify their clinical decisions even though they were an experienced clinician and that the environment was not a learning and supportive one
- Felt that their job plan was different from peers and caseload was higher
- Appointments were booked in times which were allocated for prayer

FTSUG asked what outcome staff member would like and they identified the following

- To be treated the same as their peers
- To be supported with health and wellbeing
- To have access to the department 'H' Drive
- Flexibility in the working environment

FTSUG contacted line manager to discuss concerns, line manager met with the staff member, and arranged regular meetings to support and monitor progress.

After two months staff member decided to leave the Trust. The Guardian arranged for them to have an exit interview by the E&D Lead. Staff member felt this was positive as they felt 'safe' to share honest feedback about their experience in the Trust.

Staff member's feedback on the Guardian evaluation form (quote lifted directly from the evaluation form and therefore staff member's own words): 'I am leaving this trust. I hope you make an effort to at least prevent any non-English or western staff to this department as I know they don't think they did anything wrong. Just don't let this happen to other people please'

Learning from this case study included the importance of staff being able to complete exit questionnaires with someone other than line manager and staff member's comments and experience will be fed into the ongoing culture work.

5. Regional and National Information and Data

5.1 National update

The National Guardians Office (NGO) has released the third and final module of its e-learning package for healthcare workers later in April 2022.These have all been developed in partnership with Health Education England. The third module is aimed at Senior Leaders including Executives, Non-Executives, lay members and governors and is designed to help foster a 'Speak Up' culture in their organisations.

People directorate are looking to incorporate all modules into trust training.

National figures released for 2020-21 show a total of 20,388 cases were raised with Guardians, an increase of almost 4000 cases on the previous year. Of these:

- 12% were raised anonymously (a decrease of 1% from 2019-20)
- 30% included an element of bullying/harassment (decrease of 5% from 19-20)
- 18% included an element of patient safety (decrease of 5% from 19-20)
- 3% indicated detriment as a result of speaking up (reduction of 2% from 19-20)
- 84% who gave feedback would speak up again.

The NGO have introduced a new recording category of 'Inappropriate Attitudes or Behaviours' - the recording of this additional category started in April 2022. The NGO definition of this is 'inappropriate attitudes or behaviour that is not Bullying & Harassment and the focus should be on the person's perception (who has raised the concern)'. Examples of 'Inappropriate Attitude or Behaviour' are given as:

- Actions contrary to an organisation's values
- Incivility

- Microaggressions

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. This offers peer support and is a source of identifying best practice, as well as being a channel through to the NGO. Meetings are held bi-monthly.

6. Proactive work of the FTSUG during 2021-2022

- Monthly 1 to 1's with CEO/DOP
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Monthly meetings with Associate Director for Quality Governance
- Quarterly Attendance at Patient Safety Champion Meetings
- Attendance at Trust inductions for Doctors and Overseas Nurses
- Attendance at Regional meetings
- Attendance on Health & Wellbeing Steering Group
- Walk rounds with NED for FTSU, Trust Chair and Chaplaincy

Future Plans

- Work of future combined Champions is being considered by the People Directorate.
- Introduction of FTSU Guardian as part of the new Trust Induction and Manager's training packages currently being developed.
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian including more walk rounds/promotion in canteens
- Use of social media to continue to raise awareness of FTSUG and the role
- Member of Cultural Transformational Board and working group

7. Indicators of Success

The NHS Staff Survey results for the following questions are used by the National Guardians Office (NGO) to calculate the Freedom To Speak Up Index for each trust. The 2019 score for NLaG was 73%, in 2020 this had increased to 75.4%. Given the change of questions in the 2021 staff survey, the NGO will not be producing a FTSU Index in the future.

The results from the 2021 survey indicate an increased confidence in staff feeling able to raise concerns about unsafe clinical practice, although there is a decrease in confidence that the organisation would address the concern. There is also decrease in confidence of staff feeling able to raise any concerns about the organisation.

The FTSU Guardian will help support the organisation to improve staff confidence and is part of the cultural transformation board.

NUMBER	QUESTION	NLAG 2020	NLAG 2021	National Average for combined Acute and Community Trusts (2021)
14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	46.5%	43.5%	46.5%
17a	I would feel secure raising concerns about unsafe clinical practice.	68.1%	70.9%	71.9%
17b	I am confident that my organisation would address my concern.	50.5%	47.8%	57.6%
21e	I feel safe to speak up about anything that concerns me in this organisation	58.7%	53.3%	60.7%
21f	If I spoke up about something that concerned me I am confident my organisation would address my concern	Not in survey	36.9%	47.9%
People Promise Overview	'We each have a voice that counts' – Raising concerns	Not in survey	6.1%	6.4%

8. Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian over the last year and how this work supports the Trust's overall strategic objective of being a good employer. It also links with the Trust priorities of 'leadership and culture', workforce and quality and safety.

9. Recommendation

The Trust Board is asked to:

a) Note the report for assurance
b) Approve the report

Compiled by Liz Houchin 5th May 2022

NLG(22)087

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	7 June 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 M01 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 – 25 05 22
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)	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 1

April – 2022/23

Executive Summary Month 1 2021/22

NHS Northern Lincolnshire and Goole NHS Foundation Trust

The Trust reported a £0.11m deficit for the month of April, which was £0.51m worse than plan.

Income was £0.16m worse than plan in month.

• Clinical Income was £0.22m above plan due to deferred income with a corresponding offset in expenditure. Other income was £0.04m above plan because of minor favourable variances across several areas including R&D income. Covid Outside Envelope income was £0.03m below plan offset by lower testing costs. Donated income, excluded from NHSE&I financial targets, was £0.08m above plan.

• Elective Recovery Funding (ERF) – the Trust did not achieve the 104% activity target for April despite spending the Capacity Reserve set aside in the plan, placing the Elective Recovery Funding at risk if lost activity is not recovered. As a result, 75% of the Elective Recovery Funding has been deferred in case of potential clawback from the ICS driving a £0.5m variance in month..

Pay was £0.62m overspent in month.

• Medical staff was £0.69m. The Trust continues to incur COVID19 related expenditure for sickness and isolation and backfill for risk assessed staff (£0.15m). Over-established posts are driving adverse variances across several Specialities, particularly within the Surgical Division and need to be reduced to budgeted levels. Urology (£0.06m), Orthopaedics incl Hot Clinics (£0.05m), ENT (£0.01m), Ophthalmology (£0.01m), ED (£0.01m), Stroke (£0.05m), Geriatrics (£0.03m), Acute Care (£0.1m), Paediatrics (£0.04m) and Gynaecology (£0.02m). Anaesthetic Middle Grade rota continues to be a pressure (£0.04m), along with additional Cellular Pathology (£0.05m) and Endoscopy (£0.04m) waiting list expenditure. Non delivery of the CIP savings of £0.14m compound the adverse to plan position.

• Nursing was £0.11m underspent in month. However, the underspends in Maternity, Community District Nursing and NICU obscure material cost pressures driven through circa 60 additional escalation beds (£0.16m), Covid related sickness and isolation costs (£0.15m) and extra ED and SDEC staff (£0.12m).

• Other Pay was £0.05m overspent. Over delivery in CIP of £0.12m within Corporate functions masks material overspends across E&F support staff (£0.1m) and (£0.09m) with in the Workforce Resource centre mainly on unfunded developments within Transfer Teams (£0.04m), Care Navigators (£0.01m) and Site Management (£0.02m), and Urology admin (£0.01m).

Non Pay was £0.36m underspent in month mainly because of outsourcing being lower than plan, along with a number of minor underspends including high cost drugs, Microbiology and Orthotics consumables.

Post EBITDA items were £0.33m underspent in month mainly due to a high cash balance in the month, resulting in interest received and a reduced PDC charge.

COVID-19 Specific Expenditure

• The Trust continues to have material ongoing Covid-19 specific expenditure driving a cost pressure of £0.3m adverse to plan. Further analysis of this specific expenditure is under review to ensure that costs are correctly classified and to take mitigating action where necessary

Income & Expenditure to 30th April 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	365,822	30,485	30,734	248	30,485	30,734	248
ERF Income	7,987	666	166	(499)	666	166	(499)
Block Top Up	58,002	4,834	4,834	(0)	4,834	4,834	(0)
Covid Inside Envelope Block	11,387	949	949	(0)	949	949	(0)
Covid Outside the Envelope	1,700	142	115	(27)	142	115	(27)
Other Income	39,332	3,263	3,299	36	3,263	3,299	36
Donated Income	0	0	77	77	0	77	77
Total Operating Income	**484,230**	**40,338**	**40,173**	**(164)**	**40,338**	**40,173**	**(164)**
Clinical Pay	(260,072)	(21,278)	(22,266)	(988)	(21,695)	(22,266)	(571)
Other Pay	(67,295)	(6,008)	(5,643)	365	(5,592)	(5,643)	(51)
Total Pay	**(327,367)**	**(27,287)**	**(27,909)**	**(622)**	**(27,287)**	**(27,909)**	**(622)**
Clinical Non Pay	(70,187)	(5,294)	(5,298)	(4)	(5,294)	(5,298)	(4)
Other Non Pay	(71,312)	(5,767)	(5,401)	366	(5,767)	(5,401)	366
Total Non Pay	**(141,499)**	**(11,062)**	**(10,699)**	**362**	**(11,062)**	**(10,699)**	**362**
Operating Expenditure	**(468,866)**	**(38,348)**	**(38,608)**	**(260)**	**(38,348)**	**(38,608)**	**(260)**
EBITDA	**15,364**	**1,990**	**1,565**	**(425)**	**1,990**	**1,565**	**(425)**
Depreciation	(16,169)	(1,194)	(1,266)	(72)	(1,194)	(1,266)	(72)
Interest Expenses & Other Costs	(233)	(19)	13	33	(19)	13	33
Dividend	(6,251)	(485)	(413)	72	(485)	(413)	72
Total Post EBITDA Items	**(22,653)**	**(1,698)**	**(1,666)**	**33**	**(1,698)**	**(1,666)**	**33**
Remove Capital Donated I&E Impact	1,289	107	(8)	(116)	107	(8)	(116)
I&E Surplus / (Deficit)	**(6,000)**	**399**	**(109)**	**(508)**	**399**	**(109)**	**(508)**

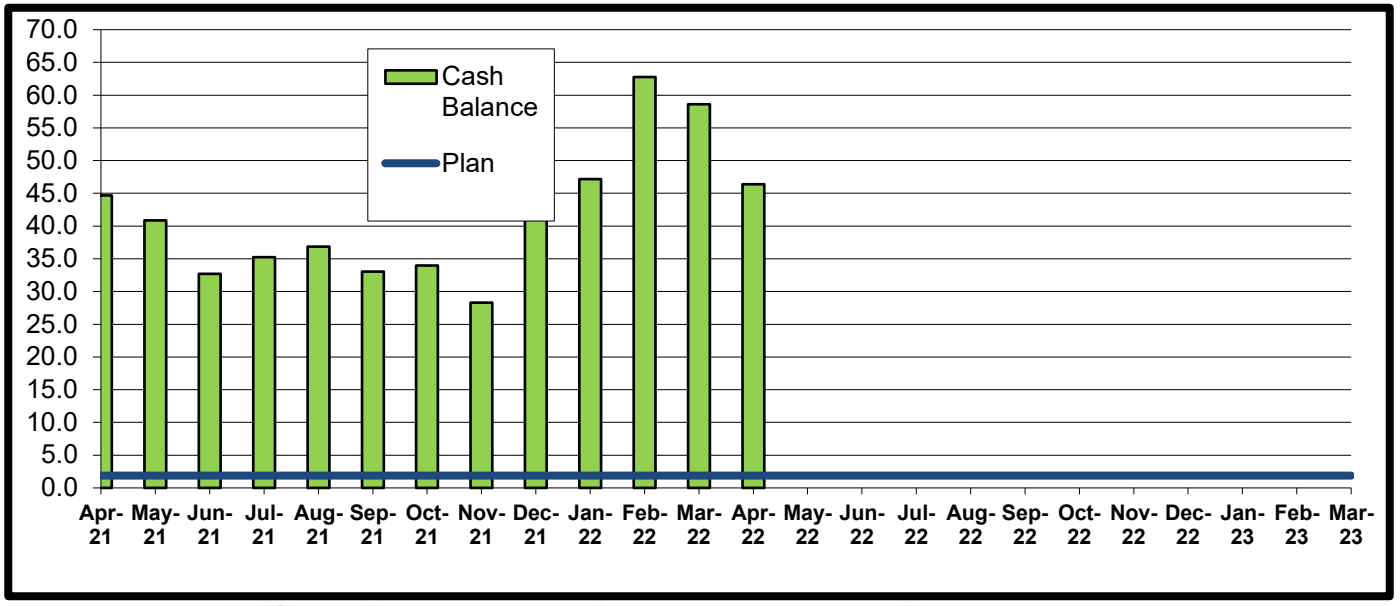
COVID-19 Expenditure

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	136	0	136
Existing workforce additional shifts to meet increased demand	133	0	133
Backfill for higher sickness absence	158	0	158
Total Testing - In Envelope	27	1	27
PPE associated costs	0	-1	-1
Segregation of patient pathways	0	8	8
Decontamination	0	44	44
Outside Envelope COVID-19 virus testing - rt-PCR virus testing	14	2	16
Outside Envelope COVID-19 virus testing - Rapid / point of care testing - locally procured reagents costs	0	72	72
Outside Envelope COVID-19 virus testing - Rapid / point of care testing (for DHSC provided Samba2, DNA Nudge, Primer Design, LumiraDx and Abbott ID NOW)	27	0	27
Total COVID-19 Expenditure	494	125	619
Total Trust Operating Expenditure (Including Covid-19 expenditure and all other operating expenditure)	27,909	10,699	38,608
Covid 19 Expenditure as a Percentage of Total Trust Operating Expenditure	1.8%	1.2%	1.6%

Cash

The cash balance at 30th April was £46.38m, an in-month decrease of £12.24m.

	£m	£m
Cash Balance as at 30th April		**46.38**
Commitments:		
Income received in advance	4.03	
Capital creditors	10.41	
Capital loan repayments	0.61	
April PAYE/NI/Pension	12.26	
Public Dividend Capital payment	0.41	
To support other creditors due	16.75	
		(44.47)
NHSi minimum balance		**1.90**



Balance Sheet as at 30th April 2022

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	244.09	260.34
Stocks & WIP	3.46	3.88
Debtors	19.23	19.00
Prepayments	3.16	3.56
Cash	58.62	46.38
Total Current Assets	84.47	72.82
Creditors : Revenue	49.96	44.91
Creditors : Capital	22.77	10.41
Accruals	17.54	19.26
Deferred Income	1.18	4.03
Finance Lease Obligations	0.00	2.19
Loans < 1 year	1.41	1.42
Provisions	0.80	1.16
Total Current Liabilities	93.67	83.38
Net Current Assets/(Liabilities)	(9.20)	(10.56)
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	0.02	14.48
Provisions - Non Current	5.50	5.50
TOTAL ASSETS/(LIABILITIES)	222.42	222.85
TOTAL CAPITAL & RESERVES	222.42	222.85

- Stock has increased in month in pharmacy and theatres.
- Debtors have reduced slightly. The Trust is still experiencing delays in payment of our invoices to United Lincs Hospital £1.7m. Debtors also includes Health Education £3.7m and Salix £4.2m.
- The Trust cash balance has reduced to £46.38m following the payment of year-end capital and revenue creditors.
- Deferred income has increased in month. This now includes Health Education income for May and June of £2.6m.
- Revenue creditors and accruals have reduced in month linked to the payment of invoices. This relates to an increase in pay-related accruals at year-end. The BPPC figures for the Trust continue to be above 90% for Non NHS, at 90.47%. Unfortunately NHS invoices has fallen to 74.39%. We are continuing to monitor the BPPC and are communicating to staff the importance of authorising invoices.

NLG(22)088

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7th June 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:	7th June 2022
Report From:	Finance & Performance Committee – 20 0422 and 25 05 22

Highlight Report:

The Trust achieved its control total requirement for 2021/22 reporting a marginal surplus of £40k. Month 12 adjustments for Pension and DoH Consumables were the drivers for material variances to plan in month but were neutral in total with income offsetting expenditure. The Trust achieved its core capital programme spend for the year, except for Salex funded Energy Schemes.

Month 1 of 2022/23 the trust reported a £0.11 deficit for the month, which is £0.51m worse than plan. For the same month pay was £0.62m overspent. ERF was not achieved due to not achieving the planned 104% of activity. The associated costs of independent sector usage had been incurred. Delays on ED and Ward 25 programmes had caused increased capital spend. The Committee questioned the medical agency unsocial rates paid in month 1, as it showed a stark increase.

COVID expenditure for 2021/22 was £13m. Savings delivery was good and delivered over plan for H2 however large amounts of this was non-recurrent. The impact of non-recurrent savings on the CIP challenge for the 22/23 financial year remained a concern for the Committee.

Reliance on premium temporary staffing remained a significant financial and operational risk to the delivery of the Trust's operational and financial plans and the Committee's concerns about the workforce related risks were raised with the Workforce Committee.

The Committee received an update to its underlying financial position (pre 22/23 plan changes) and a verbal update to the 22/23 financial plan. The current position was a planned break-even position which was broadly driven by inflationary pressures above tariff in energy costs and other non-pay contracts and also assumed full payment of the ERF. The Committee noted the tight margins of error in relation to staffing assumptions.

Benchmarking of the Trust Emergency Departments with HUTH highlighted the Trusts significantly greater reliance on temporary staffing. This was felt by the Committee to be an area worthy of further investigation to establish if lessons could be learned from colleagues in HUTH.

The national cost collection activity was discussed, and the Committee agreed to the methods proposed, the required activity report and the future actions.

Humber and North Yorkshire Procurement Collaborative (HNYPC) draft procurement plans were discussed, and the Committee queried workforce implications.

Confirm or Challenge of the Board Assurance Framework:

SO3.1 was discussed, and the Committee were happy with the actions, gaps and risk rating.

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)089

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	7th June 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	**Executive Report - 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 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 – May 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
    - Integrated Care Partnerships of North and North East Lincolnshire
    - HNY Cancer Alliance and associated professional networks

- 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 **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) • Formal Clinical Senate review complete – formal report due end May 22 • Revised Draft PCBC issued end May 22 • Final version due end June 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 • 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	• 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	• 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 Community Diagnostic Hub programme implementation • Potential further COVID wave 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
- 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 and U&EC Network 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 **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

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	7 June 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 – 5 May 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 5 May 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:	7 June 2022
Report From:	Health Tree Foundation Trustees' Committee held on 5 May 2022

Highlight Report:

Approval of Wishes

- The Trustees considered two 'Wishes' from NLAG staff members. After reading the written submissions; listening to presentations from those requesting the items; asking questions of the 'Wish' originators and debating the merits of the requests, both 'Wishes' were approved. Trustees noted that in each case, some of the required information was omitted and asked that the gaps be satisfactorily closed before further action is taken and that future 'Wish' submissions are complete prior to committee presentation. The 'Wishes' were:

  a. Portable Ventilator for the MRI at SGH
  b. A Siemens Innovision – MRI Ambient Experience for SGH

Financial Plans

- The Trustees received an annual update report from CCLA, the HTF Charity Investment Managers. The outcome was that despite a difficult final quarter to FY 2021/22, the annual return exceeded the peer group and was in line with the benchmark. It was noted that the long-term relative performance of the HTF portfolio remains strong with no requirement to alter current focus.
- Trustees noted that the fund balances at end FY 2021/22 had increased rather than decreased in line with plans. It was agreed that effort must be re-doubled to enhance the rate of spending over the coming years and to pay particular attention to each monthly finance report to ensure that appropriate action is taken to ensure spend trajectory is maintained.
- Trustees approved a revised income and expenditure budget for the next three financial years starting with the current one, the twin aims being to generate more income with concomitant spend.

Quality Improvement

- Trustees asked the Charity Manager to work with the QI Lead to develop 'Wishes' that would support the QI theme and to publicise how HTF could support QI.

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

NLG(22)091

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	7 June 2022	
Director Lead	Sean Lyons, Chair	
Contact Officer/Author	Sean Lyons, Chair	
Title of the Report	**Humber Acute Services Development Committee Highlight Report & Board Challenge**	
Purpose of the Report and Executive Summary (to include recommendations)	The report presents the highlights from the meeting held on 20 April 2022	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ 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

Report to the Board in Public

Humber Acute Services Development Committee held on 20 April 2022

Item: Director Overview Report P2 Update	Level of assurance gained: Substantial
Work was ongoing regarding the programme and changes to clinical models and the economic and social impact of moving services was being reviewed. Statutory reviews such as Ockenden was being included in the planning process. A number of briefings had taken place with the Local Authority private cabinet, MPs and Overview and Scrutiny Committees. Engagement work with the Primary Care Networks was positive and clinical leaders were working collaboratively with the teams. Following a Gateway review in July and sign off my DHSC and NHS E/I, the consultation was planned for September 2022.	
Item: P3 Capital Update	Level of assurance gained: Substantial
The Committee received a presentation that highlighted the capital investment objectives and their evaluations. The options ranged from 'business as usual' to 'do maximum' and what each of these options meant. The option chosen will depend on the amount of funding the Trusts get. Every scenario was being explored and strategic business cases developed.	
Item: Integrated Care Programme Update	Level of assurance gained: Reasonable
Resourcing and the future of the digital clinical admin of the ICP was discussed. Concerns were raised regarding programme slippage, clinical engagement, what was expected of the leadership roles and how the Joint Development Board was progressing. It was agreed that the leadership model for the ICP was discussed at the Joint Development Board and an update presented to the HASDEC in June 2022.	

NLG(22)092

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7 June 2022	
Director Lead	Linda Jackson, Vice Chair	
Contact Officer/Author	As above	
Title of the Report	**Strategic Development Committee Highlight Report & Board Challenge**	
Purpose of the Report and Executive Summary (to include recommendations)	Highlights of the Strategic Development Committees held on 18 May 2022	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ 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.

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7th June 2022
Report From:	Strategic Development Committee – 18th May 2022

Highlight Report:

Strategic Framework 2019-2024 Review of Priorities– The committee reviewed and supported the priorities detailed in the report presented and the amended approach. It was noted that the launch of this refresh would take place July /August 2022.

ICS Update –The committee noted the concern from several members about the collaborative of acute providers and the community collaborative working in two separate silos. Efforts are being made influence and address this as greater partnership working is required specifically around the UEC work which will need to be addressed at place. The Committee were informed that the Director for the CAP was moving on and a recruitment process was underway to fill this role.

HASR Programme 2 – The committee received a comprehensive update on progress**.** The clinical senate feedback recommended further focus in 5 areas: Ockendon impact and workforce safety models, UEC pathways, workforce profiles, digital interoperability and displacement impact. The programme is still on track to commence consultation the second week of September and the next key step is the setting up of the JHOSC which will be chaired by Rob Walsh from North East Lincolnshire.

HASR Programme 3 – The earliest anticipated announcement regarding our capital bid is still July. The committee reviewed the risks associated with the options of full funding, partial funding and the do minimum option. The risks identified that need addressing as we move forward are deliverability – workforce, Ockendon, if we do not get on the NHP shortlist, out of hospital programmes at various stages of development, risk of political/other challenge.

Strategic Digital Update - The committee were briefed on the setting up of the Humber acute digital service which is currently focusing on reorganizing the two acute trust teams, consolidating the joint work programme and agreeing the 6 key priorities. The committee were informed there was concern surrounding an EPR supplier changing it's strategic direction which will have an impact across the Humber which is currently being worked through.

Strategic Capital Update – The committee took receipt of a paper which covered the achievements in 2021/22 and the work plan for 2022/23. The committee noted the excellent work undertaken in the last year by the teams and requested future reports capture the benefits realization being achieved by each scheme.

Confirm or Challenge of the Board Assurance Framework:

The BAF strategic risks 1.3, 3.2 and 4 were reviewed. The committee commended the detailed work that had been put into the narrative and were satisfied that the BAF reflected the strategic risks facing the organization. The committee requested that the scoring of strategic risk 3.2 was reviewed for the next iteration of the report.

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.

Linda Jackson
Vice Chair / Chair of Strategic Development Committee

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	7 June 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 – April 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 21 April 2022: 1. **Going Concern Report 2021/22** – The Committee endorsed the view that the Trust is a going concern for the 2021/22 annual accounts process. **For Board to Note.** 2. **Draft Annual Accounts 2021/22** – Approved for submission to NHSE/I and the External Auditor. **For Board to note.** 3. **Draft Annual Governance Statement (AGS) 2021/22** – Board to consider whether workforce challenges are sufficiently explicit in the BAF and Strategic Risk Register to ensure consistency with the AGS. **For Board to consider.** 4. **Draft Head of Internal Audit (HoIA) Opinion 2021/22** – Overall draft opinion is 'Significant Assurance', however Executive support is needed to reduce the number of overdue recommendations prior to the final HoIA Opinion due in June 2022. **For Board to note.** 5. **Internal Audit Progress Report** – Positive Internal Audit review of the BAF, however Board to reflect on divergence of views between the Executive team and the Non-Executive Directors as to whether the BAF delivered its intended aims. **For Board to consider.** 6. **Annual Health and Safety Policy Statement** – Approved for submission to the Board. **For Board to note.** 7. **Salary Overpayments Report** – Significant reduction in Q4, and overall improved annual figure, however timely submission of pay impacting paperwork remains problematic. **For Board to note.** 8. **Declarations of Interest** – Executive Directors to be asked for a push on completion of declarations in their areas, particularly in respect of Decision Making Staff. **For Board to note.**

	9. Internal Audit Tender Outcome – The Committee approved awarding a three year contract (with the option of a one year extension) to Audit Yorkshire. **For Board to note.**	
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 21 April 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:	7 June 2022
Report From:	Audit, Risk & Governance Committee – 21 April 2022

Highlight Report:

1. **Going Concern Report 2021/22** – Following discussion, and with no objections from the External Auditor, the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise for 2021/22.

2. **Draft Annual Accounts 2021/22** – Received by the Committee, with key points highlighted in writing by the Assistant Director of Finance – Planning and Control. Approved for submission to NHSE/I and the External Auditor (Mazars). The Committee commended both the quality of the financial statements and the speed of their production, noting it to be an extraordinary achievement by the Finance team.

3. **Draft Annual Governance Statement (AGS) 2021/22** – The Committee considered that the Board should reflect on whether workforce challenges, in terms of recruitment and retention, were sufficiently explicit in the BAF and Strategic Risk Register to ensure consistency with the AGS.

4. **Draft Head of Internal Audit (HoIA) Opinion 2021/22** – The overall draft opinion is one of 'Significant Assurance'. The Committee noted the less positive aspect in relation to the number of overdue Internal Audit recommendations – 31% of 137 live recommendations during 2021/22. The Chair of the Committee proposed writing to all Executive Directors immediately to ask for their support in reducing this number with a view to showing an improved position for the final version of the HoIA Opinion due in June 2022.

5. **Internal Audit Progress Report** – The Committee were pleased to note the number of Internal Audit reviews resulting in a 'Significant Assurance' rating, concluding that basic controls are generally sound but recognising that there is work to do in ensuring agreed management actions resulting from reviews are implemented (see also point 4). The Committee noted the positive review of the BAF, but also discussed the divergence of views between the Executive team, who hold a more positive view, and the Non-Executive Directors, whose view is less favourable as to whether it delivered its intended aims.

6. **Annual Health and Safety Policy Statement** – Received and approved for submission to the Board.

7. **Salary Overpayments Report** – Despite a significant reduction in Q4, and an overall improved annual figure on the previous year, there remains an issue with managers failing to submit timely paperwork in relation to pay impacting changes. Work will continue to address this issue. The Committee also noted the impact of pay incentives, etc. introduced at speed which created additional pressure on the Payroll team.

8. **Declarations of Interest** – The latest position on declarations of interest made by staff was reviewed, and the Committee agreed that it would ask Executive Directors for a push on completion in their areas, particularly in respect of Decision Making Staff (as outlined in the Standards of Business Conduct Policy).

9. **Internal Audit Tender Outcome** – The Internal Audit tender evaluation panel made a recommendation to the full meeting of the Committee to award a three year contract (with the option of a one year extension) to **Audit Yorkshire** (incumbents) based on the outcome of the recent procurement exercise. The Committee considered the recommendation and formally approved it. The three bidders were notified of the outcome on 22.4.22 and the new contract will commence on 1 June 2022.

Confirm or Challenge of the Board Assurance Framework:

Q4 BAF not available for this meeting. To be presented at the June 2022 ARG Committee meeting.

Action Required by the Trust Board:

The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed.

Simon Parkes
Non-Executive Director / Chair of Audit, Risk & Governance Committee

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2021 / 22

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 - 2021 / 22

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)	

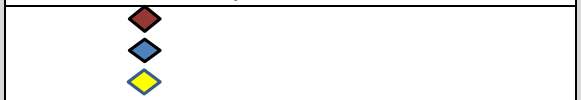
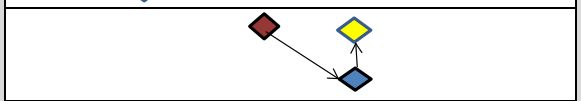
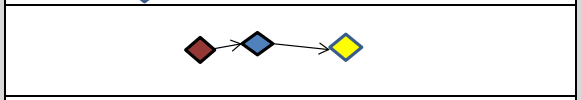
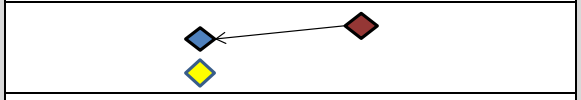
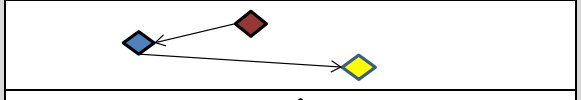
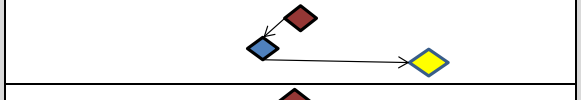
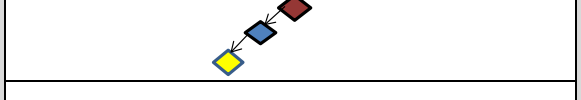
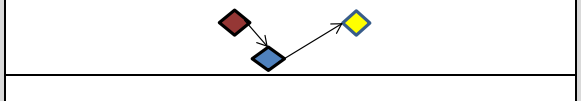
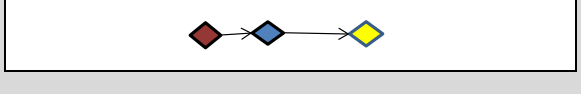
Based on this scoring methodology broadly the Trust's risk appetite is:

• 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 / Impact Assessment	Risk Appetite	Risk Rating 2021-22 Q1	Q2	Q3	Q4	Target Risk 31.03.22	Owner	Assurance Committee
		Catastrophic: 25 / Major: 20, 18, 16, 15 / Moderate: 12, 10, 9, 8 / Minor: 6, 5, 4 / Insignificant: 3, 2, 1								
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		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		20	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	12	12		8	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	12	12	12		9	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		16	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	20	20		8	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	12	12	12		5	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		Moderate	12	12	12		15	Director of Strategic Development	SDC
SO4	The risk that the Trust is not a good partner and collaborator		Moderate	12	12	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	12	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:
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 Register Confirm and Challenge Risk Management Group
- Trust Management Board
- Ethics Committee
- 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

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- 15 Steps Challenge 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
- Patient Safety Specialist and Patient Safety Champions Group
- 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

Q2 2021/22
- Continue to establish a vulnerabilities team (Learning Disabilities team) by Aug 2021 - COMPLETED

Q3 2021/22 - actions completed

Q4 2021/22
- Implementation of End of Life Strategy
- Risk stratification report with trajectories and continued oversight through Operational Management Group - COMPLETED
- Continue to add metrics as data quality allows
- Implement supportive observation
- Develop a NLAG Patient Safety Incident Response Plan by Spring 2022
- CMIO to implement results acknowledgement - COMPLETED
- 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 HASR 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
- Progress with the End of Life Strategy
- Ophthalmology Waiting List
- Delays with results acknowledgement
- Delivery of Oncology Service (further information to be provided at the Q&SC meeting in February 2022, by the Chief Operating Officer)
- Workforce sickness and vacancies (further information to be provided at the ~~Q&SC~~ WC meeting in ~~February~~ March 2022, by the Director of People)

Gaps in Assurance

- Mandatory training
- Cancer Service (further information to be provided at the Q&SC meeting in February 2022, by the Chief Operating Officer)
- 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:

Divisional / Departmental Risks Scoring >15:
- Inability to segregate patients in ED due to lack of isolation facilities (2695) - Risk Rating 12
- Risk to overall cancer performance - Clinical Support Services (2244) - Risk Rating 16 (previous risk rating 16)
- Deteriorating patient risks - Medicine (2388) - Risk Rating 15, Surgery (2347) - Risk Rating 15, Paediatrics (2390) - Risk Rating 4 (previous risk rating 8, before that 15)

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)

(27 Moderate Risks and 10 Low Risks linked to quality and safety; previously 28 Moderate and 5

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:
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
- Emergency Department (ED) Performance and Ambulance Handover Group
- Planned Care Board
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group

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.
- 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
- Continued development and implementation of risk stratification for RTT incomplete and completed pathways (COMPLETE)
- 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
- Continued development and usage of independent sector through H2 (COMPLETE)
- 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
- Implementation of robust tracking for patients risk stratified as high risk, escalation processes to notify patients not treated within risk timeframe (COMPLETE)

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
- Opening of new ED build at DPoW
- Implementation phase 3 of AAU business case
- Implementation of the UCS Model (funding based on Business Case agreement)
- 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

Q3 2022-23
- Diagnostic breach tracker tool
- 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

- COVID-19 third surge and impact on patient experience
- 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

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

Gaps in Assurance

- QSIS Standards improvement plans.
- Demand and Capacity planning for Diagnostics.
- RTT and DM01 not meeting national targets.
- 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:
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 2021/22.
- Humber and North Yorkshire Coast and Vale Health Care Partnership (HNY HCV 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 (HASR).
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership Council of Members.
- 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 HASR, JDB, CiC, SDC
- Humber and North Yorkshire Coast and Vale 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
- Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case (end May 22)

Q1 2022/23
- Draft report from Clinical Senate review (end May 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 and Covid-19 recovery 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 HASR 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.
- HASR 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

Lead Committee: Finance and Performance Committee

Last Reviewed: 12 April 2022 / 11 January 2022

Risk Owner: Director of Estates and Facilities

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

Current Controls

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

Assurance (internal & external)

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

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director 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

Q4 2021/22
- Estates and Facilities equipment plan produced and implemented as part of the 21/22 core capital annual funding (this may be reprioritised as no current contingency) - Action date; end of financial year 21/22 - COMPLETED
- The Decarbonisation Funding (£10.1M) project across all three sites, the Core Capital Programme, the Transformational Capital Schemes and the BLM Schemes were all was delivered by 31 March 2022 - COMPLETED

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
- Timeline to deliver the decarbonisation projects

Gaps in Assurance

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

Links to High Level Risks Register

There are approximately 22 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 Acute 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	12 9	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
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 June 2022 (extended from 30 April 2022)
- Digital Reporting schedule/Work plan for Board Committees completed as of the 4th Qtr 21/22

Q4 2021/22
- The Data Warehouse options appraisal to be 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
- There are eight assertions on the DSPT Improvement plan with the end date of the 31st December. In Dec. NHS Digital announced that due to the increasing impact of COVID-19 and Log4J, organisations were no longer required to submit updated improvement plans by the 31 December 2021. No new deadline was set. Organisations can submit completed plans should they wish

Of the 8 actions identified on the 20/21 improvement plan NLaG have 2 outstanding:
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 March 2022

2. Attack Detection and Response
Cyber funding was awarded from NHS Digital in October 2021. Procurement is in progress for an 'Attack Detection and Response (ADR) for Healthcare'. Expected completion end of March 2022

Once the above two are completed, the Trust will share the completed Improvement Plan with NHS D and request that the publication status for 20/21 be changed to 'Standards Met'

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.
- Address the assertions without evidence in the DSPT
- 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 (target 4th qtr 21/22)

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) Low Risk (5)
- 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: 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

- 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)

Assurance (internal & external)

Internal:

- Regional EPRR scenarios and planning exercises in preparation for 'Brexit' have been undertaken alongside partners, including scenarios involving transportation, freight and traffic around local docks with resulting action plan
- Business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group

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)

Planned Actions

Q4 2021/22:

- Capacity to meet demand workforce)
- Mandatory Vaccinations of Staff - engagement and communication, Booster hubs (COMPLETE)
- 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.

Future Risks

- 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 does not progress (retirement of 1 of the 2 wte consultants in March 2022)
- Longer waiting times for patients 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

- 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
- Mandatory vaccinations of all staff by 31 March 2022 (as per Government requirement)

Gaps in Assurance

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)
- 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)

Future Opportunities

- 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: April 2022, March 2022

Lead Committee: Workforce Committee

Risk Owner: Director of People

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

Current Controls

- 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

Q3 2021/22
- Review of staff survey results March/April to inform overall plans for Culture Transformation Board
- 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

Q4 2021/22
- Plans to recruit 120 international nurses before end of December 2022 - funding secured to support
- Review of Recruitment Processess to ensure that they are streamlined, inclusive, responsive and timely - focus on medical recruitment
- Health and Wellbeing plan offer to be finalised and costed for implementation for 22/23
- Introduction of Just and Learning Culture Framework - subject to approval of disciplinary policy - subject to approval of disciplinary policy
- Review of staff survey results March/April to inform overall plans for Culture Transformation Board
- Introduction of Just and Learning Culture Framework to be introduced 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

Q1 2022/23

Q1 2022/23

Ongoing Actions
- Implementation of People Strategy by 31 March 2024.
- Delivery against NHS People Plan - ongoing.
- Investment in the People Directorate to develop plans for delivery against the NHS People Plan and NLAG People Strategy - this is now completed
- Continue collaboration between NLAG and HUTH and the HCV wider network.
- Implementation of new directorate structure and recruitment to vacant positions. This is almost complete

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
- A Culture and Engagement deep dive was recently conducted, the findings presented at an Executive Team time out, JNCC, Workforce Committee, and now being socialised more broadly for widening participation from all staff groups

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	1	1	4	4
Risk Rating	10	5	5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 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 Review (HASR) engagement to redesign fragile and vulnerable service pathways at system and sub system level.
- Monthly ICS Finance Meetings
- Finance Meeting - HASR
- 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 - ACTIONS COMPLETED - Financial targets met at year end. Financial Accounts prepared and now undergoing External Audit
- Develop financial (incl comprehensive CIP plan) and service plan for 22/23 - target by end of Feb 2022
- Secure approval for Acute Assessment Unit Full Business Case January 2022
- Secure agreement of income to cover forecasted costs and containing costs to within forecasted levels.
- Undertake financial planning as part of HCV ICS 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
- ~~Agree financial implications of P1 completed specialties for transacting in qtr 4 21/22~~

2022/33
- Likely receipt of three year income and expenditure allocations and therefore need to develop plans for 2022-25 to commence planned publication of year two and three allocations
- 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 third further surges and impact on finance and CIP achievement
- National policy changes
- Impact of HASR 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:
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	Assurance (internal & external)	Planned Actions	Future Risks
• 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	**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	**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	• 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	**Gaps in Assurance**	**Links to High Level Risks Register**	**Future Opportunities**
• 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	• 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	• AAU / ED Business Case approval not yet received • Salix funding gap • HASR Capital EOI risk of not being part of Top 30 and subsequent 8	• 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: 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 CV HCP.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HASR and HASR 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

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 (interviews Feb 2022) (complete and in post)

Q4 2021/22
- HAS two year programme (current to March 2023 2022) - 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.
- Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case.

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.
- Local Authority Chief Executives.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Hosting of HAS clinical services to support planning.
- 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 CV 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		
Likelihood	4	3	2		
Risk Rating	16	12	8		

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment:
1 May 2019

Last Reviewed:
6 April 2022
March 2022

Lead Committees:
Workforce Committee and Trust Board

Risk Owner:
Chief Executive

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

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS.
- CQC and NHSE/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

Q3 2021/22
- Continued contribution to the Trust Priorities quarterly report, by Q2 2021 and supporting People Plan which outlines plans to scope out a Leadership Development Programme for leaders at all levels by December 2021.
- A Trust-wide Leadership Deep Dive is scheduled for review with the Executive Team and Workforce Committee in November/December 2021, to set out an integrated programme of leadership development pathways and activities supporting the Culture and Engagement Transformation Programme and feeding in to our aims for talent identification and succession development. The scope includes a range of initiatives addressing: establishing more effective line manager skills in leading people for existing line managers (building on the work of the HRBPs)

Q4 2021/22
- Compliance and performance improvement to be monitored at PRIMS by 31 March 2022
- Leadership Development Framework to be completed - Delivery plan to be developed to support the roll out of the Leadership Strategy from April 2022 - scoped and costed - to be submitted to Board in April
- Implementation of the Culture Transformation Board to oversee delivery of Leadership strategy
- Development of Performance metrics to support delivery of Leadership strategy

Q1 2022/23
- Introduce a leadership and career development portfolio governance board in 2022 with representation from all stakeholder staff groups, whose purpose is to ensure any and all 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
- Providing further knowledge and skills 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 Trust's strategic objectives;
- Continued quality/financial special measures status;
- CQC well-led domain of 'inadequate'.
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives;
- Failure to obtain support for key changes needed to ensure improvement or sustainability;
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.

Gaps in Controls

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

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

NLG(22)094

<table>
<tr><td>Name of the Meeting</td><td>Trust Board of Directors – Public</td></tr>
<tr><td>Date of the Meeting</td><td>7 June 2022</td></tr>
<tr><td>Director Lead</td><td>Helen Harris, Director of Corporate Governance</td></tr>
<tr><td>Contact Officer/Author</td><td>Alison Hurley, Assistant Director of Corporate Governance</td></tr>
<tr><td>Title of the Report</td><td>Board Assurance Framework (BAF) 2021-22 Quarter Four</td></tr>
<tr><td>Purpose of the Report and Executive Summary (to include recommendations)</td><td>The Trust Board is asked to:

a) to review the strategic risks which remain at 15 and above as of quarter four, and consider whether any actions are required (as per the table below);

<table>
<tr><th>Strategic Objective</th><th>Current Risk at Quarter 4 position</th><th>Target Risk by 31 March 2022</th></tr>
<tr><td>SO1-1.1</td><td>15</td><td>15</td></tr>
<tr><td>SO1-1.2</td><td>20</td><td>20</td></tr>
<tr><td>SO1-1.3</td><td>12</td><td>8</td></tr>
<tr><td>SO1-1.4</td><td>20</td><td>20</td></tr>
<tr><td>SO1-1.5</td><td>9</td><td>9</td></tr>
<tr><td>SO1-1.6</td><td>16</td><td>16</td></tr>
<tr><td>SO2</td><td>20</td><td>8</td></tr>
<tr><td>SO3-3.1</td><td>5</td><td>5</td></tr>
<tr><td>SO3-1.2</td><td>12</td><td>15</td></tr>
<tr><td>SO4</td><td>12</td><td>8</td></tr>
<tr><td>SO5</td><td>8</td><td>8</td></tr>
</table>

b) receive for assurance the Board Assurance Framework (as at Appendix A) which details the progress against the delivery of the Trust's strategic objectives;

c) note the above sub-Committees have considered the Board Assurance Framework at their meetings;

d) note the report below, the controls, assurances, planned actions and underpinning high level risks associated with each strategic risk.</td></tr>
<tr><td>Background Information and/or Supporting Document(s) (if applicable)</td><td>N/A</td></tr>
<tr><td>Prior Approval Process</td><td>✓ Strategic Development Committee – 18.05.2022
✓ Quality & Safety Committee – 24.05.2022
✓ Finance & Performance Committee – 25.05.2022
✓ Workforce Committee – 31.05.2022
☐ Other: Click here to enter text.</td></tr>
</table>

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

Board Assurance Framework (BAF)
Quarter 4 Review (1 January – 31 March 2022)

1. Purpose of the Report

1.1 To present the quarter four BAF to the Trust Board. The BAF triangulates relevant information on the risks to the delivery of the board's Strategic Objectives, highlighting risks, controls and assurances. It is an essential tool to support the Board in seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Trust Board can have confidence that they are undertaking thorough oversight of strategic risk. The BAF is utilised to support the Board in receiving confidence about the likely achievement of each of its Strategic Objectives.

1.2 The Trust Board Sub-Committees are responsible for reviewing the relevant objectives and risks and providing assurance to the Trust Board on progress.

1.3 The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack of, assurance during the year as to what extent the level of risk is being managed.

1.4 The Trust has in place a 'ward to Board' process for risk management, which allows for the BAF to include reference to relevant risks from the High Level Register where they may impact on the achievement of the Trust's strategic goals.

2. Background

2.1 Following the Trust Board meeting on 7th December 2021 the following actions were agreed and have been completed:

- Add annual targets to the risk scores for each strategic risk;
- To review and consider additional sub-categories for Strategic Objective 2. Following a meeting with the Chief Nurse, Director of People and Director of Corporate Governance it was agreed to move the safe staffing element from Strategic Objective SO2 to SO1-1.1.

2.2 Further developments include the separation of planned actions on a quarterly basis for each Strategic Objective. This is to provide an easy reference against required actions at set timescales**.**

2.3 All strategic risks have been reviewed by their associated Board Sub-Committee with the exception of the Audit, Risk and Governance Committee who are due to meet on 10th June 2022.

2.4 Please note that the blue text in the updated BAF signifies updated information and red illustrates text to be deleted once this has been reviewed and approved at the Trust Board.

3. Summary of Current Risk Ratings by Strategic Objective Risk

3.1 The full BAF is available at Appendix A, and the Strategic Objectives are detailed below with the current risk ratings for quarter four:

4. Strategic Objectives – Current and Target Risk Ratings

4.1 The table below demonstrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2022:

Strategic Objective	Current Risk at Quarter 4 position	Target Risk by 31 March 2022
SO1-1.1	15	15
SO1-1.2	20	20
SO1-1.3	12	8
SO1-1.4	20	20
SO1-1.5	9	9
SO1-1.6	16	16
SO2	20	8
SO3-3.1	5	5
SO3-1.2	12	15
SO4	12	8
SO5	8	8

4.2 The Risk Ratings for each Strategic Objective have been reviewed and the Trust Board are required to note that several strategic risks remain at a high level of 15 and above, as detailed in the table above.

5. Recommendations

The Trust Board is asked to:

a) review the strategic risks which remain at 15 and above as of quarter three, and consider whether any additional actions are required (as per section 3.1);

b) receive the complete BAF (at Appendix A) which details the progress against the delivery of the Trust's Strategic Objectives;

c) note the above Sub-Committees have considered the BAF at their meetings;

d) note the detailed report, the controls, assurances, planned actions and the underpinning high-level risks associated with each strategic risk.

NLG(22)095

Name of the Meeting	**Trust Board**	
Date of the Meeting	Tuesday 7th June 2022	
Director Lead	Jug Johal – Director of Estates & Facilities	
Contact Officer/Author	Bill Parkinson – Associate Director of Safety & Statutory Compliance	
Title of the Report	**Annual Health & Safety Policy Statement**	
Purpose of the Report and Executive Summary (to include recommendations)	Annual update of public health & policy statement for Trust for approval	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Audit, Risk & Governance 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)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates & Facilities

HEALTH & SAFETY AT WORK POLICY STATEMENT

Reference:	DCM081
Version:	
This version issued:	
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	
Owner:	Jug Johal, Director of Estates & Facilities
Document type:	Miscellaneous
Number of pages:	4 (including front sheet)
Author / Contact:	Bill Parkinson, Head of Safety & Statutory Compliance

HEALTH AND SAFETY AT WORK POLICY STATEMENT

Northern Lincolnshire & Goole NHS Foundation Trust recognises its health and safety duties under the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations 1999 (as amended) and Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

In keeping with the Trust's Strategic Plan the transformation of the services and it's sites the Trust is committed to the health and wellbeing of employees, contractors, patients and other members of the public. This will be achieved by providing a working environment, appropriate controls and suitable training which satisfy the health and safety standards set out in regulations, practices and procedures, codes of practice, contracts and specific Northern Lincolnshire & Goole NHS Foundation Trust policies.

During this period of transformation there is likely to be some disruption in relation to some services, traffic and patient flows and car parking arrangements until the works are completed. The Trust will look to keep these disruptions to a minimum and will not be to the detriment of the health and wellbeing of anyone. Regular updates on progress and forewarning of any temporary changes will be issued at the earliest opportunity to give suitable advance notice to service users and staff alike. However, it is recognized that there may be changes which may occur at short notice and service users and staff are asked to accept these as part of the overall move towards the Trust objectives. As these projects near completion further risk assessments will be undertaken to identify any residual risks and mitigating actions that may be present going forward.

This Health & Safety Policy Statement outlines the Trust's commitment and approach to the management of health & safety and does not provide the detail on the management of specific health & safety risk topics. Policies and procedures covering the assessment and control of specific health & safety risks (e.g. Occupational Road Risk, Lone Working, Violence & Aggression etc) are in place. These documents are maintained within a central document control system, which ensures that a consistent approach is adopted, that suitable consultation and approvals processes are in place and that documents are regularly reviewed and updated, and are made available to staff as appropriate.

Whilst the Chief Executive is ultimately responsible for the implementation of effective health and safety arrangements, as outlined in the Trust's Risk Management Strategy, the Director of Estates & Facilities has delegated responsibility from the Chief Executive for all elements of in relation to health & safety (whilst accepting that the Medical Director and Chief Nurse have delegated operational responsibilities within their areas). The Deputy Director of Estates & Facilities in turn has responsibility for the central co-ordination of these arrangements, with the day to day management of health & safety management at local level being devolved to Directorates.

The Trust Board and Directors/Managers therefore collectively and individually accept their duties and responsibilities arising from the Health and Safety at Work etc Act 1974.

The Trust recognises that a proactive approach to the management of health & safety risks is considered an essential element in a good safety management system. As part of its approach, the Trust has in place a system of formal and informal inspections, visits and audit processes which include Directors and Governors. Where appropriate, the Trust also sources external verification of its health & safety management arrangements.

In complying with its duties to its employees as outlined in the Health and Safety at Work etc Act 1974 and the Management of Health and Safety Regulations 1999 (as amended) the Trust is committed to:

- Introducing, developing and maintaining safe systems of work which employees and others working for the Trust are expected to follow and also to reviewing and improving existing systems to further raise standards
- Increasing the knowledge and skill base of its employees in relation to health and safety, ensuring that staff are competent to identify, assess and manage health and safety risks within their working environment
- Supporting Directorate/Division forums to ensure active involvement in health & safety matters and performance
- Using internal data acquired from reactive sources (e.g. incident reports) as well as proactive systems (e.g. inspections, site visits and audits) together with information from managers and staff and external sources (e.g. legislation updates, etc) to allow the Trust to review the robustness of its safety management system and afford the opportunity to benchmark its performance against other Trusts
- Setting both annual and longer-term strategic objectives as part of the business planning process in order to further develop and improve health and safety arrangements/standards
- Maintaining a robust incident/accident reporting system, which facilitates learning lessons through corrective action and re-audit and the identification of the underlying or root causes of failures identified
- Ensuring that equipment is purchased to required specifications, meets all statutory requirements and that staff using equipment have received adequate instruction and training and importantly that inspection and maintenance occur as required
- Maintaining a comprehensive Trust-wide Risk Register and Central Risk Assessment System which includes specific health and safety risks and which are used to assist in the setting of priorities and the allocation of resources as well as in the development of health and safety planning
- Developing a positive safety culture throughout the organisation through our vision and values and strategic objectives
- Implementing a strategy to promote and improve the mental health and wellbeing of staff within the Trust
- The provision of health surveillance for its employees where appropriate
- The appointment of competent personnel to support and advise staff in all areas of health and safety
- The development of a safety management system to a recognised certified standard

In accordance with statutory provisions the Trust will ensure that adequate resources are allocated to achieve the above commitments.

In addition to the responsibilities of the Trust as an employer, all employees and other persons working for the Trust, e.g. volunteers and contractors, are expected to participate and co-operate with the systems of work implemented in order for the Trust to discharge its statutory duties. This also involves taking reasonable care of themselves and others who may be affected by their actions (or omissions), including the safe and appropriate use of equipment (including safety equipment) and reporting any safety issues appropriately.

The Trust Board, both directly and through its designated sub-committees will monitor performance against agreed health & safety objectives with any issues escalated where required.

Formal monitoring of the Trust's Safety Management System is undertaken through a variety of measures as mentioned above. A formal audit plan is also in place and outcomes are reported to and are monitored by the Trust Health, Safety & Fire Group and, as required, the Audit, Risk & Governance Committee and Trust Board.

This Health and Safety Policy Statement will be reviewed annually, or sooner should the need arise.

Peter Reading	**Jug Johal**
Chief Executive	**Director of Estates & Facilities**
Version: 11.8	**Reviewed & Re-issued**

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

NLG(22)096

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7 June 2022	
Director Lead	Gill Ponder, NED / Chair of Finance & Performance Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Finance & Performance Committee – Minutes of the meetings held on 18 February and 23 March 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Finance & Performance Committee Meetings held on 18 February and 23 March 2022 and approved on 23 March and 20 April 2022 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	☐ 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.

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **18 February 2022 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Fiona Osborne	Associate Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Lee Bond	Chief Financial Officer
	Shaun Stacey	Chief Operating Officer
	Simon Tighe	Deputy Director of Estates & Facilities
	Ian Reekie	Lead Governor
	Chris Evans	Associate Director of Information & Systems
IN ATTENDANCE:	Jennifer Moverley	Head of Compliance and Assurance (For item 6.1)
	Denise Gale	Associate Director of Cancer (For item 7.5)
	Ashy Shanker	Associate Director of Planning and Operational Performance (For item 7.6)
	Helen Harris	Director of Corporate Services (For item 11.1)
	Anne Sprason	Finance Admin Manager/PA to CFO (Minutes)

Item 1 02/22 Apologies for absence were noted from: Jug Johal (Deputy Simon Tighe); Shauna McMahon (Deputy Chris Evans); Peter Reading; and Brian Shipley

Item 2 02/22 **Quoracy**

Gill Ponder noted there were sufficient Executive Directors and Non-Executive Directors in attendance to ensure quoracy.

Item 3 02/22 **Declarations of Interest**

Gill Ponder advised that she had not received any declarations of interest prior to the meeting. There were no new declarations of interest made.

Item 4 02/22 **To approve the minutes from the previous meeting held on 22 December 2021**

The minutes from the meeting held on 22 December 2021 were reviewed and agreed as an accurate record.

Item 5 02/22 **Matters Arising**

All actions from the minutes were included either on the agenda or the action log.

5.1 Action Log

The action log was reviewed.

7 (25 08 21) – Benchmarking of ED – The work had been completed but would be revisited to bring up to date, and hopefully also include maternity information; this would be presented at the next F&P meeting in March. **Action:** Lee Bond

7.1 (24 11 21) – BAF Deep Dive – Plan B included within the Estates Strategy. Included on the agenda. **Item Closed**.

7.1 (24 11 21) – BAF Deep Dive – Summary of the issues causing overall risk score of 20. Included on the agenda and part of Business Planning with corporate and clinical areas with requests for capital works.

7.2 (24 11 21) – Civils Infrastructure – This would be picked up as part of capital planning. Discussions ongoing with the ICS on how allocations would be split. Risk based lists requested which would include Fire Alarms and Oxygen as priorities.

6 (24 11 21) – Finance Report – Covid Expenditure – Ongoing work with Chief Nurse Directorate to finalise budgets, including Covid allocations. To be presented to the next F&P meeting in March. **Action:** Lee Bond

5.3 (22 12 22) – Action plan from self-assessment – Added to the Highlight report for Trust Board on 1 February. No issues raised therefore **item closed**.

8.3 (22 12 22) – Correlation between digital letters and increase in DNA. The provisional feedback had been no direct correlation, but the data needed to be triangulated. Shaun Stacey to include in the OPD report due at the next meeting. **Action**: Shaun Stacey

8.4 (22 12 22) – Non-face to face appointments – Shaun Stacey understood the results of the survey had been shared with Divisions through business meetings. To be included in next month's Transformation Report. **Action:** Shaun Stacey

Following review, the Action Log was noted.

5.2 F&P Workplan V4

Gill Ponder advised that further changes would be made to reflect discussions she had had with Simon Parkes and Ivan McConnell on the demarcation of items to particular committees, i.e. SDC for blue sky thinking; F&P for managing delivery of plan and services to patients; ARG for Cyber Security.

Item 6 02/22 **Presentations for Assurance**

6.1 CQC Progress Report

Jennifer Moverley presented the report and highlighted the changes since the last report including one action moved from red to amber which was Surgery mandatory training; five actions moved from amber to green; three actions moved from green to blue. Six actions had been submitted to the CQC including one position paper on diagnostics waiting lists.

There were 27 actions aligned to the F&P Committee i.e. eight amber; two green; and 15 blue plus two either retired or on hold.

Gill Ponder referred to the summary and the risks to delivery of CQC improvement plans and identification of recurrent funding for the financial cost of implementation for some funded actions and suggested that as these were "one-offs" they would be picked up as part of business planning process. Shaun Stacey agreed but whilst the priorities for the Divisions linked to the CQC ongoing commitments were known, until the business planning process had been finalised it was unclear what funding would be available.

Fiona Osborne queried the waiting lists that were still at amber and acknowledged the significant amount of work on-going and the objectives to reduce the waiting lists but, given the reliance on third party organisations to help reduce the lists, asked how confident Shaun Stacey was of getting to green in a reasonable timescale. Shaun Stacey was confident in the continued progress noting the loss of traction of 52ww due to sickness. Shaun Stacey highlighted a piece of work being undertaken at regional and national level on long waiters and the potential impact on NLAG in supporting ICS level on 104ww, therefore would not want to move to green or blue given the potential for a natural increase in waiting lists.

Maneesh Singh asked how NLAG could control their waiting lists and who would be accountable for the ICS waiting lists. Shaun Stacey explained that the ICS had no formal legal powers until July therefore it was being delivered by the regional team and accountability would sit with the individual organisations. The biggest challenge would be managing the populations' expectations.

Lee Bond added that the Trust would continue to have statutory obligations as would ICS once formally in place so almost joint accountability. The result would be an inability to prioritise the Trust's patients as they would become part of the system discussions. The Trust's waiting list position was one of the best, but this would probably deteriorate given the levelling up process required.

Maneesh Singh asked that if the Trust were doing well, would the Trust get penalised for doing well when funds were allocated. Lee Bond advised that more work was being undertaken but he expected to have a greater share of the income if more work was being carried out to recover waiting lists.

There were no further questions raised and Jennifer Moverley left the meeting.

Item 7 02/22 Review of Monthly Performance and Activity Delivery (IPR)

7.1 Unplanned Care

Shaun Stacey presented the report and highlighted issues to note.

- Continued pressures with emergency care and moving patients through the system which were reflected in the overall performance of ED. Challenges with vacancies, skill mix and sickness compounded the difficulties with patient flow.
- Both 7- & 14-days LOS holding but seeing 11% of discharges greater than 21 days; approximately 55 patients at any one time above their agreed readiness to be discharged. That related to community capacity linked to staffing challenges.
- Ambulance handovers continued to be a challenge with a high number of ambulances waiting over 60 mins. The average time in the department was 8 ½ hrs.
- The urgent care service had gone live in DPOW on 18 January and saw similar improvements to those seen at SGH, leading to a small increase in performance. It had resulted in a better streamlined pathway of patients, achieving 99% of patients seen, managed and dealt with in 4 hours which was an excellent outcome and was being sustained. The service ran to 10.00pm in SGH and 8.00pm in DPOW, but with more funding could run a 24hr service with staffing levels phased appropriately.
- Work was being undertaken with family services on the acute assessment model and it was hoped that would lead to improvements in services for patients.
- Improvements were being seen with the introduction of EMAS direct streaming to same day emergency care and hot clinics at both sites. The hot clinics and assessment units were funded through winter monies which would end in March.
- 111 First continued to reduce the number of ambulance attends.

- Covid was still a significant problem in January, but some improvements were now being seen.

Lee Bond referred to the winter allocation and highlighted that it was unclear if money would be available from commissioners' perspective to invest in the next 12 months, particularly if only marginal improvements in ED performance were being made as stated in the report. Shaun Stacey stated that 99% performance in walk-ins was more than marginal given that prior to the new system it was 24%. The 4hr challenge was on majors and the flow in the community was affecting performance.

Shaun Stacey acknowledged the money element and stated that the urgent care model worked better and was worth investment.

Fiona Osborne noted there were 15 different targets that required process redesign to meet targets but was unsure from the information if process redesign had begun when the trajectory for completion was due. Shaun Stacey suggested adding to the deep dives on the workplan and including the position against plan, which would cover those questions. Fiona Osborne asked if they could be included within the IPR as headlines. It was noted that the urgent emergency care item was not due until July, but a shorter paper would be brought to the next meeting.

Action: Shaun Stacey.

7.2 Planned Care

Shaun Stacey explained that the level of waiting list was being held but there was a small risk with 52 weeks which may not hit the zero position by the end of March due to mutual aid which was affecting the figures. Secondly, the Trust had had eight weeks of high levels of absence in the theatre workforce which was also a risk to that target. Improvement continued in most specialties in waits below 40 weeks, except for ENT.

- Non-obstetric ultrasound had gone live, leading to an improvement in performance since November.
- There has been an improvement in Cardiology waits.
- Outpatients were above target for non-face to face appointments, but this was a risk as the increase in face to face appointments was being led by Consultants.
- Cancer continued to struggle to hit the 31 day and 62-day targets.
- Risk stratification of outpatients continued to improve at 89%.

Gill Ponder raised whether harm was being caused to patients waiting beyond target times and Shaun Stacey advised that harm reviews were being undertaken, but no concerning outcomes had been found from those.

Lee Bond queried theatre utilisation at SGH and Shaun Stacey explained the difficulties with Theatre A in terms of the air plant, which was on the overhaul schedule but that would impact on capacity to provide services. He explained that one solution was to have a temporary theatre to ensure continued activity, noting that all capacity plans were built without theatre A in place next year. Infection control was being managed but need HDU at SGH to be compliant; this would be added to the 3-5-year plan. Theatre efficiency at SGH was 89%; Grimsby 87% of available sessions; and Goole 92%. Theatre A was currently being used as a side room.

7.5 Monthly Deep Dive - Cancer

Denise Gale attended the meeting to present the report and highlighted the three elements of the cancer pathway and the constraints which resulted in the failure of the 28 day FDS, 38 day Inter Provider Transfers and failure of first treatment by Day 62. Denise explained that this was a major problem in all cancer pathways across all other alliances in the country. There was also a 4-6 week wait for oncology appointments, which also impacted on achievement of the performance standards.

Denise Gale highlighted the number of removals (page 9) due to "no cancer diagnosed" which took a significant amount of time and effort.

Lee Bond referred to the statement that PTL removal was the biggest significant thing that the Trust could do, noting the delays caused by diagnostic testing requests taking seven days and asked what HUTH could do, suggesting PET CT scans. Denise Gale explained that one of the reasons for delays was the paper-based system used by diagnostics; also, the national contract was based on working days and not calendar days therefore if a week was taken to decide to treat then another seven days were lost. Out of the 28 day pathway, it took HUTH 7 days to decide if it would accept the patient, a further 7 days to offer an appointment and another 7 days to carry out the test, leaving only 7 days remaining for results and treatment.

Chris Evans highlighted that discussions were being held with Radiology to remove paper-based processes and suggested he could speak with Denise outside of the meeting to discuss further.

Action: Chris Evans / Denise Gale

Fiona Osborne commented on an excellent report which was easy to follow with a clear summary. She referred to Breast 2ww/symptomatic that had been affected by increased 2ww referrals from outside the area (Appendix A) and asked how wide that area was and what was being done to address the issue. Denise Gale explained that it was predominantly Doncaster and ULH, with GPs on the borders sending to NLAG; noting that diagnosed patients were then opting to be treated by Doncaster / Lincoln. Discussions were being held between Humber Cancer Board and relevant CCGs to review how to reduce that impact, although there had also been an increase in the local area.

Shaun Stacey commented that the service was struggling and looking to the Humber Cancer Board to support the wider need, but it was unlikely to be resolved in the short term so was potentially a long-term challenge.

Denise Gale also highlighted the extra breast pain clinics from April which were being overseen by Jenny Smith and delivered by advanced nurse practitioners on both sites. Breast pain had a low conversion rate of 0.04%.

Gill Ponder noted in the paper reference to a shortage of bowel screening Endoscopists and Denise Gale explained the capacity issues due to Doctors retiring and returning and working one week in three; with one Dr retiring and returning to undertake only bowel screening which would help with patient flow, but succession planning was required.

There was also an issue with Drs who had undertaken a training programme but not yet passed which was causing difficulties at both NLAG and HUTH. Shaun Stacey explained an anomaly with bowel screening requiring separate training which was nationally run, which had standards that even experienced endoscopists were failing to achieve; this was being looked at nationally. The endoscopies that were being undertaken were under the JAG accreditation standard.

10.14am Following the update Denise Gale left the meeting.

7.6 Draft Operational Plan 2022/23

Ashy Shanker joined the meeting and gave a brief presentation which detailed the operational plan for 2022/23 and gave further details of future deadlines for the Trust.

Ashy Shanker highlighted the progress made within NLAG including the focus on the development of ambitious but also realistic plans with the Divisional and Corporate teams. A Marketplace Event had taken place on 27 January with Executive challenge and prioritisation meetings taking place in early March to ensure the plans aligned to Trust priorities for 2022/23. Recommendations would then be made to TMB in March.

Ashy Shanker explained that the expectation in the national guidance was the delivery of 110% elective activity against 2019 levels which was challenging for NLAG to achieve without a series of transformation programmes taking effect. Waiting time targets were also stringent however NLAG had been in a good position compared with partners in the ICS over the last few months, already achieving some of the those. Other areas included 120% target on diagnostics, 5% on Patient Initiated Follow-up, 16% on Advice and Guidance, 25% reduction in outpatient activity, no 104 week waits, reductions in 52 week waits, meeting the Ockenden Report maternity requirements; in urgent and acute care to eliminate 12 hour waits in ED; reducing Ambulance handover times and the development of virtual wards to facilitate timely discharges.

The plans being finalised would need to align with the five ICS collaborative workplans and the capital plan, both at ICS and place level. There was a heightened focus in the plan to reduce health inequalities, but the guidance available so far was limited, with more expected. In NLAG, work was ongoing to review waiting lists, ethnicity and deprivation with no anomalies identified so far. Other requirements were better use of digital alternatives, system efficiency targets and financial plans, which had deadlines for submission to the ICS after going through internal governance processes.
Ashy Shanker highlighted the CQUIN requirement where the five most important indicators agreed with commissioners could equate to £4m income. That work was being undertaken by the Quality Team with the Planning and Performance team overseeing performance and progress.

Ian Reekie queried if the CQUINs were set for NLAG or for each Commissioner and Ashy Shanker explained that the expectation within the national contract was for NLAG to achieve the five indicators agreed with the commissioners that most align to its priorities.

Fiona Osborne queried the timings, noting the initial submission of drafts were planned for 7, 9 and 17 March with final submissions on 28 April, and asked how the feedback fitted between those dates. Ashy Shanker explained that some guidance was still expected, and any feedback would come through the planning meetings. Several iterations would take place before the final submissions.

Lee Bond highlighted that the finance submission was required before the activity had been determined and there was also a set of competing agendas so would expect more work required between the draft and final submission at the end of April. The complexity and intensity of the national and regional process and how it would impact on NLAG was acknowledged.

Following the update Ashy Shanker left the meeting.

7.7 BAF Risk Review – SO1 – 1.6

Shaun Stacey presented this item and referred to the full BAF at 11.1 on the agenda and highlighted specifically the Gaps in the Assurance section (Page 11) which referred to the internal audit review of standards which stated completed. Shaun Stacey explained that the report was completed the previous year and therefore no longer a gap.

Links to the high-level risk register included Breast Oncology Services which related to the discussions held earlier in the meeting on Cancer; and future risk to Oncology with HUTH pressures.

The current risk score was 16 until the end of the year with expectation that would reduce to 8 next year.

Item 8 02/22 Finance Report – M010

8.1 Lee Bond presented the report and highlighted issues to note as follows:

- A deficit reported for January of £0.37m which was equal to plan, with the year-to-date position £0.01m deficit, which is £0.01m worse than plan.
- Secured £2.5m investment money for extra activity carried out to support the financial position.
- Pay was £3.3m overspent in month with the majority being on medical staffing. The key drivers were understood but continued to grow
- Temporary staffing was showing that agency use had increased by 21% since the previous year and that growth was a real concern. The agency use was predominantly from suppliers on the framework, but unit charges had increased
- Nursing was £0.45m overspent in month which had been helped by an underspend in maternity
- Non-pay continued to underspend in month due to underspends in the independent private sector activity
- Covid - £11m to date noting the £5.5m for ward and bed changes and £3.5m for shielding and isolation which were linked to medical and nursing figures
- Nursing budget compared with previous year had increased from £90m to £97m and Medical £68m - £70m. There was a piece of work ongoing to determine how that related to additional money for Covid.
- CIP delivery had seen an over-achievement of £130k and slightly ahead of target in-year delivery. Key point to note was that 1.3 was non-recurrent, which would impact in 2022/23.
- ERF funding had not been achieved in month due to the ICS not achieving its ERF target, but Target Investment Fund money had been secured, as stated above
- Capital – CIB earlier in the week reviewed the programme given there was only 6-weeks to year end when capital should be spent. Notifications were still being received of additional capital funding to be spent by the end of March.
- Risks flagged by Estates for their capital, but they were confident that would deliver. Medical equipment received £120k and were confident that orders would be received and could meet that part of the programme.

- Major uncertainty on the digital side due to joint working with HUTH. In overall terms however, were confident that capital would be spent by the end of the year.
- Conversations were taking place about the energy schemes £40m funding and the Trust had been advised that BEIS and SALIX were unable to pay money in advance of the works for EPC2 i.e. approx. £30m and have agreed to revise the scope for SGH which was agreed at CIB. That would mean that a further bid would be submitted for 2022/23 and plans would have to be revisited for the remainder of the year
- No concerns highlighted on revenue or capital
- The underlying position for 2022/23 continued to be circa £20m. Clarification was required on he availability of funding for the Ockenden requirements.
- UTC and hot clinics funded from winter monies would require recurrent funding, which might not be available

Fiona Osborne queried Covid spending and the commentary that urgent decisions were required in both this report and the M08 report and asked if there was any update on progress. Lee Bond advised that there was little to update other than discussions were being progressed on the nursing establishment and medical staff which were being done through the business planning process.

Fiona Osborne also referred to the reduction in CIP in the Surgery Division and asked how this had been achieved so quickly and if lessons could be learned that could be applied to other divisions. Lee Bond noted that the surgery team had been reported in M08 as over delivered by £223k and agreed to pick up with Mike Smith to clarify.

Action: Lee Bond

Gill Ponder noted that CIP procurement savings had been pushed back to Q4 and asked if assurance should be received on Procurement generally through the F&P Committee. Lee Bond advised that a new Director of Procurement covering NLAG, York and Hull had recently commenced in post and his overarching thoughts had been that procurement was 15 years out of date across all sites. He was working on formulating improvement plans for the three organisations. Lee Bond anticipated that interim reports would be provided to the three-individual organisations through their respective Finance Committees. It was agreed to add this to the workplan for May 2022.

Action: Anne Sprason

8.2 Capital Investment Board Minutes

Fiona Osborne asked if there were any further updates on the emergency schemes. Lee Bond advised that the gas fired boilers had now been replaced at Goole. Written confirmation had not yet been received, but verbal conversations that had taken place would suggest that approval for the AAU business case had been given. This would be a major step forward for the Trust and enabled contracts to be signed with Kier in the next couple of weeks.

The minutes from the last CIB were noted.

8.3 Recovery Support Programme for finance (RSPf) – Letter for Information

Lee Bond advised that there had been an issue with the 2022/23 planning process and that would delay the lifting of special measures.

Lee Bond noted NHSI/E were seeking further assurance that there was unified Trust Board ownership and accountability for the financial recovery.

8.4 Addressing the underlying deficit position of the Trust

Lee Bond highlighted that by the following month he would be in a better position and would have made progress on several issues that were still outstanding. The rules were still not clear so there was some uncertainty. Lee Bond agreed to provide a more detailed report on the underlying position at the next meeting.

Action: Lee Bond

8.5 Planning Guidance Summary

A paper had been provided which gave an update on the high-level priorities and associated guidance related to the plan and contractual arrangements. Lee Bond highlighted that it gave more detail of the key requirements, but it should be read in conjunction with the paper provided by Ashy Shanker at 7.6 earlier on the agenda.

8.6 Benchmarking undertaken of running two EDs

Lee Bond advised that the information would be presented at the next meeting.

Action: Lee Bond

8.7 Finance Cost Efficiency – Benchmarking Reports comparing HUTH and NLAG

Lee Bond advised that analysis had been undertaken of the 19/20 reference cost submission which would be presented at the next meeting.

In terms of the corporate benchmarking based on 2021/22 numbers, Lee Bond advised that each Executive Director had signed off their numbers. The results of the benchmarking had been largely positive with some pockets of service that were on the expensive side i.e. HR and Payroll. Procurement would improve with the recent appointment of the Director of Procurement across the three organisations to ensure resilience and cost efficiency.

In terms of HR, investment had been made several months ago through TMB and Trust Board, but it was not clear at what point return for that investment would be seen.

Paper records and medical records were heavily reliant on paper-based systems so an opportunity to make those improvements. Non-recurrent vacancies were a real challenge which would be considered as part of the 2022/23 planning process.

There were two areas to focus on for HR and transactional IM&T but this would probably be a longer term plan.

Gill Ponder also noted that recruitment had had investment but there were still high numbers of vacancies driving spend on temporary staffing which added to the financial pressure.

Item 9 02/22 **Digital Strategy**

9.1 Progress Report on Priorities

Chris Evans presented the report, which had already been seen at Trust Board and highlighted some key points to note to the Committee, including:

- The volume of work being undertaken in digital services following the large amount of investment in this financial year and significant external investment due in the next financial year.
- Workstreams were working to tight timescales with the PAS system and data warehouse programme spanning across financial years.
- Improvements made to the governance processes and regular highlight reports and dashboard were provided on circa 40 projects currently in place, as well as work on the business planning process; there were also additional projects waiting to be commenced and therefore a need to match capacity.
- Engagement with other areas within the Trust continued
- Scan for safety was being considered to improve process flows.
- Working with NHSE/I on adopting best practice for the IPR to provide narrative and reduce the duplication of reports and provide greater consistency across the PRIMs reports.
- Significant changes had taken place in clinical coding which was now a shared managed arrangement with Hull, which was working well.
- Staff development was being prioritised as turnover of some staff groups was a challenge in terms of the market rates within the private sector, so struggling to appoint to key posts either through skill set or remuneration.
- Development work with Web V looking at working with third party development, but this would impact on transactional IMT costs.

Fiona Osborne referred to the programme funding which showed spending was behind plan then a significant increase in spend in the next two months and asked if that was on track, which Chris Evans confirmed. There were some capital schemes which would be carried over to the next financial year which had been agreed by CIB. There were some capital monies that came through late and the Digital team had worked with the finance team to manage those.

Lee Bond noted improvements in the network infrastructure and the fabric of IT and asked if there were any plans to replace medical records with a digital solution. Chris Evans explained that an electronic document management solution would be included as part of the business planning process and tabled at the confirm and challenge meeting with Exec Directors the following week. It was anticipated to include both organisations in medical records and corporate records i.e. medical records in 2022/23 and corporate records in 2023/24.

Following review, the report was noted.

9.4 Clinical Data Improvement Programme (CDIP)

Chris Evans explained that CDIP was a three-year programme due to finish in March 2022. The full year effect would not be seen until May and asked if the Committee required a further report.

Lee Bond stated that some areas did not seem to be closed and therefore did not think it could be signed-off at the present time. Lee Bond asked that the report was shared with the finance team to ensure alignment on programme closure before bringing the report back to the Committee in May for final sign-off.

Action: Digital Services / Finance

Item 10 02/22 **Estates & Facilities**

10.1 BAF Risk Review – Estates Strategy

Simon Tighe presented the report which showed the progress made on the Trust's Estates Strategy for 2020-2025, and highlighted issues to note.

- The 6-facet survey from 2019-20 had been reviewed in 2020/21 and the updated BLM funding required had increased as had the CIR number.
- BAF – Page 10, links to high risks and risk register with 22 risks of which 15 were high
- Capital Schemes – circa £120m capital programme. Detailed work undertaken with good internal partnership working, particularly with fire alarms and oxygen and thanked Ops for their help with those schemes.
- Positive news in Goole where the £3m investment scheme had seen the coal fire boilers replaced, which had had a massive reduction of the Trust's C02 emissions.
- EPC3 programme – currently drilling bore holes to a depth equivalent to the height of the Shard building in London to get to the geo-thermal layer
- Estates Strategy 2020-25 updated - Major schemes included success of the Roost building for accommodation. SGH did not have similar accommodation and pilot work was being undertaken with the Local Authority as part of Scunthorpe regeneration scheme and project anchor.
- Plan B – if the expression of interest was successful for a new build hospital at Scunthorpe the site would still require to be managed for the next 10 years on a reactive basis in conjunction with HASR. If unsuccessful, then Plan B would need to be more detailed and require funding from other sources e.g. NHSE/I.

Lee Bond referred to SGH and the critical infrastructure cost of £31m and asked if the major part was the Coronation Block, and if removing that would reduce the £31m significantly. Simon Tighe explained that the BLM would only reduce by circa £1m due to the condition of the water infrastructure and because there was a limited clinical risk, as only fracture clinic remained in the building.

Lee Bond referred to the cost of new build of £350m but the critical infrastructure could be sorted for £30m so suspected this would require explaining further into the process. Simon Tighe explained that the CIR of £31m for SGH related to the infrastructure only e.g. LV, water, MGPS; it did not include the reconfiguration of wards as a consequence of Covid, such as ward 25 where a standard 26 bed facility was being reconfigured into 14 single rooms and the £350m was required to build a fit for purpose hospital.

Gill Ponder noted NED responsibility for various activities and observed that there appeared to be a gap with security, noting there was nothing on the workplan and asked if there was another governance route. Simon Tighe confirmed that security and CCTV was overseen by ARG Committee. It was noted that facilities services, including catering, portering and cleaning was not included within the workplan and Simon would speak with Jug Johal to provide a Facilities Services report. It was suggested that as August was a free month it could be included then.

Action: Simon Tighe / Jug Johal

Item 11 02/22 **Board Assurance Framework (BAF)**

The BAF had been provided for information and Helen Harris advised that it had been reviewed by all Directors; the yearly target risk scores against each strategic risk were now included, and the progress on planned actions would be reviewed on a quarterly basis.

It was noted that the target score for S03-3.1 for 2023/24 had increased from 5 – 20 and Gill Ponder queried the reason. Lee Bond explained that this was to reflect the change in the financial environment. The underlying deficit of circa £20m could be higher which was a concern and resulted in a higher risk rating.

Gill Ponder referred to the removal of some risks from the F&P Committees remit and agreed to speak with Helen Harris outside of the meeting.

Action: Gill Ponder / Helen Harris

Following review, the BAF risk ratings and report was noted.

Item 12 02/22 **Items for Information**

12.1 Performance Letters to Divisions following PRIMs Meetings

The letters from January 2022 had been provided for information and were noted.

Item 13 02/22 **Any Other Business**

There were no matters raised.

Item 14 06//21 **Matters to highlight to other Trust Board Assurance Committees**

There were no items raised that required highlighting to other Trust Board Sub-Committees.

Item 15 02/22 **Matters for Escalation to the Trust Board**

The following items were noted:

- Ongoing challenge with ambulances and waits in ED on majors.
- Whilst holding waiting position marginal risks with 52 weeks worsening
- BLM and scale on estate
- Digital – closure of CDIP with final report in May aligned with the Finance team

Gill Ponder agreed to pull together the highlight report for the Trust Board and circulate to members of the Committee for agreement.

Action: Gill Ponder / All

Item 16 02/22 **Review of Meeting**

Shaun Stacey commented that good conversations had been held with some good challenge.

Maneesh Singh commented on how the committee aligns to Q&S and needed boundaries defining.

Item 17 02/22 **Date and Time of next meeting**

The next meeting was due to take place on **Wednesday, 23 March 2022 at 1.30pm-4.30pm**

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	*Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Linda Jackson	Apols	✓	✓	Apols	✓	Apols	Apols	-	-		-	
Stuart Hall	✓	✓	✓	Apols	Apols	Apols	Apols	Apols	Apols			
Andrew Smith	✓	✓	✓	Apols	✓							
Michael Whitworth				✓								
Fiona Osborne					✓	✓	✓	✓	✓		✓	
Simon Parkes						✓	✓	✓	✓			
Maneesh Singh											✓	
Lee Bond	✓	Apols	Apols	✓	✓	✓	✓	✓	✓		✓	
Peter Reading	✓	✓	Apols	Apols	✓	Apols	Apols	-	✓		Apols	
Shaun Stacey	✓	✓	✓	Apols	✓	✓	✓	✓	✓		✓	
Jug Johal	✓	✓	Apols	Apols	Apols	✓	Apols	Apols	✓		Apols	
Ivan McConnell	Apols	✓	Apols	✓	✓	✓						
Shauna McMahon	✓	✓	Apols	✓	✓	✓	✓	✓	✓		Apols	
Helen Harris	✓	Apols	-	Apols	-	✓	-	-	Apols		✓	
Brian Shipley	✓	✓	✓	✓	✓	✓	Apols	✓	Apols		Apols	
Simon Tighe	-	-	✓	✓	✓	-	✓	✓	-		✓	
Ab Abdi	-	-	-	✓	-	-	-	-	-		-	
Chris Evans											✓	
Ian Reekie	✓	Apols	✓	Apols	✓	Apols	✓	✓	✓		✓	
TOTAL ATTENDEES	**12**	**11**	**8**	**8**	**11**	**10**	**8**	**9**	**9**		**9**	

* January 2022 – meeting stood down due to operational pressures

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **23 March 2022 – via Teams Meeting**

PRESENT:	Gill Ponder	Non-Executive Director / Chair of F&P
	Fiona Osborne	Associate Non-Executive Director
	Maneesh Singh	Associate Non-Executive Director
	Peter Reading	Chief Executive Officer
	Shaun Stacey	Chief Operating Officer
	Brian Shipley	Deputy Director of Finance
	Craig Hodgson	Associate Director of Commercial Services
	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 7.6)
	Janet Mellor – Executive Personal Assistant (Minutes)	

Item 1 03/22 Apologies for absence were noted from: Lee Bond, Jug Johal, Simon Tighe (Craig Hodgson as Representative for E&F)

Item 2 03/22 **Quoracy**

Gill Ponder noted there were sufficient Executive Directors and Non-Executive Directors in attendance to ensure quoracy.

Item 3 03/22 **Declarations of Interest**

Gill Ponder advised that she had not received any declarations of interest prior to the meeting. There were no new declarations of interest made.

Item 4 03/22 **To approve the minutes from the previous meeting held on 22 December 2021**

The minutes from the meeting held on 18th February 2022 were reviewed, once the following amendments are made it was agreed the minutes were an accurate record.
P1. Maneesh Singh - Job Title needs to be corrected
P3&4 - paragraph 7.1 should read 'from the information if process re-design had begun when the trajectory for completion was due'. Fiona Osborne agreed to send the appropriate wording after the meeting.

Item 5 03/22 **Matters Arising**

All actions from the minutes were included either on the agenda or the action log.

5.1 Action Log

The action log was reviewed.

25/08 financial benchmarking information – deferred to next meeting

Items 7.1 x 2 and 7.2 are now closed

Item 6 – This would be covered during today's meeting. Fiona Osborne asked for this item to be left open for clarity of the exit plan.

Actions from the meeting on 22/12/21
Item 5.3 is now closed.

Item 8.3 would be covered within the agenda.

Item 8.4 a meeting has been held to share data with clinicians. Shaun Stacey assured the F&P Committee that data is shared with clinicians within their monthly service business meetings. Item now closed.

Actions from the meeting on 18/02/22
Item 7.1 would be covered within the agenda.
Item 7.5 there was no update received for the action arising from the cancer deep dive. Gill Ponder clarified the background to the action and would write to Chris Evans and Denise Gale to find out if the agreed discussion about a workaround for the paper referral processes that were wasting 7 days of the pathway could be developed as a temporary tactical solution until the Trust went fully digital.
Item 8.1 Brian Shipley advised that year to date position was still behind plan. There had been a catch-up on some of the items which had closed gaps. Gill Ponder agreed that the status was understood. The action was closed.
Item 8.1 There would be a report from the new Procurement Director in May. A twice yearly update on procurement would then follow, so this would be added to the Workplan. Action: Gill Ponder.
Item 8.4 would be covered within the agenda.
Item 9.4 was scheduled for May.
Item 10 Linda Jackson had questioned if assurance on facilities should be on the Q&S Committee Workplan due to the link with patient experience that that Committee provided assurance to the Board on. Fiona Osborne suggested that the Q&S Committed should have some oversight of this and Maneesh Singh agreed. It was agreed that Gill Ponder would write to Mike Proctor to get his views.
Item 11 Gill Ponder would pick this up with Alison Hurley, who was covering for Helen Harris' absence.

5.2 F&P Workplan V4

All items due from the workplan were covered on the draft agenda, but some items had subsequently been deferred to allow a detailed presentation and discussion on the 2022/23 draft operational and financial plans. The deferred items would be picked up next month. *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 confirmed that there were errors in the assurance routes shown in the papers, as the items in question were on the Finance & Performance Committee Workplan so were proper to be reviewed at the meeting. Craig Hodgson agreed to pick this up with the divisions outside of the meeting.

Item 6 03/22 **Presentations for Assurance**

6.1 CQC Progress Report

Jennifer Moverley gave a detailed update on the CQC Progress report advising that around 81% of the actions were either blue or green. There were 25 actions for the F&P Committee with 8 actions at amber, and none at red.

Medicine division Waiting Lists and Cancer currently have 32 52 week waiters and 154 patients over 40 weeks to the end of February. Weekly monitoring was ongoing.
A Business Plan for Family Services Waiting List has been produced with a target per speciality, per site. There were no patients over 52 weeks which had not been risk stratified and the position continued to improve.
The cancer referral levels for gynaecology and breast had risen with the Family Services division. The increase of referrals within breast was causing performance issues. The 28 Day Faster Diagnosis was achieved. The Gynaecology 62 day performance showed 80% and the 28 Day Faster Diagnosis showed 84% which achieved target.
Surgery Division waiting lists and cancer target for NEWS and REVIEWS was improving within General Surgery, ENT, Trauma and Orthopaedics.
Ophthalmology was supported by insourcing. Max fax had also got a recovery plan. The RTT remained static although had some issues due to workforce.
A Dedicated Intensivist for ICU at SGH was now in place. There were now 4 hours on Saturday and Sunday with ward rounds, the additional anaesthetics third tier gave greater cover for the critical care beds. An assurance paper has been completed and would be going to the Governance meeting for approval.
Within Clinical Sciences the waiting lists and reports had Improved in February. There was a potential decline in March due to long waiters.
Gill Ponder flagged the reference within the paper to the lack of funding for implementation for funded actions and asked for assurance that those items had been picked up within the business planning process for 2022/23 and the Committee were advised that they had been included. .
SS assured that all the issues flagged had had a business case prepared for them. They had not all formally been agreed yet. The process was still ongoing and there was still a potential risk until financial decisions had been made. The business cases would get final sign off at Trust Management Board, but some difficult choices would have to be made as there was unlikely to be enough funding for everything the Trust wanted to do to improve services to patients

Gill Ponder raised the item in the report that referred to the financial strategy to deliver safe and sustainable services.
BS advised that quality and financial requirements were being articulated in the business and financial planning process. Through this process any specific areas of risk not mitigated would be highlighted, but the financial strategy supported the quality initiatives being planned.
Peter Reading stated that the job of this Committee was to highlight to the Board the issues that it considered important within that strategy. The Financial strategy would need to complement the service strategy, which was likely to change during the year
Jennifer Moverley left the meeting at 2pm
Ashy Shanker joined the meeting at 2pm

Item 7 02/22 **Review of NLAG Monthly Financial position (Finance Report)**

7.1 Finance Report M11

Brian Shipley went through the headlines of the M11 and year to date Finance Report which was slightly ahead of plan. This was due to earned ERF+ income from January.
There were no new cost pressures to highlight. COVID expenditure was still within the envelope at an average at around £1m per month. The main drivers for this were ward openings and bed configurations together with the on-going cost of sickness cover.
Temporary staffing saw a slight reduction in February due to a short working month but remained a challenge.
Cost improvement delivery was slightly ahead in month. A slight over delivery for the year was forecast. The main issue continued to be the level of non-recurrent savings in year.

Scoping of savings for next year was progressing well. A 2% target had been proposed. Divisions and teams were working to identify additional savings to bridge the delivery risks for the coming year.
In terms of Elective Recovery there was some ERF funding earned from actual activity delivery where the costs of delivery were higher, but the system had not achieved the target to enable this funding to be received by the Trust. This had been mitigated due to some additional ERF+ funding.
The underlying position had been updated in month. which would be covered as part of the 22/23 plan next on the agenda.
Fiona Osborne asked for clarity around how the statement about the need to minimis COVID costs was being dealt with. In terms of meeting CIP targets a number of divisions had delivered additional savings in Quarter 4. Fiona Osborne asked if there was any key learning around communications to help them focus to deliver savings throughout the year, or if the opportunity to deliver the savings at the year end was the only opportunity available.
Brian Shipley gave some clarity around how the COVID spend was being handled. There were two main elements; the need to reduce expenditure still stood and the main driver was around ward configurations. It was anticipated that once the nursing establishment review was finalised at Board this would address some of the ward/bed changes happening now.
Brian Shipley explained that there were some seasonal savings for CIP. Most of the plans were around reduction or substitution for substantive staffing. New recruits joined in September from newly qualified nurses and Doctors.
Fiona Osborne queried if there was a possibility that clinicians were not engaged in the process of delivering savings and asked if there was a possibility of learning and feedback group in terms of communication?

Brian Shipley stressed that there was no communications issue. A monthly meeting with the financial team and divisional managers was held and it was also picked up through the PRIMs sessions.
Gill Ponder asked if the need to increase activity/productivity has been incorporated into 2022/23 planning. Brian Shipley confirmed that this was a core part of the next presentation.
Gill Ponder felt that congratulations were due to the teams. The extra savings target given to the Trust in H2 was immensely stretching, but this had been met and the forecast was now to overachieve it.

7.2 Financial & Operational Plans 2022/23

Brian Shipley & Ashy Shanker presented the draft Financial and Operational plans for 2022/23 to the Committee.
Ashy Shanker explained that the draft schedule was presented last month. The National Operations Guidance came out in December, the summary of that was included within the slides. Draft Trust Priorities had been agreed, the annual business plan process was progressing, recommendations would be submitted to the Trust Management Board for approval The ICS submissions were currently progressing.
The first cut of activity and narrative submissions was complete. There had not yet been any formal feedback.
In terms of the target investment fund, theatres had been approved and the process of developing the business case and firming up the schedule was being worked on.

The HASR services were progressing into 2022/23 working with HUTH to get joint or single services in place.
The initial NLaG draft submission comparison in terms of activity showed 101% performance which was below the requirement of 104%.
The low level of performance was due to the level at which the Trust was operating within operating theatres, acute activity pressures and IPC related issues, some relating to COVID.
Plans were being reviewed with the divisions to improve efficiency and productivity.

The Independent Sector reliance was high, the confidence in delivery of this was being considered.
The draft submission addressed sections within the Operating Plan and the Trust Priorities, including overdue follow-ups.
Work was on-going toward a trajectory of no 52 week waits from Q3 22/23 plus a reduction of 40 week waits. Factors to consider were the current commitment to the ICS for levelling up.
Cancer trajectories had been agreed by teams working with divisions. For patients waiting over 62 days, the focus would be on reducing the backlog. It was expected that 28 day faster diagnosis would be achieved by Q3.
Within Community services there was focus on the guidance for opening up virtual wards. Plans were in place for 69 virtual ward beds, plus 12 paediatric virtual ward beds. In terms of 2 hour urgent care response there were plans in place to open 8am to 8pm seven days per week.
All risks had been mitigated.
Fiona Osborne asked about the cancer target. The IPR had this flagged as a cause for concern, however the paper inferred that there would be a recovery by Easter. Ashy Shanker assured that this was based on discussions and agreements within the divisions. It was agreed that Ashy Shanker would provide the detail of those plans to the Committee.

Action: Ashy Shanker

Maneesh Singh suggested that there were a lot of assumptions and variables which may not be deliverable and asked for assurance that the plan was deliverable.
Shaun Stacey advised that in terms of the 62 day backlog, this was reported as a difficult target to meet. There were a high number of patients on 62 day pathway that did not have cancer. Work was being carried out to move these patients onto other pathways by Easter. There was a high level of confidence that the change would be made. It had been agreed with Q&S Committee that they would support with the clinicians to focus in terms of delivery. Shaun Stacey stated that the high number of assumptions had to be there in order to build the plan. In terms of flow, elective beds and theatres had been ringfenced since 2018. Since 2019, there had been three theatres that were not viable because they did not meet current standards. Those theatres had been utilised for ITU beds during COVID . Shaun Stacey stated that the problem for elective was workforce. There was a pressure not stated in the paper that there may be a national directive to prioritise emergency work in the future. Plans had been built around the existing workforce.
Fiona Osborne clarified that her concerns were around timescales for the cancer services and she was confident that once the information was received her concerns would be reduced.
Fiona Osborne also flagged that there was an elective requirement to deliver a 25% reduction in activity with a CQC requirement to lose 40% of out-patient activity. The transformation paper stated that this was unrealistic.
In terms of eliminating handover delays, Fiona Osborne suggested that social care in the community was the biggest blocker of flow and expressed concerns about the manageability of that.
Ashy Shanker responded that a 25% reduction in follow ups plans was realistic as these had been discussed and agreed with the divisions. Ashy Shanker went on to explain how these had been agreed and included into the planning process.
Fiona Osborne challenged around the two papers that had been submitted to the Committee which contradicted each other around this part of the plan.

Shaun Stacey flagged that the follow-ups were currently at 14% and not 25%. This correlated to the transformation report in that it is a challenge for the Trust. There had been a CQC action for the last few years to reduce overdue follow-ups; there would be an imbalance in this area.

Gill Ponder asked about the 52 week waits being eliminated by Q3, as the previous target had been to reduce those to zero by the end of March 2022.
Shaun Stacey sated that the March delivery needed to be revised due to 100 patients that

were delayed due to anaesthetic needs who could not be re-scheduled. The position overall would deteriorate from this week due to referrals now being accepted for urology, general surgery and orthopaedics from other Trusts. The board had been warned about this.
Ashy Shanker agreed with Shaun Stacey and stated that plans were not that relevant in terms of numbers now being received. The total RTT would also change. Dual monitoring was being looked at but that was not an easy task.
Gill Ponder asked around the 101% v 104% and what would have to happen to get to that level of performance. Ashy Shanker advised that there were a few variants involving infection prevention control limitations, over-due backlog and theatres running at full capacity that would help to reach the target.
Shaun Stacey flagged that within some specialties some of the issues were workforce related.

Financial Plan

Brian Shipley went through the slides from the Financial plan.
The plan which has been submitted had a deficit of £32m. The underlying position was c£20m, this was part of the long-term financial plan. This position had been reported for some time, however there was a high amount of scrutiny around this.
Brian Shipley went on to explain the main bridging items within the plan which included a reduction in income of £26.7m, but some of that was offset by lower expenditure, leading to a £10m shortfall Non-recurrent CIP savings in 2021/22 of £4.7m also added to the pressures in 2022/23, which were £14.7m..
In 2022/23 there has been £7.9m growth funding. Some of this was to address the opening deficit position not to fund investment. Inflation funding of 2.8% had been received which had been earmarked for expenditure.
There were additional risks within Estates due to increased utilities costs due to higher than anticipated inflation. There may be additional funding for that but it was not confirmed.
The national 2022/23 CIP requirement had been set at 1.1% (£4.3m) plus a convergence factor further savings requirement of £1.6m. The total new CIP requirement for 2022/23 as per national planning is £5.9m.
Currently included in the plan is a 2% efficiency target of £9.98m and a further 1% non-recurrent system efficiency stretch of £5m representing £14.98m (3%). There was a risk that a higher target might be set, which may not be achievable.
Covid expenditure forecast was £12.7m and most of the Covid funding had been retained. There was a risk from further stages of the pandemic.
Included in the plan was £15.1m for priority investment which included un-scheduled care services and the nursing establishment review.
The Trust's draft activity plan was currently at 90% of the 2019/20 baseline from within its core funded capacity. The challenge may be to do 90% activity at less cost, as the funding was based on 100%. IS work would continue which would take the Trust to 101%, but that was not the most cost-effective option.
There were opportunities to close the gaps by minimising the £15.5m gap by increasing activity, questioning investment proposals to establish if they were a must do and essential for quality and delivery of improvement, bringing Covid expenditure down, addressing sickness issues and considering an expansion on CIP. Some additional funding might be available for increasing capacity, by that was still under discussion with commissioners.

Shaun Stacey suggested that by taking a different approach to flow from an elective perspective the plan should be achievable with the right conversations, however there was still a challenge around medical workforce.
Fiona Osborne enquired around the nursing establishment review and how much of a risk was associated with £4m? The relevant skill sets may not be available, is it assumed that any recruitment will be at substantive rates. Brian Shipley assured Fiona Osborne that there was a balance in terms of recruitment and reconciliation to future recruitment plans.
Gill Ponder flagged that temporary staffing had been a significant issue in 2021/22 and posed a risk to the financial plan and questioned the provisions that had been made around this in

the plan.
Gill Ponder enquired if there were any further things to be done to grow some of our own staff or create new roles.
Shaun Stacey assured Gill Ponder that there were some good plans to grow our own, however the balance was difficult. There was a challenge around what Covid would look like in 2022/23.
Maneesh Singh flagged that agency staff did not have ownership of the service and that would affect service performance, quality and safety.
Peter Reading observed that demand for staff in the health service had grown with not enough staff trained throughout the country. The position was getting worse and was compounded by lack of training of clinical staff and in the labour market. Peter Reading suggested that this was the territory of the Workforce Committee and the F&P Committee could express concerns to the Workforce Committee.
Action: Gill Ponder
Brian Shipley advised that the first draft of the overall ICS position was not in the slides but relevant to the conversations being held. There was a deficit of £140m before any additional stretch target. All providers were showing deficits.
Ashy Shanker stated that there had been feedback there would be more scrutiny on the plans in terms of breaking down into IS and value adding, KLOE's were being worked on.
Gill Ponder thanked Ashy Shanker and Brian Shipley for the very detailed presentation and good debate.

Recovery Support Programme for finance
(RSPf - Letter for Information) – Item Deferred to next meeting

7.3 Capital Investment Board Minutes
These were provided for information.

7.4 Efficiency Update – Item Deferred to next meeting
- Use of Resources
- Benchmarking undertaken of running two Eds

7.5

7.6 BAF Risk Review – SO3 – 3.1 - Item Deferred to next meeting

Item 8 03/22 **Digital Strategy Review – No reports due this month**

Item 9 03/22 **Estates & Facilities**

9.1 BAF Risk Review – Water

The paper was taken as read.
Craig Hodgson gave a brief over-view of the paper and confirmed that the report noted that the safety paper was delivered in February 2022. The next paper would reflect the correct date of delivery.
In terms of funding Craig Hodgson stated that it was important to note within the financial planning paper there is £1m for water safety, which was required funding. Since the paper had been written, the Trust has been served with an infringement notice by Anglian Water and work needed to be completed to the water tanks before the next inspection in October 2022. The paper also considered the plans for other high risks.
Gill Ponder questioned the infringement notice from Anglian Water. Gill Ponder also mentioned that she had been previously unaware of the HSE investigation referred to in the report and wanted assurance that the Board was sighted on that.
A discussion was held around P15 of the paper and the infringement notice for GDH being withdrawn and the risk of prosecution and COSHH. Gill Ponder asked for clarification

around the risks and if there was a notice which had been served.
Craig Hodgson advised that the paragraph within the report related to HSE and on-going legionella investigation and his comments were around Anglian Water.
Gill Ponder clarified that she was not previously aware of the HSE Legionella investigation and suggested that there may be other members of the Board that were not aware.
Shaun Stacey stated that he was in full support of Craig Hodgson and advised Gill Ponder that the legionella issue had been around for a long time and Trust Board members were aware of it. Risks described were accurate and Jug Johal would be able to give a full explanation.
Craig Hodgson suggested that this was taken away and discussed in Estates & Facilities and reported back for clarity.
Gill Ponder suggested that a quarterly summary of outstanding notices and status of notices should be submitted to the Committee.
Action CH – To discuss with E&F and the division to produce a quarterly summary.

Craig Hodgson advised that the Anglian Water situation was linked to water tanks at Scunthorpe and it was understood that support was required to do the works planned within the capital allocation. An inspection visit was planned for 25th October 2022.
Craig Hodgson confirmed that the work could be completed within the timescale providing the funding was agreed. Craig Hodgson also confirmed that the funding required was included within the request in the capital plan.
Gill Ponder asked for assurance that the water tanks were on the risk register and that the risks were being mitigated in the period between them being identified and the work being completed. Capital funding requirement which is on the risk register is being mitigated.
Craig Hodgson stated that the risk register was reviewed on a monthly basis, risks were mitigated if possible and the document was a live working document. If it was not possible to mitigate the risk it was escalated based upon an analysis of the risk.

9.2 BAF Risk Review – Lifts

Craig Hodgson advised that the risk on lifts was clear within the paper, there were plans to address the risks but there were no high risk items. Plans were based upon addressing issues in 2023/24.
Fiona Osborne asked how much SGH lift 4 was an issue for operations due to it being a theatre lift.
Craig Hodgson confirmed that lift 4 did have an impact and plans were in place to address this when there was available funding.
Items would be in the plan for 2023/24 unless higher priority items come in the meantime.

Item 10 03/22 **Review of NLAG Monthly Performance and Activity Delivery (IPR)**

10.1 Unplanned Care

Shaun Stacey asked that the report be taken as read in both planned and unplanned.
Unplanned care continued to see significant pressure. The main challenge was flow out of ED, ambulance handover delays were rising.
The urgent care model was working and had been consistent for two months on both sites. There was a challenge around funding going into April. There had been some further improvements in month with hot clinics, emergency streaming and EMAS streaming plus the category 5 work which was having some benefits.
Overall attendance by ambulance had dropped due to diversions.
The Right to Reside had seen a deterioration in month. This was due to lack of control of flow to nursing and care homes. There was a deterioration in the three major parts of the system, North Lincs, East Riding and Lincolnshire.
A conversation took place around how to address the issue with the community providers and patient discharge.

Shaun Stacey advised that he leads on this for the Trust, the CEO supports at a strategic level. Further to discussions with adult social care providers it had been agreed to do as before the pandemic. A concept was being tried which was being used in the USA which involved moving the medically fit patient into a hotel as a transitional route which enabled other options to be explored. This was being carried out at GDH. Shaun Stacey believed that there was a future for this model. It would take 30 days for first improvement markers to show, 60 days for the next improvement marker and so forth.
It was hoped to have this different approach from 60 days after the workshops are completed.
Fiona Osborne reminded the Committee that action 7.1 had not been addressed. Further to discussions outside of the meeting, Fiona Osborne felt that from the statement made in the IPR it undermined work from teams to deliver process re-design. Fiona Osborne stated that this would be addressed next month due to Richard Peasgood being on Jury service prior to this month's meeting. Shaun Stacey stated that the document did need to be clearer if re-design had started. The comment would be taken out of the IPR for next month. Shaun Stacey flagged that the format of the IPR would be different next month and would be worked around bullet points rather than statements.

10.2 Monthly Deep Dive – OPD with Long Waiting Patients

Shaun Stacey stated that the OPD paper had been updated on all elements. The document realistically demonstrated the transformation that was happening. There were still particular challenges with face to face versus non face to face. This was very much around culture and encouraging the benefits of virtual appointments.
Fiona Osborne asked if the Clinical lead would be appointed with funding from ICS.
Shaun Stacey stated that the funding had been requested, but that contingency plans were in place. A primary care practitioner and a hospital Doctor would work together as a joint clinical lead on the transformation project.

10.3 Planned Care
Shaun Stacey advised that this was built into the plan. There had been some improvement in month. There were still workforce challenges which continued to be a major issue. Some of that work was being done jointly.

10.4 Transformation Projects – Integrated Urgent & Emergency Care
Shaun Stacey asked for the paper to be taken as read. The paper brings the Committee up to speed with the Urgent and Emergency Care Transformation programme. There were seven streams of work, one had been completed. The project used a PDSA process. The teams look at new things to do to take things forward.
Fiona Osborne stated that on p8 the statement around the clinicians preferring to work in more traditional models. How was this being tackled?
Shaun Stacey advised that there had been a lot of hard work with the clinical bodies to ensure that they were bought into a changing model. There was a need to respect that they are independent practitioners and to continue on this journey there may be some who would not change. This would cause issues and contribute to poor performance in some cases. There was enough impetus to manage through the processes. There had been a lot of change and there were less of the people who would not change.
Gill Ponder asked around the ambulance handover issue and questioned why admission via ED was higher than the rest of England.
Shaun Stacey advised that there was not a fully modernised model of delivery, decision making within A&E was not always overseen by a senior Doctor. The Trust had a much higher percentage of admissions via SDEC with 41% going through same day emergency care and then being discharged within 12 hours. Over the next 12 months it was planned that there would be a higher percentage of people going home from ED. The average discharge was 80%, this needed to be triangulated into the data within the IPR. SDEC Services stop at 10pm and that was an issue, hopefully this will be grow to 24/7 working.

Item 11 03/22 **Board Assurance Framework (BAF) – item deferred**

Item 12 03/22 **Items for Information**

12.1 Performance Letters to Divisions following PRIMS Meetings

Item 13 03/22 **Any Other Urgent Business**

There was no other urgent business to discuss

Item 14 03/22 **Matters to Highlight to other Trust Board Assurance Committees**

Workforce impact on the delivery of operational and financial plans would be raised with the Workforce Committee
Action: Gill Ponder
Improvement notice for water tanks at Scunthorpe
Ambulance Handovers and A& E issues

Item 15 03/022 **Matters for Escalation to the Trust Board (Public/Private)**

Item 16 03/22 **Review of Meeting**

Gill Ponder reminded the Committee members to return their self-assessments of Committee effectiveness
Fiona Osborne flagged the lack of quoracy in the second half of the meeting

Item 17 03/22 **Date and Time of the Next Meeting**

20th April 1.30pm to 4.30pm via Microsoft Teams

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	*Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Linda Jackson	Apols	✓	✓	Apols	✓	Apols	Apols	-	-		-	-
Stuart Hall	✓	✓	✓	Apols	Apols	Apols	Apols	Apols	Apols			
Andrew Smith	✓	✓	✓	Apols	✓							
Michael Whitworth				✓								
Fiona Osborne					✓	✓	✓	✓	✓		✓	✓
Simon Parkes						✓	✓	✓	✓			
Maneesh Singh											✓	✓
Lee Bond	✓	Apols	Apols	✓	✓	✓	✓	✓	✓		✓	Apols
Peter Reading	✓	✓	Apols	Apols	✓	Apols	Apols	-	✓		Apols	✓
Shaun Stacey	✓	✓	✓	Apols	✓	✓	✓	✓	✓		✓	✓
Jug Johal	✓	✓	Apols	Apols	Apols	✓	Apols	Apols	✓		Apols	Apols
Ivan McConnell	Apols	✓	Apols	✓	✓	✓						
Shauna McMahon	✓	✓	Apols	✓	✓	✓	✓	✓	✓		Apols	
Helen Harris	✓	Apols	-	Apols	-	✓	-	-	Apols		✓	Apols
Brian Shipley	✓	✓	✓	✓	✓	✓	Apols	✓	Apols		Apols	✓
Simon Tighe	-	-	✓	✓	✓	-	✓	✓	-		✓	Apols
Ab Abdi	-	-	-	✓	-	-	-	-	-		-	Apols
Chris Evans											✓	Apols
Ian Reekie	✓	Apols	✓	Apols	✓	Apols	✓	✓	✓		✓	✓
TOTAL ATTENDEES	**12**	**11**	**8**	**8**	**11**	**10**	**8**	**9**	**9**		**9**	**7**

* January 2022 – meeting stood down due to operational pressures

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	7 June 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 March and April 2022 meetings**
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for March and April 2022
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ 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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 22nd March 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
Ellie Monkhouse	Chief Nurse
Abdi Abolfazl	Deputy Chief Operating Officer
Jan Haxby	Chief Nurse, CCG
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Helen Turner (item 059/22)	Divisional Head of Nursing Therapy & Community Services Group
Mathew Thomas (item 061/22)	Associate Medical Director, Surgery & Critical Care
Victoria Marshall (item 061/22)	Associate Chief Operating Officer, Surgery & Critical Care
Jane Warner (item 062/22)	Associate Chief Nurse Midwifery, Gynaecology & Breast Services
Jo Loughborough (item 063/22)	Patient Experience Lead
Vicky Thersby (item 065/22)	Head of Safeguarding
Jennifer Moverley (item 067/22)	Head of Compliance & Assurance
Hayli Garrod (item 068/22)	Acting Head of Quality Assurance
Laura Coo	PA to the Medical Director **(for the minutes)**

054/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Shaun Stacey, Mathew Thomas*

055/22 Opening remarks

056/22 Declaration of Interests

There were no declarations of interest.

057/22 To Approve the Minutes of the Previous Meeting held on 22 February 2022

Item 030-22, second paragraph should say 'remained a concern'

Page 5, last paragraph should say Fiona asked 'what the mitigation was'

Page 6, the action for EoL Helen Turner would be attending today's meeting to provide an update.

Page 8, Fiona Osborne mentioned that at the previous meeting there was a discussion about inviting cancer services to the meeting for each of the areas to talk about patient safety. Mike Proctor had subsequently had a conversation with Shaun Stacey and agreed that Mike would be invited to the Cancer Board and they would ask clinicians to attend QSC to talk about specific patient pathways where there were thought to be issues so Mike was going to look to get that included in the Committee's work plan. It would most likely start with Colorectal or Gastro. Fiona stated that the previous conversations were centred on the difference in quality or reporting with the F&P report on Performance being excellent and the Q&S report lacking clarity. There needed to be consistency in the reporting i.e. one report for all. Fiona reminded members that the previous conversations were only regarding the quality of the different reports going to different Committees and that there needed to be consistency of quality in the reporting.

A discussion took place about the sub-committee reporting arrangements and it was agreed this would be discussed further outside of the meeting.

The minutes were otherwise agreed as an accurate reflection of the previous meeting.

058/22 Matters Arising

There were no matters arising.

059/22 EoL Update

Helen Turner referred to the report distributed which was taken as read, following a request at the previous QSC the report was focused on EoL and the ongoing improvements.

Helen invited any comments or questions.

Fiona Osborne thought the work was excellent however noted that there were a lot of things within the project plan (appendix A) that were not yet started i.e. the business plan deadline was 31st March. Helen confirmed the business plan was completed and submitted on time but the report had not been updated to reflect that.

Kate Wood drew the Committees attention to a few points; the report was brought here to remind everybody of the amount of work that had been done across the Trust. The work on pain management, for example, had required cross divisional focus to

achieve progress. There was also the roll out of the Bluebell Model within the organisation which enabled and encouraged the discussions and identification of EoL patients whilst providing staff with the skills and confidence to have those difficult discussions with the patients and their families.

Helen and the team had put in bids for funding for EOL and Kate would like to record the massive amount of work Helen had led the team through, the changes needed to be sustained and Kate wanted to have this committee's support for that. Mike Proctor asked if the EOL work had a direct impact on the SHMI. Kate explained that if we could identify our patients when they were approaching EoL they could be discharged to enable them to conclude their lives at home. It was also about identifying patients in their last year of life which was about minimal shift changes and knowing how to identify patients when they were well enough to stop them coming back in. The EoL work would most likely not affect the in-hospital SHMI as those patients were already included but could see an increase in the number of patients dying where they wanted to which was important from a patient experience point of view.

Mike Proctor thanked Helen for attending and providing the update.

060/22 Review of action log

All actions were up to date.

Regular Reports

061/22 Surgery update

Mathew Thomas referred to the report distributed which was taken as read and summarised the key points

- From the CQC point of view overall progress against the CQC action plans remained positive and they had submitted their self-completion surveys
- NICE guidance – the division had sustained improvement of NICE guidance and they were maintaining an average of approx.95%
- Document control – this was being overhauled within the division and a new process was in place working towards 100% compliance.
- ALERT courses – the division continued to have a high number of staff not attending. Managers had contacted staff to find out why and work was ongoing to get that resolved.
- Never events – following the four Never events in the last year an Ergonomist was invited to attend all three operating theatres to carry out a review and would then make recommendations based on what they had observed.
- Q&S days – were looking to take over a Q&S day to look at Never events
- Quality improvement with DP and Sepsis was continuing

Mathew invited any comments or questions

Angie Legge added in terms of the Ergonomist they were working with staff to identify solutions which would work for the organisation.

Fiona Osborne referred to page six and the areas of concern and noted that the top concern was equipment noted as a considerable risk and asked if Mathew was able to give an idea of progress and what was being done for that.

Matthew responded to say that the division prioritised equipment risks and looked for other avenues to replace equipment. They had done a really good job so far of putting equipment in through different routes such as the Equipment group, Health Tree and Charitable Funds.

Fiona was not convinced that the risk to patients was being reduced. Vicky added that the process included identifying mitigation, e.g. where other equipment could be utilised where needed. Fiona was trying to get a sense of the impact on patient care and Vicky's response had given Fiona some comfort.

Maneesh Singh asked Mathew what his opinion was about why Never events kept happening. In response Mathew commented that looking at the last four never events they had been unable to identify thematic links. They did not emerge from one specialty, one site or one person easier but were across a multitude of specialties and sites. The Ergonomist was brought in to re-evaluate how one of the processes worked when factoring in human behaviour and culture. . From a sepsis point, a lot of patients get labelled as having sepsis and Mathew did not think patients had come to any harm from people being identified as having sepsis. Kate Wood added that they tried to look at the deteriorating patient as much as sepsis and did have harm for delayed diagnosis so although Mathew was technically correct it was why we need to get the sepsis recognition correct.

Mike Proctor summarised the discussion. The four Never events were a bit of red flag for the CQC and us as a Committee but one of the simple things to be addressed was people not following process and not feeling they were able to shout out if people were not following process, that culture needed to change.

Peter Reading thought it would be very helpful to know how many Never events other Trusts had although he thought four was too many, he would be interested to see the comparison across the region. Mike agreed with Peter's suggestion but thought we should not get complacent and needed to be the best we could be regardless of other Trusts.

Action: Angie Legge to source the figures for comparison of Never Events across the region to share outside the meeting.

Mike Proctor thanked Mathew Thomas and Vicky Marshall for the update.

Mathew Thomas and Vicky Marshall left the meeting at 2.08pm

062/22 Ockendon Assessment Tool

Jane Warner joined the meeting at 2.10pm

There was a national mandate for the Board to view this submission and the Committee was acting as a proxy for the board. Mike Proctor was the Vice Chair of and attended the Maternity Transformation Board.

Jane referred to the presentation distributed which was taken as read and gave a summary of the key points. The presentation referenced the Ockenden report one year on, on the back of a letter from Ruth May followed by the Chief Nurse setting out what was expected.

The preliminary report was published in 2020 and it had been very evident in the news and the Trust was awaiting the second part of the report which would be a more detailed report.
The key issues were;

- Risk assessment
- Management of complex women
- Failure to escalate
- The culture that they had for ladies having a normal birth
- Poor fetal monitoring practice
- Lack of kindness and compassion
- Lack of anaesthetic support
- Poor Governance structure
- Failure to listen to the women and families.

There were seven immediate and emerging actions including 12 clinical priorities for which an update was required. . These were revisited in February and of those 12 the Trust currently meet 11 of them. The one element that still needed work was the risk assessments that needed to be completed with the women throughout pregnancy.

The letter from Ruth May was about workforce plans and maternity currently had a vacancy rate of 27%. The Trust was being proactive venturing into overseas recruitment, had applied for monies from NHSE/I for retention and were putting in pastoral support to support the young midwives. They had undertaken birth-rate plus and along with Ellie Monkhouse's establishment reviews they were formulating where they needed to be with workforce.

The division knew they needed to roll out Continuity of Carer and an additional 16 midwives would be required to deliver this. A Diabetes Midwife and Project Manager to support the Ockenden work were also required

Jane described that whilst Kirkup had focused on the hospital at Morecambe Bay, Ockenden showed that since the 2015 report there had been a lack of sustained improvement and they had slipped back so the emphasis was on sustained improvement. What was interesting was that both the Kirkup and Ockenden reports were saying similar things.
All red actions through all action plans were on their risk register.
The division had made great strides into positive change. One of the great changes was the fetal monitoring, in that they had two enthusiastic clinicians and a midwife who had developed training videos for other units. They did get some money which meant they were able to increase training and had ensured our partnership.
Maternity had also achieved CNST, which was something that they had not been able to achieve in previous years.
The division had commenced the work to build Continuity of Carer teams and had managed to provide carers so those that needed the care the most would get it the earliest. A mailbox had been set up as well as a shout out Wednesday and staff were happy to speak up.

What the team had achieved had been immense and that work was ongoing so improvements were continuing. They had secured funding from NHSE/I and had

outsourced some training delivered from those monies. Work was still required on SOPs and support for birth rate view and needed leaders to support them,
The team needed to focus on progress, monitor action plans, ensure engagement from the team to sustain the improvements. They wanted to continue with the audit cycle and embed the safety champions but most of all needed to share their achievements as they were making some great inroads into safety for the local women.

Maneesh Singh though there were some great achievements but asked how well the two units worked together and noting workforce was a major problem asked what the impact would be of the two units joining as one.

With regards to the two units the SGH and DPoW units merged many years ago. All the guidelines and policies had merged so where clinicians needed to work on opposite sides the guidance was the same. The senior management team were visible across all units including GDH. Midwives had the oversight of both sites and were doing the very best to ensure they were getting the support.

With regards to the workforce it was going to be very difficult to maintain the staffing and they were aware there would be changes and it was the outcome of the HASR that would be the decision of the future.

Fiona Osborne noted the huge amount of work and congratulated Jane and the team on a good job but was confused about the risks being red and asked why that was.

Ellie Monkhouse thanked Jane and Mike for their support in the Maternity Transformation work, it was fair to say maternity services had been under scrutiny for the last 18 months and the spotlight would continue.

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Picking up on the external scrutiny we had our maternity improvement adviser and had funding extended to support that role for another year. The team were doing their best and Ellie was doing her best to try to support them.

In terms of the board, Mike would include this in the highlight report but Ellie was expecting that something short would be taken to board as well to say that the QSC were assured.

All supported the submission as Jane had described.

Mike Proctor thanked Jane Warner for attending and providing the update.

063/22 Patient Experience Report

Jo Loughborough referred to the report distributed which was taken as read.
Based on feedback they had decided to change the format of the report and linked it with the Patient Strategy. It was still draft as had not been finally ratified and approved.

The highlight was around theme summary and the top themes arising were:

- Care - families not being kept updated. Pain management and poor discharge planning were the most significant themes alongside treatment. The

improvements with the helpline in place, pain audits and ongoing work around pain and had commenced the discharge progress were all helping address these.

- FFT – the rates remained low, nationally it had low returns which had got worse since covid.

- PALs - a lot of work had been undertaken on engagement and the team had managed to shift off the 50% and improve our timeliness

- Complaints – there were several challenges and they had found the complexity of the complaints had increased and it spread across different specialities.

- Compliments – they knew they were not capturing those across the Trust. In the past it had been quite complex and were hoping that Ulysses would help with that going forward.

- Internal process – data was collected every month and fed into the nursing matrix. In Q3 the two areas were Ward 23 and Ward 28 and that was picked up through the matrix. Main themes were staff not introducing themselves and patients not being informed

- National survey – had always been a challenge to get engagement so created an overarching action plan. The Divisions held their own action plans and Jo had oversight to challenge them on what improvements would be made and how to close the loop.

Fiona Osborne asked about the family liaison role as that was due to finish on 31st March this year. There was a business case that went in which came with a very substantive investment but the impact of the role was very difficult to prove. Ellie Monkhouse added that the Family Liaison Role was a forward-thinking idea funded through covid monies and Ellie was very supportive of the role. The impact had been quite significant on their staff and they did not envisage these people were able to step into health care from those posts. What they had discovered was that they were actually having quite an impact on the patient experience as they were able to get around the wards and speak to the patients but there was the danger that this resource was going to be withdrawn as Ellie had only managed to get these roles extended for another 3 months.

064/22 National Inpatient Survey

The National Inpatient survey had always been a challenge to get engagement which was why they had created an overarching action plan so the divisions owned their action plans and Jo Loughborough had the oversight to challenge them on what improvement were going to be made to close the loop.

065/22 DoLS & Safeguarding

Vicky Thersby joined the meeting at 2.40pm

Vicky referred to the report distributed which was taken as read and highlighted some key points.

- The new MCA DoLs lead Helen Leary would be starting with the Trust in April

- There were significant operational pressures within the team due to varying reasons and that Vicky highlighted the Complex Transition and Learning Disability business case which was yet to be approved as indicated in the last report that came to this Committee. They had provisionally appointed to that role however further work was needed on the funding stream for backfilling into the post holder's previous role. The role was key and was linked in with strategy and analysing data including the 2022/23 planning cycle.

- The consultation had opened for the Liberty Protection Safeguards until 7th July, The CCG had been linked in to decide whether that would be done across an ICS patch.

Mike Proctor asked for reassurance that the situation for looked after children was improving. In response Jan Haxby noted that the numbers were not improving and whist there was a small decrease in numbers they had not managed to get a grip on them. There was a lot of effort on sustaining but it was about ensuring how they had that early intervention training. The governance had really improved but that whole early intervention and agenda had to be part of the solution. Mike would advise the Public Board that this was on the CCG and NLaG's risk registers and as organisations they recognised the risks but were in a position they did not want to be. With regards to the arrangements and oversight an improvement board had been set up and a local authority buddying lead had been appointed to support. There was as much support and expertise being put in place to try to improve the situation. Mike asked if NLaG were doing everything they could to assist and improve the situation. Jan's view was they were and Vicky agreed with that, the two organisations worked well together to support each other and felt they were moving in the right direction. From an NLaG performance point of view Ellie Monkhouse commented that the children were looked after well once they come into NLaG. Ellie did not want us to become the owner of a wider problem but wanted to thank Vicky for the support and improvements she had made since joining the Trust. Vicky would feedback that thanks to the team.

Vicky Thersby left the meeting at 3pm

066/22 Nursing Assurance report

Ellie Monkhouse referred to the report distributed which was taken as read.

The report showed the difficulty in sustaining this level of activity and bed base whilst maintaining some level of quality and quality indicators. Ellie was happy to take any questions.

Fiona Osborne was curious about the unestablished beds and how that worked particularly given how the staff had worked with the established beds. Ellie acknowledged it was a challenge and was difficult to further stretch an already stretched group of staff. Ellie and Shaun Stacey had some very challenging conversations about what could be done in and out of hours but they had to work together to manage the risk that was in front of them. It had been incredibly difficult for a sustained period and on top of the operation issues there was Norovirus and increased Covid numbers as a result visiting had been suspended until at least the

end of this week to try to contain it. This was the first case of Norovirus in a couple of years. Staffing was a struggle already but the teams were doing their best.

Maneesh Singh was worried how sustainable doing this daily was going to be. Abs Abolfazl thought that was a really important point and one thing that raised at Quality Board was that it was going to be really challenging to sustain in addition to everything else noting they were still facing community challenges as well.

This Committee could not offer any practical help but Mike Proctor would note the concerns about sustainability in his highlight report to the Board.

067/22 CQC Improvement plan update

Jennifer Moverley referred to the report distributed which was taken as read. The overall Trust position was 81% of 145 actions green or blue. 91 actions in total 0 red, 7 amber, 45 green, 39 blue. 2 retired/on hold. 1 action had gone from green to blue, relating to an emergency call bell. Evidence of this had been sent to CQC

In terms of the amber actions, Jennifer noted that progress had been made on community nurse staffing (CT5) There had been an agreement to recruit the additional resources up to 12 wte RNs substantively with funding to follow April 2022. This action would be monitored closely with a plan to further progress to green/blue only upon posts being filled

Jennifer noted that progress was still being made in respect of EoL (18EOL) as the pilot of the Bluebell model had commenced and the last days of life care plan was under review by stakeholders. The position with oxygen prescribing (11ED and 16M) remained static, with a re-audit due, as was the work on confidential records (17M). But in terms of the safety information displays (15P), boards had been installed and an assurance template had been drafted for submission to Governance.

Finally, Jennifer noted that the standard for RSCN's in ED (7ED) was not met but that there remained robust mitigation in place.

Kate Wood noted that it was good to see there was that consistent checking back and triangulation across EoL. There had been a huge amount of work undertaken around the RSCN, and while the Trust was not actually meeting the absolute standard mitigation had been put in place to keep children safe in.

Mike Proctor thanked Jennifer Moverley for attending and providing the update.

Jennifer Moverley left the meeting at 3.11pm

068/22 Quality Account

Hayli Garrod referred to the report distributed which was taken as read.

There was as yet no detailed published guidance on this year's Quality Account, only the NHS reporting manual currently it was based on last year's account. They were still waiting for information to come through to be able to progress and it would be in consultation with the Governors.

Hayli asked for the committee to approve the timescales in the production of the Trusts Quality Account to the board, the aim was to bring what was suitable to go out to stakeholders to this committee before it finally went to the board. The team wanted

to make a start but this may need modification dependant in any further national guidance provided .

Fiona Osborne noticed there was only one presentation to Trust Board but suggested it was presented more than once, however the nationally mandated timescales for publication did not support that.

Mike Proctor thanked Hayli Garrod for the update and the Committee supported the timetable.

069/22 IPR

Kate Wood referred to the IPR report distributed which was taken as read. From a mortality perspective the Trust was in a good position to which the work on coding, SJRs etc had contributed. Work continued around the in-hospital verses out of hospital SHMI and an out of hospital mortality group had been set up. Although the out of hospital SHMI remained high Kate was confident and comfortable that a lot of things were being done to try to address that. There had been a commitment to funding for palliative care, the job descriptions had been written and submitted and Kate was confident that the ICS could take that forward. Overall, the changes and work that continued was very positive. Jan Haxby added that the other significant workstream was frailty in the community and how they could be supported. In the out of hospital SHMI numbers, it had come to light that 20% of those were Lincolnshire residents. NHSE/I was supporting the Trust and audited last year to look at the number of patients who had died in and out of hospital.

In terms of VTE, Kate noted that the denominator had been incorrect. This was in the process of being amended, but the March data was still incorrect and showing us in a poor position whereas the patients were receiving the appropriate treatment. The whole point of having information was to use it to make changes as required.

Kate noted the work on NEWS, this was about recognising our deteriorating patients early and making sure they were escalated appropriately. Some of this related back to the work on acuity and staffing levels and the need to ensure the appropriate people were provided with the appropriate tools to be able to do their jobs. It was useful to keep it on our radar, issues were also picked up through the risk management process and SJRs.

Fiona Osborne referred to point 36 of the report and the disparity between sites and asked how long that had been going on. Kate responded that this was long standing and a lot of that could be put down to the difference in palliative care provision between the sites. With regards to SJRs, Kate noted that the GP's were not as familiar with the process and it was not well received so there needed to be further work with GP colleagues. There were lots of variables but we needed to be able to identify the problems before any solution could be met.

Jan Haxby did not think it was necessarily about GPs but knew there was more to do in community to manage and understand the data. Looking at some of the National data it told us North East Lincs were one of the best in country for people dying at home which contradicts our data in respect of the OOH SHMI so there was a lot more work to do and this was why the out of hospital strategy was being refreshed.

Mike Proctor thought the shift to move care on in the community was the biggest challenge for the ICS and looked forward to that being more successful.

070/22 Patient Safety Partners Framework

Angie Legge referred to the document distributed which was taken as read which was part of the National patient safety work. The partners were people who came into organisations to represent the patient view. A national framework had been produced last year which gave more details, enabling Trusts to move forward to design local plans to bring in the role of the Patient Safety Partner. Angie had put this local framework together and the plan was to recruit up to 10 Patient Safety Partners. The framework would underline these roles and Angie was very grateful to her colleagues across the Trust for their input. Angie was seeking approval to have a patient safety partner joining this group Mike Proctor thought there was some work still to do with the Governors in terms of explaining the differences between the role of the Governor and that of the Patient Safety Partner.

Kate Wood mentioned there was an excellent e-learning package on the national Patient Safety work which the Committee Chair had already completed and Laura Coo would share the links again with the Committee.

071/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read which included the full action plan for the closed Serious Incidents as per the requirements of the Ockenden review and invited any comments or questions.

Fiona Osborne noted that the deteriorating patient incident last month said it was delayed by eight weeks but was now delayed for a further four weeks and asked if there was anything, that could be done to expedite that as ultimately there was a patient waiting for answers. Angie responded that they were working hard to try to focus on getting the Never events through first but this had been affected by the prioritisation on top of the operational pressures.

Maneesh Singh thought it was really saddening to hear when a family suffered from still births and did not feel there was enough assurance there but would take that further outside of the meeting. Kate Wood reassured Maneesh that still births were investigated externally by HSIB independently who were doing investigations across the country and had a lot of knowledge. Maneesh was surprised with how lightly it was worded. Angie noted that the summary provided was for sharing learning and did not cover the entirety of the report.

Angie added that any SI declared would be discussed at the SI panel weekly meeting where they would talk about what could be done to reduce the risk and suggested it might be useful for Maneesh to see how one of the them was worded.

072/22 Potential Deviations from National Documentation

None

073/22 Committee Annual Review

Distributed for information to take to the Board

Highlight reports

074/22 Quality Governance Group (QGG)

Angie Legge highlighted that the action plan on the National Neonatal Audit was received and provided some assurance

075/22 Mortality Improvement Group (MIG)

Nothing to discuss

076/22 Patient Safety Champions

Mike Proctor asked about the EPMA roll our being delayed and if that was going to be resolved. Angie Legge clarified that was a temporary suspension in Maternity and was about making sure it was going to be safe and that there was no risk

Items for information

077/22 Quality Governance Group (QGG) minutes

078/22 Mortality Improvement Group (MIG) minutes

079/22 Any Other Business

Nothing raised

080/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

- Ockenden update
- Safety partners
- Safeguarding and where we are in N E Lincs
- Maternity Sis
- Never Events
- Cancer
- Committee Review

081/22 Meeting review

Not discussed.

082/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 26 April 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 15:45pm

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
Michael Proctor		✓	✓	✓		✓					
Michael Whitworth	✓	✓									
Fiona Osborne	✓	✓	✓	✓	✓	✓					
Maneesh Singh	✓	✓	✓	✓	✓	✓					
Dr Kate Wood	✓	✓	✓	✓	✓	✓					
Ellie Monkhouse	✓	✓			✓	✓					
Dr Peter Reading	✓	✓	✓	✓	✓	✓					
Angie Legge	✓	✓	✓	✓	✓	✓					
Helen Harris		✓									
Jan Haxby	✓				✓	✓					
Jennifer Moverley	✓	✓	✓		✓	✓					
Shaun Stacey			✓								
Ian Reekie		✓			✓	✓					
Diana Barnes	✓		✓								

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 26th April 2022 from 12.30pm to 3pm
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
Shaun Stacey	Chief Operating Officer
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Jane Warner (item 089/22)	Associate Chief Nurse Midwifery, Gynaecology & Breast Services
Mr Kishore Sasapu (item 090/22)	Deputy Medical Director
Hayli Garrod (item 092&93/22)	Acting Head of Quality Assurance
Kay Fillingham (item 094/22)	Lead Mental Health Professional
Simon Buckley (item 096/22)	Associate Chief Nurse, Medicine
Jennifer Moverley (item 099/22)	Head of Compliance & Assurance
Laura Coo	PA to the Medical Director **(for the minutes)**

083/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Jan Haxby, Peter Reading*

084/22 Opening remarks

Mike Proctor advised that the Risk Stratification and Clinical Harm update from Mr Sasapu would be a verbal update and that there was not a MIG highlight report this month due to the meeting in March being curtailed due to operational pressures.

085/22 Declaration of Interests

The Quality and Safety Committee was quorate and there were no declarations of interest.

086/22 To Approve the Minutes of the Previous Meeting held on 22 March 2022

For accuracy the following amendments were suggested;

Page 4 mentioned the report from the Ergonomist and Mike Proctor asked if this Committee would see that report. Angie Legge was more than happy to share it.

Action: Laura Coo to add to the action log for the next meeting.

Page 6, paragraph starting *'Fiona Osborne noted'* to replace *'about the risks being red and asked why that was*' with *'why so many risks were red when many actions and mitigations had been delivered'.*

Page 6, paragraph starting *'Picking up on the external scrutiny'* Ellie Monkhouse advised it should say '*quality improvement money for a Quality Improvement Manager'.*

Page 8, last paragraph of item 065/22. Ellie Monkhouse noted that the sentence '*From an NLaG performance point of view Ellie Monkhouse commented that the children were looked after well once they come into NLaG'* was referring to the KPI's and needed changing to reflect that.

Page 8, last paragraph, first sentence. Fiona requested to replace *'and how that worked particularly given how the staff had worked with the established beds'* with *'and how staff shifts were being filled particularly given the staffing issues with the established beds*'.

Page 9, at the top of the page Ellie Monkhouse noted that it was an '*outbreak*' of norovirus rather than a single case

Page 10, second paragraph. Fiona requested to replace *'However the National Mandated timescales*' with '*However Hayli advised National Mandated timescales'* as Fiona felt the minutes suggested that was what Fiona had said rather than Hayli.

The regional Never Event comparison figures had been included on today's agenda under items for information

With regards to item 062/22, Ockenden Assessment Tool Mike Proctor thought that at the end of that section the minutes should note '*the Committee approved the submission of the report and would inform the Board of their decision'*.

It was suggested and agreed that the attendance table at the bottom of each set of minutes should be updated to just include Executives and Non-Executive Directors only and Ellie Monkhouse had attended the January meeting and this should be reflected in the attendance record..

The minutes, with the changes above were agreed as an accurate reflection of the previous meeting.

Action: Laura Coo to make the amendments as above

Matters Arising

087/22 Revised QSC Workplan

Angie Legge referred to the revised Quality and Safety Committee workplan distributed which was taken as read, all changes were highlighted in yellow. Angie pointed out that we would need to consider how the existing CSS services would report into this Committee given the recent structural changes to the Directorates; these services would now fall into other divisions, with pharmacy and Pathlinks independent specialties under Operations.

Mike Proctor thought the Exec team should advise and Shaun Stacey agreed there needed to be a fundamental review and was happy to work with Kate Wood and Ellie Monkhouse to provide a summary.

Ellie noted that the IPC update was not included but thought that could be an oversight. She reflected on the frequency with which Maternity would need to report here given the work underway to respond to national work and suggested bi-monthly updates. Kate's view was at least bi-monthly updates were needed as things seemed to be changing daily. There was going to be a change across the organisation with the way we learn, act etc and if Ellie was suggesting bi-monthly Kate was happy to support that rather than quarterly.

Ian Reekie asked if monthly quality priorities updates were necessary and if so, had June been missed. Angie clarified this was part of an engagement process that built up after each meeting. It was not in June as this allowed time to see the early results from the existing years Quality Priorities. Consultation commenced in July through to February, with March to May being the Quality Account.

Kate noticed the workplan update only said community but should say community and EoL. Kate also mentioned that Kishore Sasapu would be making a proposal about the risk strategy and clinical harm updates later in the meeting.

In terms of what was happening in Obstetrics Mike felt that every other month was fine but wanted to be careful that the Committee still heard about the rest of the Division and was happy for updates to be added to the agenda as and when.

Mike Proctor summarised; would pick up the workplan again at the next meeting, the key issues were for Obstetrics changing the frequency of the reporting but ensuring the rest of that division was included in the updates, to adjust around the cancer reports and quality priorities and consider where the CSS update would be included.

088/22 Review of action log

All actions were up to date.

Regular Reports

089/22 Family Services with Maternity / CNST / Children's Services

Jane Warner referred to the report distributed which was taken as read and summarised the key points.

Jane had attended to give an update on CNST, Paediatrics and the rest of the Division as well as an update on Ockenden.

The 10 safety actions for CNST compliance were achieved last year and Jane hoped to achieve the same again this year.

- Safety action 4 - incorporated Obstetricians, clinicians, anaesthetic, neonatal workforce and consultant workforce.

- Neonates would have to include some mitigation reflecting the Humber Acute Services work that was going on in the background

- Safety action 6 – was Saving Babies Lives

- Safety action 10 - Training was a challenge but they were seeking the support of Shaun Stacey and Kate Wood as necessary

CNST currently had a three month pause which concluded at the end of March but the Division were still waiting to hear whether there would be an extension.

The divisional report that went to QGG was included in the update and highlighted the areas that had gone through the 15 steps challenge and the awards they received.

Following the CQC visit improvements had been embedded around observations. Children's services were much improved, and the improvements were consistent.

EPMA was suspended within Maternity services as it was deemed a safety issue, it was escalated and discussed with the involvement of Pharmacy. The problem was that a lot of women in Maternity were quite transient, Inpatients and Outpatients in the same day and EPMA was unable to capture that. A task and finish group was set up which had unpicked all the elements of maternity prescribing so they were now re-joining.

There was a risk of not being able to meet the Facing the Future Standards across Paediatrics, Emergency Care and Surgical/Critical Care workstreams due to financial and/or service configuration constraints so that had been a big piece of work for Paediatrics.

The Trust were having an assurance visit the following week from the Regional Midwife and the team to see if the changes had been made following the initial Ockenden report.

The final Ockenden report was 250 pages with 15 immediate essential items for Trusts to comply with and within those 15 actions there were over 90 actions for each.

The regional and national midwifery teams would not be looking for any assurance until after the next report was published after June.

Mike Proctor noted that he was involved in a Neonatal 15 step review at SGH and it was awarded outstanding.

Kate Wood thanked Jane for providing the report and covering off Paediatrics as well but felt there was a gap in the report about Breast although Family Services covered Breast. Mike thought Jane had done an admirable job in putting the report together but suggested other individuals could provide that part of the update where services other than Maternity were referenced.

Ellie Monkhouse concurred with Mike's point and suggested that Debbie Bray could provide an update about facing the future and where we are.

Action: Debbie Bray to provide an update on facing the future to the July Quality and Safety Committee.

Jane Warner left the meeting at 1.05pm

090/22 Risk Stratification & Clinical Harm (verbal update)

Kishore Sasapu joined the meeting at 1pm

Kishore Sasapu gave apologies for not providing a paper but wanted to use this opportunity to discuss doing things differently going forward. Due to the pandemic, it had been necessary for the Quality and Safety Committee to receive regular updates about how we understood and reduced the risks to patients on our waiting lists. Jackie France and Colin Farquharson had put the risk stratification process in place. As soon as anybody was referred to the Hospital, they were automatically risk stratified 95.9% of people were risk stratified which was the best position we had ever been in. The figures were monitored through the Operation Management Group (OMG) on a weekly basis and at PRIMs on a monthly basis. One idea was to see if we could focus on specific areas such as long waits and cancers. This was being discussed with Jackie France, Shaun Stacey and Kate Wood and the plan was to come up with a paper to look at what the risks were for cancer long waiters.

Fiona Osborne thought it was a good proposal but suggested as well as the long waiters, the patients who had moved between those levels as well if that information was available. Kishore thought we needed to look at if anybody was coming to any sort of harm, how that could be monitored as a group and what could be learnt from it. The report could also reference how many people were coming to moderate or severe harm and if there had been any specific cases.

Maneesh Singh felt that there tended to be a lot of performance figures at QSC but he wanted to hear how patient care was being improved and how it was making a difference and to understand where it was failing. Kishore agreed it was very difficult to tease out and there was no way objectively to say exactly what was happening with a patient but we had never been in a better place and because of what people know about this there was more openness in telling patients if they had come to any harm. Kishore accepted Maneesh's point and would include it in the paper

Shaun Stacey pointed out that we would not lose visibility around the data but thought it was more an understanding about the clinical impact and to get the best out of our services. It was a good example of the balance between statistical and impact reporting.

Mike Proctor agreed that what this Committee really want to know is whether our risk stratification process meant that a patient was delayed in getting treatment and if they did come to harm was that a result of the delay.

Kate Wood thanked Kishore for the work he was doing as it had been such a huge amount of work to get to this stage and thanked the NEDs for the challenge and support.

Kishore Sasapu left the meeting at 1.19pm

091/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and highlighted the key points. The period reported on demonstrated quite a high level of acuity and activity from an outbreak of norovirus and covid perspective, compounded further by the fact we had escalation areas open.

Ellie was concerned the report gave a false assurance, it had been very difficult to quantify the information and playing catch up was slightly throwing some of the data from the Wards. Peoples clinical time and ability to follow through on this information and validate and reporting was an issue.

Clinical placements were good news, and we were doing incredibly well from an Infection control point of view when compared to other organisations

In respect of areas of concern, midwifery vacancies were now on ‘Safe Care Live’ which was a real time acuity tool used daily and based on the acuity of people on the Ward. The Team was ensuring services were kept running and all escalation processes and policies were being reviewed. The workforce problems were not isolated to NLaG and were affecting Trust across the region.

There were some good QI outcomes from the teams and given the circumstances they had been working under, Ellie thought they had done incredibly well all things considered.

Ellie invited any comments or questions.

Fiona Osborne referred to the information on falls and although there was a statistic discrepancy Fiona still thought it was quite concerning and asked how soon the actual impact would be known as the increase in falls seemed out of character.

Ellie did not think it was out of character given the increased numbers of patients with complex issues and frailty, many of them were frequent fallers and the information corresponded with that, so it was not as worrying as it looked but Ellie still did not want the report to provide any false assurance

Fiona asked about Amethyst Ward and whether there was a reason why those Wards continued to appear in the top ten sickness levels. Ellie explained that Amethyst had been through an intense time of support, there were a lot of things going on in that ward and they were now moving to a better a place.

With regards to recruitment Fiona asked if there was a problem in terms of retention and if there was something that could be done to reduce leavers Ellie felt she was

doing a lot to support the recruitment but agreed that further support focussed on improved retention would be helpful

Maneesh Singh asked when the HASR review was for maternity as he did not think things could move forward until we knew the planning. Ellie advised there was some work going on looking at service provision across the two sites.

Kate Wood added that the HASR review would not come out with a single idea as they had to go out to the public consultation. What the senate did say was that we needed to look at our staffing levels very clearly and should not base our assumptions on what may or may not happen in the future. A model could not be based on ifs, whys and wherefores so Kate thought we should wait and see.

Mike Proctor asked about the night-time register nurse fill rates and if we were ever left with one RN on night times. Ellie confirmed she always made sure there were two on shift.

Mike noticed the fall resulting in significant harm on SDEC and asked what the detail around that was. Ellie thought it was a good example of where we have had to place patients on a temporary basis. Shaun Stacey reinforced that there was a huge balance of risk, we had a local community where people were not getting access to health in a timely manner and they were challenged by an A&E compounded by the exit block. An ambulatory flow had been created but with that came a level of risk and to try to mitigate that Shaun and Ellie tried to ensure the staffing levels were as maximum as they could be but there needed to be a whole balance of the risks on a regular basis.

092/22 PROMS

Hayli Garrod joined the meeting at 1.30pm

Hayli Garrod referred to the paper distributed which was taken as read. The paper showed that although the Trust had maintained the good scores for knee replacements, the Trust had deteriorated for hip replacements and the team was starting a deep dive in to the data next month to ascertain the underlying cause. They would be happy to bring the findings back next month. Previously the Trust was an outlier for knees and did well on hips but it had switched around.

The Trust overall participation rate had decreased but the team had found a bit of disparity at GDH and had discussed with the staff at GDH to ensure they were getting the opportunity to complete the surveys

Fiona Osborne thought it would be interesting to see what physical changes with key learnings and processes were being made in terms of the patients care as well as the statistics.

Hayli advised that the intention was to put an action plan together and would bring that back.

093/22 Quality Priorities & Quality Account

Hayli Garrod referred to the paper distributed which was taken as read. The Quality Account was in draft and Hayli asked if the Committee was happy to release it to external stakeholders for review. The deadline for external comments would be 31st

May 2022. Haylie asked if Mike Proctor wanted it brought back here before it went to the board in June. Angie Legge advised that we were legally required to give the external stakeholders a certain amount of time to review. It was always a tight turn around to get this to the board and Hayli had to follow a very rigid way of writing the report, it was statements of fact and proposed it was sent around everybody virtually but that it went to the board.

Maneesh Singh had some concerns and so Mike Proctor suggested for Maneesh to put his thoughts down and circulate offline to Kate Wood and Mike to forward on to Hayli.

Hayli Garrod left the meeting at 1.48pm

094/22 Mental Health Strategy

Kay Fillingham joined the meeting at 1.45pm

Kay Fillingham referred to the paper distributed which was taken as read and highlighted the key points. The idea was to put mental health needs on level with the physical needs. The strategy set out a dynamic but achievable plan towards this vision. The strategy was the framework for the Trusts overall vision for patients with mental health needs within our care and within the wider promotion of mental health and wellbeing for our patients

The key objectives were;

- Improve our compliance with the Mental Health Act
- Provision of regular, comprehensive mental health training
- Ensure our practices are in line with NICE guidance and NCEPOD recommendations
- Embed a culture of continuous learning, taking on board the latest regional and national best practice and learning following serious incidents.

This would be reviewed every 12 months.

Priority objectives were to improve compliance which remained a challenge and there was a lot of work needed to do but from an assurance perspective we were in the right place. One area which needed work was to look at flexibility as our workforce were increasing busy.

Kay noted that it was important to ensure our mental health practices were in line with NICE recommendations.

Kay went on to outline that the strategy was about embedding a culture of shared continuous learning and she would share the improvement action plan tracker. The launch of the strategy was aimed to coincide with the mental health awareness week, the main theme of which was loneliness.

This strategy went to OMG and TMB in January, it had also been shared with NEDs and went to Private Trust Board in February and was approved at TMB on 4th April with its final governance to be brought to this Committee.

Fiona Osborne really liked the strategy and thought it was very clear. Shaun Stacey wanted to express his thanks to Kay and for the help of the Comms team as it was incredibly difficult to write in a non-mental health environment and thanked everybody for the comments and feedback after the initial hearings and they were planning to do a big mental health launch during the mental health week.

The Committee were content to ratify the strategy and inform the Board the Committee had done so.

Kay Fillingham left the meeting at 1.57pm

095/22 IPR

In terms of VTE Mike Proctor thought it was great to see that improvement. Kate Wood reminded colleagues that she had been advising that once the denominator was corrected, the figures would improve, and we would be able to identify where improvements needed to be focused but the improvement in the numbers could now be seen and we could trust them.

Kate thanked everybody for their perseverance and acknowledgement, but we now had the numbers to provide us with that assurance.

Kate Wood referred to the IPR distributed which was taken as read and Kate invited any questions

SJRs were always six to eight weeks behind so there would always be a drop on the chart when they were behind with them. There were five SJRs from last year still be done but the team were working on them at pace.

The drop in the duty of candour in December was an isolated incident where Duty of Candour had been delayed but had been undertaken.
With regards to the quality priority to NEWS and sepsis, the Trusts quality improvement team under the leadership of Ellie Monkhouse were doing some work on the deteriorating patient.

Fiona Osborne liked the Exec summary but was going to make the same comment that we had three low lights and was really interested in what was happening with those and if the actions were being completed what monitoring was there to ensure they stayed within those target levels. Kate noted that as a hospital we were there to deliver patient care and Kate and Ellie were the two Directors who had quality in their portfolio and the restriction of only three highlights and lowlights was a challenge. She noted that actions could take longer than one month to deliver and hoped the Committee would be assured by the narrative given when presenting the IPR.

Fiona was not aware that the lowlights were limited specifically to three and agreed that this should be flexed if appropriate for the circumstances. Mike Proctor commented that he would like to see a summary that Kate and Ellie agreed on and thought they should be allowed to do that in a way that they felt was best and would include that in his highlight report to the Trust Board. Kate added there had been a lot of time spent doing this work but they could not include a narrative so would appreciate a bit more freedom.

Maneesh Singh asked about the out of hospital SHMI, Maneesh knew there had been some progress but thought he had read that NHSE/I was getting involved in that. Kate clarified that NHSE/I had been involved for over a year at Kate's request.

Ellie agreed with Kate it was a valid point that the Committee had talked about a lot of things today that was not in that report but was of significant concern to us. There was something about the degree of trust that the Committee gives to Kate and Ellie in the narrative that comes out in the IPR. It was quite difficult to write a joint summary as they had very different focusses.

096/22 Diabetes Management

Simon Buckley joined the meeting at 2.05pm

Simon Buckley referred to the paper distributed which was taken as read. Recommendations were included in the paper about audits and how they would be stepped down, the yearly national audit and oversight to maintain governance for ECC and how to focus on the KPIs.

Fiona Osborne wondered if there was a likelihood that we would not be able to respond to top trends by not monitoring the audits so closely. Simon noted that there were other mechanisms in place where they would continue to monitor that.

Kate Wood partly agreed with the recommendations but was partly nervous too, the ward data did not worry her so much as that was monitored regularly via other routes, but Kate was more worried about ED and did not think there was sufficient data to indicate an embedded practice yet, noting that maybe her thoughts were influenced by recent reports for ED about an undiagnosed DKI patient who got sent home (although the case was in 2017).

Simon agree with Kate that the ward audits should not continue but that those in ED should with a further review in July. All agreed with that timeframe.

Simon Buckley left the meeting at 2.21pm

097/22 Key SI Update including Maternity

Angie Legge referred to the paper distributed which was taken as read and highlighted two new maternity incidents;

- HSIB incident – this was a potential missed opportunity to deliver a baby sooner. When discussed at SI panel it was not clear if there was an error but there were concerns about the abnormal CTG with a two-hour timeframe from that to delivery, so it was felt it was better to declare as an SI to unpick whether there was any learning. Maneesh Singh asked about the outcome for that baby. Angie confirmed there was a poor outcome in a separate Paediatric incident. Maneesh commented that the anaesthetist involved acted very quickly and responsibly which was a good thing but asked about the syringes and if there was a 'stop before you block' policy and were those types of syringes available. Kate Wood confirmed there was a very robust process in place. All Trusts had the syringes and it was not accidental but did not want to get into speculation but the process for

investigation was robust and our Commissioners provide really good feedback and would get the assurance once the investigation was complete.

Mike Proctor would include the two Maternity SI's in the highlight report to the Trust Board.

098/22 Potential Deviations from National Documentation

None

099/22 CQC Improvement plan update

Jennifer Moverley referred to the report distributed which was taken as read. Changes since the last report had assurance for five previously signed off actions. The current position was 81 % actions blue or green

Community nurse staffing was amber and continued to be closely monitored and the plan was it would only be progressed further upon the vacant posts being filled.

EoL training around Respect had increased and a paper was going to the next divisional governance meeting.

In respect of confidential records in medicine, the division were recommencing spot checks and ward visits. This had seen improvements; all visits had been completed at SGH and the team were just finishing at DPOW.

Jennifer noted that Paediatric boards had been installed and the evidence template had gone to Paediatrics governance meeting for sign off.

Jennifer Moverley left the meeting at 2.31pm

Highlight reports

100/22 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed which was taken as read. Angie highlighted that an issue was raised about unacknowledged reports however it was unclear whether this represented a safety concern, as the view was that the reports had been acted upon, just not acknowledged on the system. QGG had asked for a deeper dive into the data to understand the level of risk.

101/22 Mortality Improvement Group (MIG)

Not applicable due to the April MIG meeting being curtailed due to operational pressures

102/22 Patient Safety Champions

Attached for information and taken as read.

Items for information

103/22 Quality Governance Group (QGG) minutes

104/22 Mortality Improvement Group (MIG) minutes

105/22 Patient Safety Champions minutes

106/22 Regional report on Never Events

107/22 Any Other Business

Nothing raised

108/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

- Numerous changes to workplan which would be attached
- Adjustments to the risk stratification & clinical harm report
- Reflect on staffing difficulties leading to difficult decisions
- Approved mental health strategy
- Improvements in VTE
- Maternity SI's
- IPR

109/22 Meeting review

Not discussed

110/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 24 May 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 2:35pm

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
Michael Proctor		✓	✓	✓		✓	✓				
Michael Whitworth	✓	✓									
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓				
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓				
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓				
Ellie Monkhouse	✓	✓		✓	✓	✓	✓				
Dr Peter Reading	✓	✓	✓	✓	✓	✓					
Angie Legge	✓	✓	✓	✓	✓	✓	✓				
Helen Harris		✓									
Jan Haxby	✓				✓	✓					
Shaun Stacey			✓				✓				

NLG(22)098

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	07 June 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 - March 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Workforce Committee Minutes of the meeting held on Tuesday 29 March 2022 and approved at its meeting on Tuesday 31 May 2022.	
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	☐ 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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 29 March 2022 at 14:00 hours via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Michael Proctor	Non-Executive Director (Deputy Chair)
Linda Jackson	Vice Chair
Fiona Osbourne	Associate Non-Executive Director
Simon Parkes	Non-Executive Director
Robert Pickersgill	Governor, Membership Office
Christine Brereton	Director of People
Nico Batinica	Associate Director for Workforce, Systems and Recruitment
Paul Bunyan	Associate Director of Workforce Operations
Alison Dubbins	Associate Director of Leadership, Culture and OD
Kate Wood	Medical Director

In Attendance:

Jenny Hinchcliffe	Deputy Chief Nurse
Anthony Rosevear	Associate Chief Operation Officer, Community & Therapies and Family Services
Jennifer Moverley	Head of Compliance and Assurance (agenda item 10)

1 Apologies for absence

Apologies were received from Peter Reading and Stuart Hall.

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. Michael Whitworth stated he was doing some work with Grant Thornton in Coventry and Warwick helping with their elective recovery plan.

3 Minutes of the previous meeting held on Tuesday 30 November 2021

The minutes from the previous meeting held on Tuesday 30 November 2021 were accepted as a true and accurate record.

The Chair commented that the Committee had not met since November 2021 missing its meeting in January 2022 due to operational pressures, so there was a full agenda. He commented that workforce was the number one risk across the NHS and stated that was represented in the volume of papers being presented to the committee today.

4 Matters arising from the previous minutes

There were no matters arising from the previous minutes

4.1 Review of action log

Action 91 – To provide an organisational structure chart with names once the restructure has been finalised
The People directorate organisational structure charts had now been finalised and shared with the committee for information. It was agreed to remove this item from the action log.

Action 93 – Table the Disciplinary Policy at a future meeting when finalised for Trust Board oversight
It was noted that this item was on the agenda therefore, it was agreed to remove this from the action log.

Action 95 – FTSU Reports to include comments when things haven't gone so well
It was noted that the Q3 report submitted to the committee was on the agenda and had included comments on things that hadn't gone so well. It was agreed to remove this item from the action log.

5 People Strategy – Deep Dive

Introduction
Christine Brereton introduced the deep dive and explained to the committee that the presentation circulated with the papers would cover a number of items that were all interlinked. She explained that these items were either outlined on the annual workplan for a timed update to the committee or had been specifically requested by the committee for an update/inclusion. Christine Brereton explained that the presentation from herself and the team would include:

- Update on Culture Transformation Programme
- Leadership Development Strategy
- Retention
- Staff Survey
- Just and Learning Culture

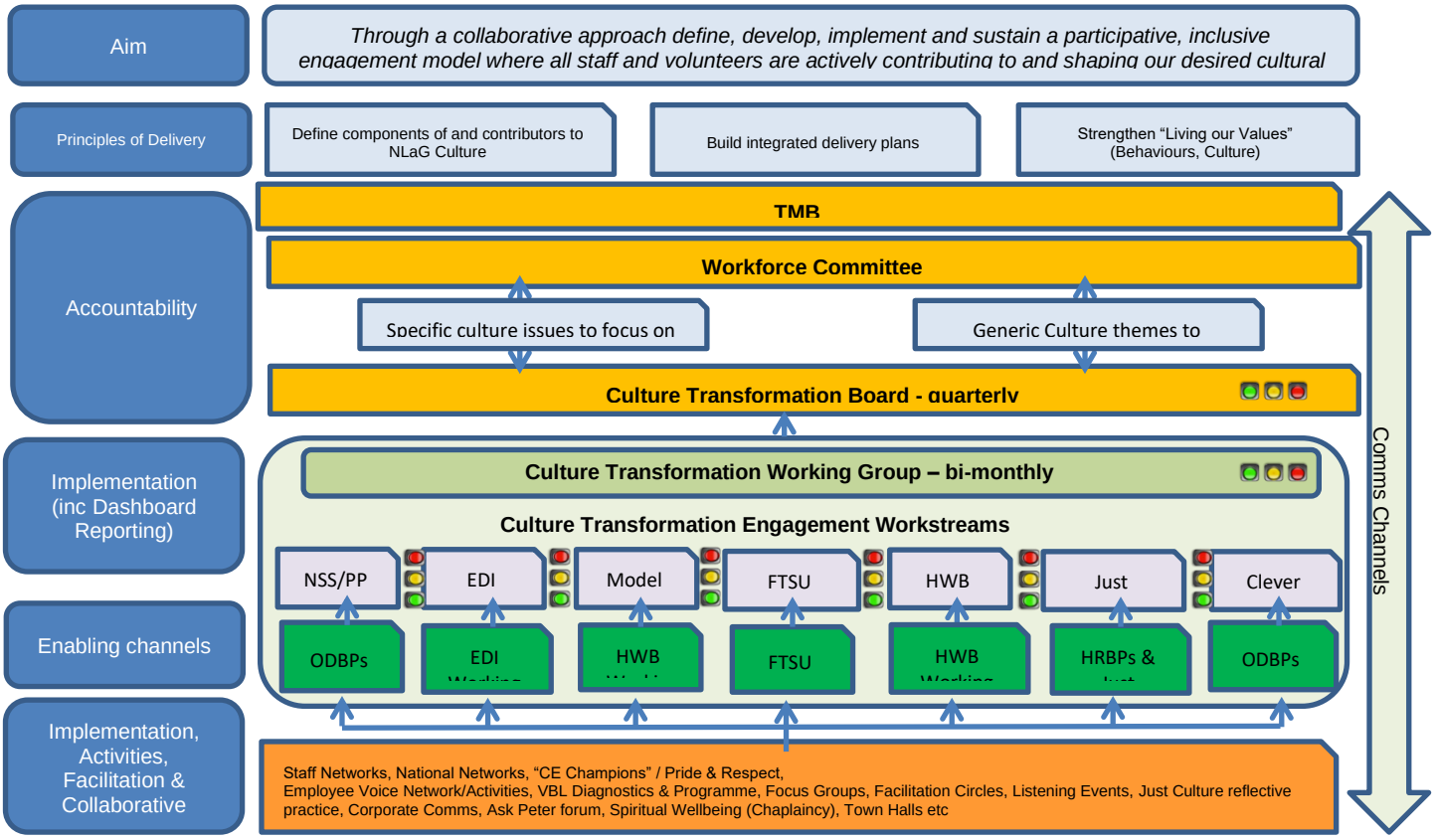
Christine Brereton explained that work had been ongoing to develop a framework for a Culture Transformation Board which would oversee a number of workstreams, such as Leadership Strategy, FTSU, Staff Survey and Just and Learning Culture so that all work connected with improving culture would be monitored and managed with oversight through one channel. This is outlined in table 1 below.

This would allow a collective overview and for information to be triangulated, rather than separate action plans being drawn up which is a transactional approach. The aim was to have transformational oversight and the Terms of reference for the Board are currently being finalised.

Once established the Culture Transformation Board and supporting working group will identify areas of priority for the Trust to focus on with an aim of improving overall culture within the Trust.

Table 1

Culture & Engagement Transformation Framework



The Chair talked about the importance of having performance metrics to measure and monitor culture transformation. Christine Brereton talked about the development of "softer" measures around the workforce to support the model employer, which is focussed around culture and leadership. NLaG have been chosen to be a pilot area to work with NHSI/E to develop a set of workforce metrics which are wider than those currently on the IPR. Some data to support culture transformation is already available in the staff survey. It will be important to bring all of these together to develop a set of metrics to support this.

5.1 Leadership Strategy

Alison Dubbins talked about the research which supports that effective leadership and impacts on a positive culture. She presented developing work around the Leadership Strategy which essentially fell into three areas, Foundation in Leadership, Professional Development and Values Based Leadership.

Alison confirmed that a large amount of work was underway with the three separate strands of leadership. From September 2021 a review had been undertaken to establish what the Trust already had in place by way of Leadership Development. Good examples exist within medical and nursing directorates, which benefited some individuals however, the trust does not have a structured or consistent guardianship nor oversight in terms of the return on investment that brings back into the organisation. There is a commitment to evidence to Trust Board and external stakeholders that trust leaders are compliant, competent, fit for purpose, well behaved and highly skilled.

The team are developing an individual leadership development analysis to survey the existing 648 staff who are in manager or leader roles including band 2 and band 3 porter supervisors and healthcare assistant leads. An assessment will be conducted against a core profile to establish a level playing field of what good looks like. New leaders will go through people leader induction and the same leader leadership and individual development analysis to generate a personalised development plan. The aim is to backfill any areas of competence and compliance that they perhaps haven't used for a while and to do that in a supportive appreciative enquiry culture.

The first problem is to take all those existing management programmes that are currently procured through the NHS Leadership Academy or external providers and bring those into three portfolio governance boards. One focused and centered on clinical skills, one on talent and leadership and one on core skills. Statutory and mandatory competence and compliance is being paired down to the bare statutory minimum to strengthen the immersive learning approach to give a blended learning approach around e-learning online, in person and reflective practice.

Christine Brereton commissioned an external provider to run a diagnostics process that is now completed. The data is to be reviewed to inform the next stage of the values-based leadership programme supported by a community of coaches purely focused on leadership behaviours and bringing alive the themes of kindness, courage, and respect.

Regarding the career framework, leaders will complete the foundation leadership skills in their first 90 days supported by a buddy or mentor. Any new leaders will go through a refreshed corporate induction, people leader induction, departmental and local and divisional induction.

Questions:

- Michael Proctor stated it may be worth informing the Board that these programmes will take a long time to become tangible so they can manage their expectations. He felt there was a leadership gap in the trust and asked what was being done in terms of developing followership. Christine confirmed that the trust will measure year on year activity with the data available. Alison's team are also intending to refresh the PADR process to include conversations around enriching health and wellbeing and structured talent identification and succession planning.
- Regarding the 90-day programmes for new starters and existing staff, Fiona Osborne asked about the differences. Alison stated that for new starter people leaders there is the corporate welcome, people leader induction and conducting the individual needs analysis to understand what they've brought across with them from pre-existing roles and then providing them with a personal development plan within those 90 days and a buddy or mentor to help them in the first three months. Existing staff will have longer, starting with the people leader induction which is not compulsory for existing staff. They will complete the leadership development assessment which will produce a personal development plan and then they have a period of twelve months to fill in the gaps.
- Fiona Osborne went on to ask if buddying and mentoring was restricted to the 90 days. Alison confirmed that the buddying and mentoring resources are there to access at any time.
- Linda Jackson stated, if there is a lot of skepticism, because of previous patchy development for managers, some effort will have to go into rebranding this and Board will have a role to play in this.
- Simon Parkes stated that the trust brings people in from outside who are incredibly experienced, talented and have a certain level of skills. He asked how the trust can make sure they learn from them rather than turning them into NHS people and bring those together. He added this is a long-term programme and many organisations wouldn't see

the programme through to the end. Christine stated that there is something about how the trust uses and utilises its managers to help with the programme as well as using good leaders to help shape, be advocates, sponsors and buddies of the programme. It is also about starting small in those areas where there may be the biggest impact. If the trust gets value-based leadership right it will start to change the culture. It is a longer-term piece of work, and a follow-on from pride and respect which was a successful campaign.

The Chair stated this is a long-term programme and it will cost money to free people up to mentor and buddy. It would be good to see the outputs in a years' time to show the investment in people. Alison Dubbins confirmed funding was ringfenced for the first twelve months. Any culture shift will take a minimum of three to five years and ten years to get to any form of ideal, so at first the trust will work in those areas where there are difficulties. If you can have a leader on a programme, participate and evidence based through some form of passing out parade what they will bring back into the organisation in terms of patient experience, quality improvement, reduction in error costs, increased productivity and for their own personal growth, you will be more willing as an organisation to fund something that funds itself because you can see the direct impact.

5.2 Retention Data

Nico Batinica reported in terms of retention, they have looked at the metrics themselves and the standout metric is turnover that has increased month on month since July, from 8.6% to 11.3% and in the region, figures are around 10.2%. The top reason for leaving is 'not known' so they are writing out to leavers since July 2021 to understand why and working with divisions to make sure that exit interviews take place. They are also working with managers to reduce the number of people choosing the 'not known' option. The only staff groups remaining under target are healthcare sciences and estates and facility staff. From the staff survey data, an emerging theme is that more people are considering leaving the organisation. They have talked to 40% of leavers who left the organisation within the first two years and found it is about getting the onboarding experience right, giving candidates the best experience, and increasing inclusivity in the trust recruitment process.

Recruitment is also launching a customer satisfaction survey for applicants and recruiting managers. The team is gathering feedback from divisional meetings about their experiences of recruitment to improve the process which will need everyone to work in partnership. Work has commenced around the establishment control process to make it shorter and more user friendly and to allow people to see how quickly the process is moving. In April they are looking at safeguarding checks to make sure everybody coming for interview meets the right criteria and going forward recruitment KPIs will come to this committee. There will be dedicated recruitment focus groups facilitated by the OD team to understand roles and to work together to improve the experience. After that an action plan will be produced and brought to this committee with changes implemented by the end of June. All this will feed into the culture transformation working group to monitor progress.

Linda Jackson welcomed the shortened establishment control process. She felt that on boarding is a real challenge when people are busy, and areas are short staffed, but she agreed that time invested is time well spent. Fiona Osborne highlighted that Facebook and LinkedIn are ways to get the message out there that NLaG is a great place to work, and she wondered if there would be any benefit from putting information onto Instagram to attract a younger demographic. Nico felt it was also about celebrating some of the successes on the platforms as well.

5.3 Staff Survey - 'Embargoed'

The full report is released tomorrow after 9.30 am when the embargo is lifted. Alison Dubbins explained the graph, the pink line is the worst performing organisations. The pale blue bar is the average scores across the 60 acute trusts and NLaG was compared against 59 other acute health providers. The dark blue bar is NLaG's performance, and the green line is the best performing organisations. NLaG is in the lowest quartile, but not the worse. Some of NLaG's markers have improved and the uptake rate was up by 2%, from 36% to 38%.

Michael Proctor stated that the results are far worse than the picker average and say that NLaG is not a great place to work. Alison Dubbins agreed and explained that the staff survey is only one metric within a wider set of metrics that her team are building on. Changes will take two or three years to gain traction and be seen in real measures. NLaG needs to take a collective culture shift approach to creating a better place to work and to work on the different strands holistically, not singularly. The culture transformational work is going to Trust Management Board and Peter Reading will send a cover message out to staff and there will be a comms plan to support that. The first thing to do is to thank those 38% of staff who responded. The results will also be distributed through the divisions next week.

Paul Bunyan reported that in the past when a member of staff genuinely made a mistake, there was a retributive culture and approach to employee relations. This was the same in HR for many years and managers followed the policy. The Just and Learning Culture is about good compassionate values-based leadership and taking common sense decisions when presented with the fullness of the information. Since piloting this approach from the middle of last year the trust has seen more informal cases and less suspensions and the emphasis is on stopping mistakes happening again. If managers get this right, small problems don't become big problems, staff feel listened to and there are fewer formal cases.

Michael Proctor felt that people are reporting incidents in an open and honest way and he has seen evidence of that through the Quality and Safety Group with never events. Jenny Hinchliffe added that the Just and Learning Culture work is so important. She is supportive of it and feels it is long overdue and good to have the level of data that is coming out of this work.

6 Freedom to Speak Up (FTSU) Q3 Report

Christine Brereton, Director of People presented the report on behalf of Liz Houchin, FTSU Guardian who was on annual leave. Christine confirmed that Liz Houchin had asked her to highlight the following:

- Concerns in Q3 were high at 46 but as Q3 covers October Speak Up month, this is often the case and the NGO report the highest quarterly concerns nationally in Q3.
- Main themes were around process, behaviour, and patient safety/quality.
- 'Model hospital' data indicates that in Q2 Patient Safety concerns were higher than the national average, but B&H concerns were lower.
- NGO have now changed the Patient Safety theme to Patient Safety/Quality – this highlights that when staff say patient safety, the underlying issue is often that staff feel they cannot provide quality care, but it is not unsafe. This is something our Trust has experienced.
- Review of the National FTSU policy is ongoing, due to be published April. The NLaG trust policy will be reviewed to reflect any changes and has a 6-month extension because of this.

- The third and final eLearning module for FTSU, aimed at Senior Leaders (Board level), should be released in April 2022.
- From 01/04/2022 the NGO are asking trusts to report on a new theme – behaviours, also if staff come in a group to the Guardian, new guidance is to count them individually so trust numbers may go up initially.
- The Chair asked for some negative comments in the qualitative feedback for balance, this had now been added into the report.

Christine Brereton added that Liz will be aiming to give theme trends in the annual report at the end of Quarter 4.

7 Gender Pay Gap Report

Alison Dubbins confirmed that the report had been to Trust Management Board in February and will go to Trust Board on 05 April. If agreed today, the report will be uploaded to the Government portal. Alison Dubbins highlighted that the peak in indicator five is largely because NLaG has a larger male consultant workforce therefore, that skews the bonus payments indicators and indicator six. Page 9 and 10 of the report sets out the actions that have taken place to date and going forward. Karl Portz is producing NLaG's EDI two-year plan and a refresh of the EDI Strategy with wide local consultation and importantly to redress the balance with the gender pay gap. Regarding the medical workforce skewing the figures Michael Proctor felt that the greater the number of years of service by consultants, the more likely they are to earn more and more likely to be male. Michael would like to know if the trend is the same as the non-medical workforce. Christine Brereton stated that a more detailed deep dive will be done later in the year and presented to Trust Management Board to see where some of the areas are. The committee unanimously supported the Gender Pay Gap Report.

8 Modern Slavery Statement

Alison Dubbins highlighted that the only two figures that change in the statement year on year are turnover and workforce. This again is a statutory requirement. The committee unanimously supported the Modern Slavery Statement.

9 BAF

Christine Brereton reported that a review of Q3 had been undertaken to review the actions and mitigation and a recommendation was made to keep the scorings as they were, given the ongoing risks for workforce. This was agreed by the committee.

10 CQC Update

Jennifer Moverley reported that 81% of the 145 CQC actions are either blue or green. In the last month two actions have been signed off and uploaded to CQC. A total of 25 actions are assigned to this committee and there are three red actions:

- surgery appraisals at 74%,
- paediatric mandatory core training at 93%; IG training at 88% and role specific training at 76%,
- maternity emergency mandatory training

Amber actions include:

- end of life in relation to sufficient staff with the right qualifications, skills, and training. Work

is underway with an interim solution and this will be achieved by the implementation of the seven-day services,
- medicine mandatory core training at 88%; IG training at 84% and role specific training at 76%,
- medicine appraisals at 77%,
- emergency department appraisals at 80% from a position of 67% last month, which is good despite the current pressures they face,
- paediatric medical staffing meeting national standards,
- surgery mandatory core training at 90%, role specific training at 80% and IG training at 88%

Jennifer Moverley added that she feels the progress is sustainable and some of the actions have been kept on there because they are under target, have increased or have remained steady. Christine Brereton added that the work that Nico Batinica is doing and the detail that Jennifer gives can be triangulated at this meeting. The above information is also being managed through the PRIMs meetings.

11 Workforce Performance Report – Trust and Directorate

The report was submitted to the committee by Nico Batinica.

Jenny Hinchliffe commented that on page 8 the narrative should state that unregistered nursing is at band 2 and 3 and registered nursing associates are at band 4 and actually reported in with the band 5 registered nurses and going forward it would be useful to clarify that. Nico agreed to pick that up outside of the meeting.

Linda Jackson commented that unregistered nursing vacancies are getting worse every month and she wondered why. Jenny Hinchliffe reported that there was a big push led by NHSEI to attract people into healthcare who hadn't previously worked in healthcare and the trust has now learned from that. Over the last six months they have been looking at the recruitment process, their marketing material and how they've been running webinars. They are putting together some videos to show people what to expect. They have been developing a pool so that as people leave, they have got a cohort of staff they can bring in straight away and this work should make a difference over the next few months. Work is also dependent on the establishment review and how much of that gets funded. The numbers of people applying for non-registered posts has started to increase. Nico Batinica added that it is becoming a more competitive market with organisations growing their own and developing their nursing workforce. Christine Brereton highlighted the tremendous amount of effort that goes into this and they have started to look at how the trust recruits' people and retains them. There is evidence in the retention data that people are leaving because there are no career development opportunities. Jenny and her team have also put in a bid linked to apprenticeships.

Fiona Osborne referred to page 11 and PADRs, it says that the target cannot be met without process redesign but in the actions and mitigations there is nothing actually stated about the process redesign i.e., what's happening, whether it's begun, whether it is part way through or what the trajectory is. Fiona felt that needed some more work to give more information and assurance that the process redesign is being looked at. Jenny Hinchliffe highlighted the importance of making links across different work streams because if there isn't any career development or opportunities for staff, things are not going to get better. 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.

Nico Batinica stated that going forward the report will be providing recruitment KPIs to give the committee a better understanding on how recruitment is working and to measure process improvement work taking place.

12 Annual IPR Target Review

Nico Batinica reported that the IPR review including reviewing all the workforce metrics and all targets have been benchmarked against regional peers and performance at regional and national level. Three recommendations have been made based on that information because everybody appears to have their targets set much higher and this will bring NLaG in line with its peers. The recommendations for targets are:

- unregistered nursing vacancies to increase from 2% to 8%,
- trust wide vacancies to increase from 7% to 8%,
- turnover to increase from 9.3% to 10%

Nico Batinica asked the committee to support the decision to change the metrics going forward. Christine Brereton praised Nico for the work he has done on the review and she added that Peter Reading and Sean Lyons are in support of the suggested changes being made and that will then be covered in the Chair's highlight report to Trust Board.

The committee supported the change to the metrics going forward.

13 Workforce Resource Centre Report

John Awuah reported that the resource centre is divided into three departments: emergency and winter planning, workforce, and patient flow. Work is being done to streamline the resource centre and it may involve the changes that are happening to the clinical support services division in terms of opening that up and merging it with other divisions. The centre has implemented the new Bank and Agency Policy and is working with the Medical Directors office to push job planning on. A total of 75% of job plans have been completed and they are working hard to get that into the 90's. The new tier system is in place for nursing agencies, flat rates for tier one to achieve better fill rates. There are internal and external workforce supply challenges, and it is difficult to get staff on the bank and via agency which puts pressure on the bank and agency offices, which have admin shortages. There are over 3,000 staff registered on the bank and in February there were 5,947 requests for registered nurses and 2,200 were filled by the bank and another 2,000 via agency. There is quite a gap between what is requested and what can be filled due to the pressure in the labour market. Regarding doctors, most requests are to cover medicine shifts and the majority are covered by NLaG staff working extra shifts. Derek Conlon highlighted that doctor fill rates are very high. The number of shifts filled for registered nurses last year was around 6,000 sifts per month. The Covid blip started in November 2000 and has stayed since, with between 1,000 and 1,500 shifts per month, but if they were to disappear fil rates would improve quite substantially.

Christine Brereton stated it is about how to bring all those pieces of work into transformational programmes of work. Regarding the work that John and Derek are doing, we need to identify where projects sit across workforce, resource centre, people directorate as well as looking at processes that may integrate to make those better. An example of that would be if recruitment and retention planning got better, linked to a career pathway, there would be less usage for bank and agency staff, costs would go down and that money could be invested in the front line.

14 Workforce Policies and Procedure

14.1 Disciplinary Policy

This policy must be approved by Trust Management Board and the reason it is here today is because it came out of a set of recommendations nationally from Dido Harding. One of the recommendations was to have the policy approved at Trust Board and/or Sub Committees of the Trust Board. Paul Bunyan has provided a presentation to highlight the changes in the policy and it includes the Just and Learning Culture approach and does need to be approved by this committee.

The committee approved the Disciplinary Policy and noted that it would be submitted to the Trust Management Board.

15 Lottery Committee Update

Alison Dubbins reported that the trust is moving provider in May because the current provider is changing their business model and they no longer want to run the lottery. The trust is moving to Sterling and replacing its current service like for like. The paper provided gave oversight and the committee noted the paper.

16 Trust Board Highlight Report

The Chair to highlight things that have been approved and recommended, changes in targets and reference the deep dives undertaken.

17 Review of Annual Workplan

The Chair stated that the annual workplan is working well and the committee all agreed and endorsed that.

18 Items for information

18.1 Minutes of Health and Wellbeing Steering Group - 26 January 2022

Nothing discussed.

19 Any Other Urgent Business

Michael Whitworth referred to an old action from the Audit, Risk and Governance Committee around including a fraud video in the mandatory induction process. At the last Audit, Risk and Governance Committee meeting there were a few things which the Chair verbally briefed Christine on and he is awaiting the actions and minutes from that meeting to progress further.

20 Date, time, and venue of next meeting

Tuesday 31 May 2022 at 14:00 hours via Microsoft Teams

The meeting closed at 16:35 hours

NLG(22)099

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7 June 2022	
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Audit, Risk & Governance Committee Minutes from 24 February 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 24 February and approved at its meeting on 21 April 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	☐ 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.

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**24 February 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
	Helen Harris	Director of Corporate Governance
	Mark Surridge	External Audit – Director (Mazars)
	Mike Norman	External Audit – Senior Manager (Mazars)
	Shane Fenn	External Audit – Auditor (Mazars) (Observer)
	Helen Higgs	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Tom Watson	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
	Ian Reekie	Governor
	Nicola Parker	Assistant Director of Finance – Planning & Control (Item 11.1)
	Mick Chomyn	Associate Director of Pathology (Path Links) (Item 12.1)
	Angie Legge	Associate Director of Quality Governance (Items 12.2 & 12.3)
	Sue Meakin	Data Protection Officer (Item 12.5)
	Ivan Pannell	Head of Procurement (Items 12.6 & 12.7)
	Anne Sprason	Directorate Admin Manager / PA to CFO (Minutes)

Item 1 02/22 **Welcomes and Introduction**

Simon Parkes welcomed Helen Higgs, new Head of Internal Audit and also highlighted that this was to be Tom Watson's last meeting and thanked him on behalf of the Trust and previous Committee members, for his work with the Trust over the last four years.

Alison Hurley was welcomed to the meeting who was standing in for Helen Harris as she had a prior meeting; it was anticipated Helen Harris would join at 10.00am.

Item 2 02/22 **Apologies for Absence:**

Apologies received from Rob Pickersgill. Ian Reekie was in attendance as Governor representative.

Item 3 02/22 **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 4 02/22 **Minutes of Previous Meeting**

The minutes from the meeting held on 21 October 2021 were agreed as accurate.

The Highlight Report from 21 October 2021 had been provided and was noted.

Item 5 02/22 **Matters Arising/Review of Action Log**

6.1 (22 07 21) – Mental Health Act Internal Audit Report – Tom Watson advised that he met with the Mental Health lead nurse and actions were now complete. Once evidence had been received the final report would be published.

7.1 (22 07 21) – LCFS Induction Video – Michael Whitworth advised that Christine Brereton, Director of People, would be raising this with the Executive Team for discussion. This would also be picked up at the agenda set for discussion at the next Workforce Committee meeting.

8.1 (21 10 21) – Offer of Support to LCFS – Linked to item 7.1 above

12.4 (21 10 21) – Document Control Report – Simon Parkes had recently written to Christine Brereton, Director of People regarding this and he would update at the next meeting once a response had been received.

All other items were included on the agenda and following review, the action log was noted.

Item 6 02/22 **External Audit (Mazars)**

6.1 2021/22 Audit Strategy Memorandum

Michael Norman presented the annual Audit Strategy Memorandum and highlighted significant audit risks and areas of key judgements. Michael Norman advised that the audit team would be the same as last year, and that the scope would be like previous years with similar sector risks included. The main risk for this year was the implications due to changes to the financial systems. The VFM commentary was unchanged and reporting would run concurrently with the annual accounts in June 2022. Michael Norman also introduced Shane Fenn who was a member of the audit team and attended as an observer.

Lee Bond advised that he had worked through the strategy document with the team and he had no issues to raise. Simon Parkes queried the capitalisation of revenue spend and Michael Norman advised that it was not something unique to NLAG and because of the capital programmes in place due to the national programme rated as an additional risk.

Following review, the Committee agreed the annual Audit Strategy Memorandum.

6.2 Progress Report

Michael Norman gave a brief verbal progress update and highlighted that the Audit team had been working with the Finance team over the last couple of weeks and no concerns had arisen on controls or any other areas that required escalation.

Due to the financial system changes a bigger piece of work would need to be undertaken with liaison with Internal Audit to determine if a blended approach could be used to make best use of resources. Tom Watson agreed with this approach which would be highlighted in the Internal Audit report later on the agenda.

Lee Bond asked for an update on planning for 2022/23. Mark Surridge explained that a meeting was due to take place in March nationally to review the resource model to ensure maintenance of standards for clients and would advise Lee Bond of the outcome. Simon Parkes suggested the Committee members meet for half an hour prior to the commencement of the next meeting, including Lee Bond, to update on the resource issue.

Action: Mark Surridge / Sally Stevenson

Item 7 02/22 **Internal Audit (Audit York)**

7.1 Internal Audit Progress Report

Tom Watson presented the report and highlighted two reports finalised since the previous meeting, unfortunately staff sickness and delays in Trust responses had impacted on the ability to finalise more. Tom Watson stated that he was still confident that audits would be complete or sufficiently nearing completion by April 2022 for the draft version of the Head of Internal Audit Opinion.

Tom Watson highlighted two proposed changes to the 2021/22 audit plan i.e. combining the clinical harm & risk stratification and waiting list management reviews as a result of changes to national guidance; it was proposed to use the full planned days and increase the scope of the audit testing. There was also an additional audit request on the transfer of balances and transactions because of the new ledger system. The Committee agreed the changes proposed.

Lee Bond noted the Cyber Security review was planned for Q3 with field work in progress and highlighted the concern of potential cyber security issues because of the current Ukraine/Russia situation. The CEO had asked the Chief Information Officer for assurance in this regard.

Tom Watson explained that a mock phishing exercise had commenced with the scope agreed with IT managers, but not with Shauna McMahon as Chief Information Officer. The exercise commenced with positive feedback from the Trust's Counter Fraud team and Comms team that staff had alerted them quickly to the possible scam email and alerts to staff were communicated swiftly, with Tom Watson adding that he had not seen such a speedy response anywhere else. The theme of the exercise was however questioned, and it was therefore quickly terminated.

Simon Parkes commented that it was reassuring on the speed of escalation and asked why the exercise was terminated early given that the tensions in Ukraine/Russia had been known the previous month and therefore should not have been surprised that the exercise was being undertaken. Tom Watson explained that the early termination was a result of the theme used rather than the exercise itself. Several themes were put forward which had been used elsewhere, and the theme around Covid vaccinations was chosen. On reflection it was decided that this was insensitive at the current time, given the requirement for vaccinations to be mandatory.

Gill Ponder commented that given the government U-turn on vaccinations, it was an emotive subject a and therefore it was appropriate to terminate the exercise given the sensitivities around mandatory vaccinations. Gill Ponder added that was not to say it should not be repeated quickly but with a different theme. Gill Ponder commented that the weakness was getting staff not to get into bad habits of just clicking on emails and ensure people are aware of the risks of doing so. Michael Whitworth agreed with the comments and that the exercise should be repeated but with a different theme.

Gill Ponder raised Medical staff job planning noting the limited assurance rating and asked if this linked with delays due to Covid and if other Trusts experienced similar issues.

Lee Bond commented that he had had a similar conversation recently with the senior Finance team and the Directorate Finance Managers (DFMs) who thought it was an improving picture, although whether the speed of the improvement was acceptable was another matter, adding that the Medical Director was best placed to answer this.

Gill Ponder stated that job planning was clearly an issue for many Trusts, and had previously asked if there were any exemplar organisations we could learn from but there did not appear to be any so questioned whether there was something more fundamentally wrong and whether the process was fit for purpose. Lee Bond queried if there should be individual job plans or team job plans, as he had worked in an organisation where team job planning worked well.

Simon Parkes noted the deterioration in the number of signed job plans since 2016/17 and asked what the risks were. Lee Bond explained that the individual's pay could be incorrect, or they could be undertaking unnecessary work, not performing expected work or may not have the right number of doctors. He noted that when looked at the top 100 earners report some doctors were being paid more than 12PAs. Sally Stevenson also noted that £33k of salary overpayments in the latest report were linked to reductions in PAs with having no job plan in place for six months, resulting in recovery issues. Lee Bond also noted that there was a hidden risk in relation to costing data and having incorrect activity data from job plans.

It was noted that whilst the situation of completed job plans was improving it should be highlighted to the Trust Board as a concern of the Committee in respect of the low completion rate.

Sally Stevenson noted that in the past when similar concerns had been discussed the Committee had invited the Medical Director to an ARG Committee and wondered if it would be worth considering again. Michael Whitworth commented that the risks were not just about remuneration but other risks including costing, benchmarking, issues with mandatory training, admin time and research and so a wider strategic risk for the organisation. Simon Parkes asked if the Committee would find it helpful to invite Shaun Stacey and Dr Kate Wood to the Committee, as they had joint responsibility. Gill Ponder stated that this was initially a Workforce issue but agreed on escalation to the Trust Board on the low completion rate initially and then take from there.

Action: Highlight Report to Trust Board.

7.2 Internal Audit Recommendations Follow-up – Status Report

Tom Watson highlighted continued progress being made on the outstanding recommendations generally, but there were still several long overdue recommendations. He advised that he met with the Executive Directors during the planning process for the 2022/23 IA plan and raised overdue recommendations with them and the majority had subsequently provided updates.

Tom Watson drew the Committee's attention to a proposed new style automated report and sought comments on the revised template. It was agreed that it was helpful and easier to see outstanding recommendations and how long overdue they were.

Gill Ponder noted the high priority recommendations which were overdue and which were a concern, particularly noting. the Medical Staff Personnel Files which was originally due in March 2020 and then December 2021. Gill Ponder noted that it appeared to predicate having a business case for more resource and suggested that more balancing of priorities could be done.

Lee Bond agreed, particularly noting the discussion the previous week at the Finance & Performance Committee when looking at the benchmarking report where HR were coming out as expensive so was not able to invest in HR any further. He added that when Christine Brereton commenced in post just over a year ago, he asked if there was a non-recurrent solution before the end of the financial year. It was now only five weeks until the end of this financial year so was a little disappointed to still be in that position.

Michael Whitworth noted the completion date was March and asked if it was likely to run over into another year. Tom Watson stated that he didn't know, he was working on the basis of what he had been told. Gill Ponder noted that the narrative appeared to say that completion was dependent on more resource.

Simon Parkes suggested writing to Christine Brereton asking for a clear plan to resolve the outstanding recommendations that was not dependent on additional resource. Lee Bond noted that this had been classed as a high risk for three years so questioned if that was actually still the case in the context of everything else, and whether it was as clear cut as it appeared. Simon Parkes stated that given that it had now been over two years since the recommendations were agreed and nothing appeared to have happened, he would write to Christine Brereton to ask for a clear plan and she would have the opportunity to explain any mitigating factors. Tom Watson advised that the original high-risk rating was agreed with Christine Brereton's predecessor at the time.

Action: Simon Parkes

7.3 Insight Technical Updates Report

The Insight report was provided for information and Tom Watson highlighted specifically the Clinical Prioritisation Programme which included a requirement for an audit review on waiting list management. Sally Stevenson also highlighted the Good Practice guide for Audit Committees on cyber security given the earlier discussion in the meeting.

Tom Watson advised that in respect of the Internal Audit plan for 2022/23 he met with individual Executive Directors to determine their key themes/topics against the risk register. These would now be reviewed and prioritised by the Executive Team and then brought to the ARG Committee in April 2022 for final approval. Simon Parkes thanked Tom Watson for his work on developing the forthcoming audit plan.

Item 8 02/22 **Counter Fraud**

8.1 LCFS Progress Report

Nicki Foley presented the report and highlighted key items to note including the new functional standards which outlined that a Fraud Risk Assessment (FRA) was required in a different format to its existing one. Work had been undertaken by the LCFS with colleagues from the five collaborative Trusts and the original FRA had now reduced from 84 potential individual fraud risks to approximately 32 grouped risks. The risks would be assigned to the appropriate accountable officer as necessary. Nicki Foley added that she was meeting with the Head of Risk again in the next couple of weeks

to discuss further, and it was not anticipated that the process would be completed by the end of the financial year but would be work in progress.

The duties for the Counter Fraud Champion were still not defined nationally therefore a quarterly programme of work had been devised by the CFP team covering various topics, including promotion of the counter fraud e-learning module to increase uptake. Nicki Foley advised of six new referrals received since the last meeting, and also updated the Committee regarding a GMC outcome in which the former employee had received a warning from the GMC Fitness to Practice Tribunal. This sanction had been publicised by the Comms teams at both NLAG and HUTH.

Simon Parkes thanked Nicki Foley for the work that she does, and Michael Whitworth commented that it was a good report.

Simon Parkes referred to the number of times that staff members allegedly working elsewhere whilst off sick appeared on the report but which seemed to only get dealt with by a management "chat" with the individual, yet this was fraud, and therefore felt that management may take a relaxed attitude to it. Nicki Foley stated that she didn't believe this to be the case and explained the issues for consideration before it could be classed as a criminal act of fraud and it would depend on the scale of fraud, etc. so several factors to consider on a case by case basis. Nicki Foley stated that the individual would always be asked to pay back the money or hours be worked back where appropriate and HR go down the disciplinary route when appropriate.

Sally Stevenson commented that Simon Parkes was due to meet with Nicki Foley in his role as Chair of the ARG Committee and that this could be discussed further, which Simon Parkes agreed.

Michael Whitworth commented that it reiterated the importance of NHS fraud being included within the induction video for new starters, referencing the earlier discussion.

Item 9 02/22 **Board Assurance Framework and Strategic Risk Register**

Helen Harris joined the meeting to present the BAF which had been provided for information and assurance. The report now included yearly targets, as requested by the Trust Board. Some of the sub-committees had reviewed their strategic risks with the Workforce and Strategic Development Committees to receive their reports in March 2022.

Simon Parkes also highlighted risk management and stated that they were only seeing part of the Risk Register and suggested all high-level risk register items should be considered by the ARG Committee at least once a year. Gill Ponder commented this would be a huge undertaking and could take over a whole meeting and suggested it could be done on a rolling programme basis or would need a different approach. Simon Parkes stated that the Committee didn't need to go through them all in detail, just see it as a whole. Simon Parkes asked Helen Harris to consider how that could be effectively achieved. Helen Harris suggested that the full register could be presented at the next meeting with a view to agreeing what to provide on a quarterly basis.

Action: Helen Harris

Simon Parkes also noted the number of high risks where risk appetite was low yet making zero progress and suggested that this was maybe due a re-prioritisation. Gill Ponder acknowledged what Simon Parkes was saying and highlighted by way of example a strategic risk within the Finance & Performance Committee's remit of the challenges of patient flow through the A&E Department but reliant on the wider

community, and issues with capacity of both staff and beds therefore the risk was not reducing. Therefore, having to live with the higher risks until some of the wider issues were fixed.

Further discussion took place on the difference between the risk scores and risk appetite and the need to address long term high risks if risk appetite was set low. It was agreed to add this issue to the highlight report to invite the Trust Board, in a non-critical way, to look again at the risk appetite, and include timelines for how risks will be brought to target and to align the risk with the risk appetite that had been set. It was acknowledged it could be a long timeline and there may be significant external factors to get to that point.

Action: Highlight Report to Trust Board.

Item 10 02/22 **Losses and Compensations Report**

Lee Bond presented the losses and compensation report and highlighted areas to note, including the reducing amount generally over three years (if overseas visitors are stripped out), circa £10k salary overpayments written off where all recovery efforts had been exhausted and £14k in relation to lost patients valuables and property. Lee Bond questioned whether wards were following the correct processes.

Lee Bond also referred to the overseas visitors write offs with 12 cases over £5k equating to £76k in total, adding that some of those dated back to 2015 and they were now taking the opportunity to write off at the end of the financial year and tidy up the Balance Sheet. Lee Bond proposed to ask the team if the Trust is participating with the NET process and to review the last 6-months to determine how many were emergency admissions. However, Nicola Parker explained the process of using CCI recovery agents who are specialists in overseas visitors' debts, and only submit for write off when all other avenues had been exhausted and recommended by CCI. Nicola Parker added that they are working with the Overseas Visitors Team on these as necessary. Simon Parkes asked much the Trust recovered from overseas visitors and Nicola Parker advised that the income received was reported in the annual accounts which was about £200k-£250k at most annually, noting that the Overseas Visitors team do work to get as much money up front as possible.

Simon Parkes also referred to the amount of ex-gratia payments and the number of patient property losses which had doubled and the distress it must cause individuals when their personal items were lost particularly in relation to their dignity in the case of loss of dentures for example.

Tom Watson suggested that it could be considered for inclusion in the internal audit plan for 2022/23 to provide assurance around the robustness of controls. Simon Parkes stated that this could be looked at by the Executive Team as part of the prioritisation of the audit plan.

Gill Ponder agreed that it was not significant in terms of monetary value, but lost dentures could have a big impact on the patient. It was agreed to highlight this to the Trust Board. Lee Bond also agreed to pick up at Executive Team meeting.

Actions: Highlight Report to Trust Board / Lee Bond.

Item 11 02/22 **Management Reports for Assurance – Items for Approval**

11.1 Accounting Policies 2021/22

Nicola Parker presented the report and drew the Committee's attention to the front sheet executive summary which referred to 2020/21 which should have read 2021/22. She also advised that the items of interest for this financial year were summarised on page one of the report and highlighted issues to note as follows:

- Injury Cost Recovery – Increased to 23.76% from 22.43% the previous year. Historically the Trust normally provides for 25% and would continue to do so in 2021/22.
- Provisions – Early retirement and Injury Benefit had been revised to minus 1.3% from minus 0.95% the previous year.
- In-year re valuations – A full year re valuation would be undertaken by Cushmann Wakefield to review the land and buildings across all sites. Site visits had now taken place and they would be holding talks with the Estates Department around some of the capital scheme builds completed in-year.
- Covid-19 Income and Expenditure – Further guidance was expected around income and expenditure. As this information becomes available the Trust's accounts and accounting policies would be updated

Nicola Parker added that the Accounting Policies would be updated for any centrally notified changes from NHSE/I, but otherwise it had been a quiet year. Lee Bond queried when the Trust could expect the results of the valuation and Nicola Parker advised that it would be mid March 2022. Lee Bond also asked if there would need to be a disclosure around the NHS Pensions consultation, and Nicola Parker confirmed that they would be notified if this was necessary.

Following the review and update the report was noted. Simon Parkes thanked Nicola Parker for attending and she left the meeting.

11.2 Annual Review of Policy for Engagement of External Auditors for Non-Audit Work

Sally Stevenson advised that only minor changes had been made and were tracked for ease of reference. There were no comments and the Policy was re-approved for a further year.

Action: Sally Stevenson

11.3 Salary Overpayments – Recovery Policy and Procedure

Sally Stevenson presented the report and explained that following feedback from the Chief Executive regarding the standard overpayment letter, it had been adjusted to acknowledge the responsibility of the Trust in its shortcomings causing overpayments of salary and the impact overpayments could have on the employee. The Policy was also due its scheduled review and therefore all proposed changes were tracked on the existing document.

Gill Ponder stated that it was the managers responsibility to ensure overpayments were not made, by submitting accurate and timely paperwork, but the proposed changes to the non-compliance process watered down the policy regarding line manager responsibility in terms of repeat offenders, and they should be held to account having put their staff through the trauma of being overpaid.

Sally Stevenson explained that she had discussed the proposed changes with Christine Brereton, Director of People, and it was her view that the reference to disciplinary action should be removed. Sally Stevenson explained that it was discussed at the ARG Committee 4 to 5 years ago when the non-compliance process was brought in and the potential for disciplinary action to be taken should it get to a third letter stage. Sally did highlight that they had not had to resort to the third letter stage of the process,

so it could be argued that the inclusion of potential disciplinary action did act as a deterrent.

Simon Parkes agreed with Gill Ponder, acknowledging the wording of the Trust's culpability, that it was still down to individual managers. He was not advocating the use of disciplinary action but there should be some form of follow-up action. Simon Parkes proposed writing to Christine Brereton that managers need to be robustly aware that repeat offending would not be tolerated. He would stress the mood of the Committee that if managers kept making mistakes and Trust money is put at risk of non-recovery then some form of action for repeat offenders would need to be in place.

Sally Stevenson stated that she would wait to hear back from Simon Parkes before making final changes to the policy. Simon Parkes agreed with this.

Action: Simon Parkes

11.4 Salary Underpayment Policy and Procedure

Sally Stevenson advised that only minor changes had been made and were again tracked for ease of reference.

Sally Stevenson also highlighted that the Trust was intending to return to monthly pay for weekly paid nursing back staff in May 2022, and asked if the Committee would give authority for any references to weekly pay to be removed from the Policy and the overpayments policy (at 11.3) without the need to bring the documents back to the Committee for further approval.

The Committee approved the Policy and gave authority for references to weekly pay to be removed from these two Policies when the changeover had been made.

Action: Sally Stevenson

Item 12 02/22 Management Reports for Assurance

12.1 Mortuary and Body Store Assurance – Status of Action Plan

Mick Chomyn presented the paper and explained that a letter had been received in October 2021 from NHSE/I, which gave guidance for mortuaries and body stores and the need to ensure ongoing compliance. A report was taken to the Trust Board in December 2021 who then delegated oversight of the action plan to the ARG Committee for assurance purposes.

Mick Chomyn highlighted the action plan which required the installation of CCTV and swipe access in the Goole Body Store and the need to regularly review that access. He advised that in terms of assurance for the ARG Committee there were no concerns with the associated pathology mortuary service, however no assurance could be given at that time that a process was in place at Goole for those audits to be undertaken. Mick Chomyn also advised that the expected inspection from the Human Tissue Authority would now be May 2022, not April 2022.

Mick Chomyn confirmed to Simon Parkes that there were three clinical divisions that managed the Body Stores, despite asking if one could be the lead. Simon Parkes asked if he should write to the Medical Director to advise that good assurance was received on the mortuary service actions except for Goole Body Store. Mick Chomyn advised that he had escalated the issue to Shaun Stacey, Chief Operating Officer who had overall responsibility.

Mick Chomyn advised that all DBS checks had been completed and were now undertaken for new starters to the organisation, noting that several staff pre-dated DBS checks but this had now been resolved.

The Committee agreed that this item should be included in the Highlight Report to the Trust Board.

Action: Highlight Report to Trust Board

Simon Parkes thanked Mick Chomyn and he left the meeting.

12.2 Clinical Audit and ARG Committee

Simon Parkes presented the paper which was a result of a query at the last meeting if the clinical audit forward programme was within the remit of the Audit, Risk and Governance Committee. Simon Parkes stated that they were trying to get to a position where all Committees were not doing the same thing.

Gill Ponder stated that clinical audit fell under the remit of the Quality and Safety Committee. Sally Stevenson informed the Committee that in the past it has only been the clinical audit annual programme of work which came to the Committee for assurance (in line with the HFMA NHS Audit Committee handbook). However, over the last year discussions had emanated from this into discussions around CQIN's, etc. and as a result had become a regular feature of the meetings. Michael Whitworth agreed that it should only come to the Committee for review and assurance.

It was agreed that the Committee should move back to receiving an annual programme of clinical audit activity as an appendix to a summary of participation of the previous year. It was agreed that the most appropriate Board sub Committee to receive clinical audits would continue to be the Quality & Safety Committee.

12.3 Risk Management Strategy Development Plan Update

Angie Legge presented the latest update on the actions related to improving understanding and use of risk management within the Trust, outlining the progress on the actions that had been made, despite ongoing operational pressures.

Angie Legge highlighted that the two outstanding actions from the original strategy had been completed and work was underway to determine the next strategy. She highlighted that she had met with the Head of Risk for International Airlines to discuss how risk was presented in their organisation. The risk management group was still in progress but hampered by Covid and operational pressures. Evidence of risk was improving and the new risk management system (Ulysses) had helped with that.

Simon Parkes thanked Angie Legge for the very helpful update, and she left the meeting.

12.4 Quarterly Document Control Report

Helen Harris presented the latest report and highlighted that it was like the previous report with no improvement seen. Simon Parkes commented that documents seem to have got stuck and they needed to be moved on.

Simon Parkes advised that he would be writing to Christine Brereton and other Executives with overdue documents. Helen Harris advised that Christine Brereton did have the overdue documents on her radar and in priority order from her perspective.

It was agreed to highlight to the Trust Board that a number of overdue documents appeared to have stalled with some significantly overdue.

Action: Highlight Report to Trust Board.

12.5 IG Steering Group Highlight Report / DPO Update

Sue Meakin apologised for the late submission of the paper due to unforeseen circumstances and presented the report and highlighted areas to note, including Internal Audit undertaking phase one of two of the annual audit at the beginning of March 2022. Due to the increased impact of Covid and cyber alert, organisations were no longer required to submit improvement plans by the end of December and no new date had been set. Work was still ongoing within the Trust on the improvement plans for submission when required.

Sue Meakin advised that the DSP toolkit submission was due at the end of June and a detailed report on the status of the toolkit would be provided at the next meeting of the Committee.

Sue Meakin highlighted business continuity plans and asset register with two temporary contractors working on the actions from the previous year, audit response and the improvement plan. It was anticipated that these projects would be signed-off by the end of March.

IG Training was currently at a fantastic 90% and the team were working on the additional 5% to achieve the 95% compliance rate by the end of June 2022, but given the pressures that people were under this was a good result.

There were no open incidents reported to the Information Commissioner's Office (ICO) but there had been three complaints received via the ICO. These were being reviewed to provide responses to the ICO.

Sue Meakin advised that due to moving to the new Ulysses risk management system it was not possible to provide a detailed report of IG incidents. It was anticipated that this would be available for the next meeting.

The Control of Patient Information (COPI) notices were still being relied on to acquire confidential patient information and their continued use had been extended until the end of June. Following the ending of the COPI notice, guidance would be received from DHSC as to the alternative legal basis of processing confidential patient information.
There were no questions raised which reflected the comprehensive nature of the report. Simon Parkes thanked Sue Meakin for the update and she left the meeting.

12.6 Waiving of Standing Orders

Ivan Pannell presented the report which showed an average number of waivers received in the last quarter of 2021/22 with no concerns to highlight to the Committee.

The report was noted.

12.7 Contract Progress Report

Ivan Pannell presented the report and advised that progress had been made on several contracts, including the Revalidation Management System, which was a migration to the shared PAS with HUTH and had been awarded for three years. The Laundry

services contract was subject to lengthy procurement processes with the most recent process abandoned due to further challenge. A review would be undertaken on the longer-term options for the procurement of a laundry service. The incumbent supplier was therefore still providing the service and would continue for an indeterminate time.

Ivan Pannell commented it was a disappointing outcome given the significant amount of work that had been involved so far. Simon Parkes asked if there were any particular issues that resulted in the process being abandoned. Lee Bond explained that there were only two market suppliers who compete for every contract and challenge the process dependent on which supplier won; other local Trust's had the same issue. Ivan Pannell commented that the decision to abandon was based on legal advice who had worked with the team from the second round and had tightened up the specification and procedures. Lee Bond stated that he would be speaking to Edd James the new Director of Procurement to see how to take this issue forward.

Action: Lee Bond

Following review and discussion, the report was noted. Ivan Pannell was thanked for attending for his items and he left the meeting.

12.8 Salary Overpayment Report

Sally Stevenson presented the report and noted a significant increase in the level of overpayments in Q3 of 2021/22, including the main one of circa £33.5k due to the late notification of a reduction in PAs. Sally Stevenson advised that 18% of the overpayments were due to Payroll errors, with 82% related to other areas of the organisation. Lee Bond stated that the Payroll team were often accused of being at fault, but the vast majority were the wider organisation. Sally Stevenson stated that the overpayment figures had been going in the right direction, but it took just one significant overpayment to ruin the figures.

Sally Stevenson advised that payslips went live online the previous night and already there were derogatory remarks about the Payroll team made on the Staff Facebook group and she would be picking this up again with HR to see what could be done. Gill Ponder referred to the earlier discussion on the Salary Overpayments recovery policy and holding managers to account and it was not just the trauma for the individual who had been overpaid, but clearly also leading to abuse of Payroll staff that they do not deserve. Sally Stevenson commented that it was demoralising for the Payroll team to see such comments posted on social media when the team had worked incredibly hard over the last two years to ensure the payroll service had not fallen over. It was agreed to include in the highlight report to be Trust Board that it was not acceptable for Payroll staff to be targeted with this type of general online abuse.

Action: Highlight Report to Trust Board.

12.9 Hospitality and Sponsorship Declarations

The report was provided to the Committee. There were no concerns raised and the report was noted.

Item 13 02/22 **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

There were no questions and the reports were noted.

13.6 – Ethics Committee – No meeting had taken place.

Item 14 02/22 **Private Agenda Items**

There were no private items for discussion.

Item 15 02/22 **Any Other Business**

15.1 Results of ARG Committee Annual Self-Assessment Exercise 2022 – Draft for Approval

Sally Stevenson presented the results of the annual self-assessment exercise. She referred to the small piece of narrative in red and it was agreed that this would be updated before the results were reported to the Trust Board.

Gill Ponder noted a positive set of results and suggested in the spirit of continuous improvement and the need to think about what to do differently, if going forward there should be an action plan from the self-assessment exercise. Simon Parkes agreed the need to continuously consider how to improve. Simon Parkes also noted one of the key areas for development was to have an up to date assurance map of the different sub-committees where assurance took place. This would help to be clear on the level of assurance required for the Board. It was agreed to reflect in the report to the Board for this item when it is submitted to the April 2022 Trust Board meeting.

Action: Sally Stevenson

15.2 Annual Review of ARG Committee Terms of Reference – Draft for Approval

The annual review of the Committee's Terms of Reference (ToR) were scheduled for this meeting. Helen Harris had proposed a number of changes to the ToR to ensure they were standardised as far as possible, in terms of format and content, with other Trust Board sub-committee. The key additions to the ToR were in relation to attendance at meetings (section 7.4) and decision making (section 7.7).

The Committee approved the proposed revisions to the ToR before submission to the Trust Board for final ratification.

Action: Sally Stevenson

15.3 Annual Review of ARG Committee Rolling Annual Work Plan 2022/23

The annual workplan was reviewed and Gill Ponder queried if the frequency of receiving some reports should be reviewed, noting that some reports were presented at every meeting. Michael Whitworth agreed that this was an area worth reviewing. Simon Parkes proposed that he review the workplan with Sally Stevenson and bring back a proposal to the next meeting. Gill Ponder also re-iterated her earlier comment about the possibility of having an action plan.

Action: Simon Parkes / Sally Stevenson

15.4 Any Other Urgent Business

There was no other urgent business raised.

At this point the Internal and External Audit representatives left the meeting to allow for a private discussion on the next item.

15.5 External Audit Contract – Future provision

Lee Bond presented the paper and advised that Mazars, due to internal pressures, may not be able to audit the accounts in 2022/23 if the option to extend the current contract for a further one year was taken. Following discussion, it was agreed that it was necessary to go out to the market for a new external audit service over the summer. It was agreed to submit the proposed paper on this to the next meeting of the Council of Governors in April 2022.

Lee Bond commented that the Trust should expect to see a significant increase in any External Audit fees resulting from the market testing exercise. It was also noted that another local Trust had not been able to secure the services of an External Auditor for this years audit.

Ian Reekie also agreed that it was a sensible way forward and he would add it to the next COG agenda.

Action: Ian Reekie / Sally Stevenson

Item 16 02/22 **Matters for Escalation to the Trust Board**

The following items were agreed to be escalated to the Trust Board.

- Medical Staff Job Plans
- BAF – risk appetite and conflicts with risk scores
- Loss of patients' possessions and impact on dignity
- Mortuary Service – Goole Body Store
- Lack of Movement with Overdue Documents
- Increase in salary overpayments / Online abuse of Trust's Payroll team

Item 17 02/22 **Matters to Highlight to other Trust Board Assurance Committees**

Medical Staff Job Planning - Michael Whitworth to pick up at the Workforce Committee.

Item 18 02/22 **Review of ARG Committee Workplan**

The workplan had been reviewed at item 15.3.

Item 19 02/22 **Review of the Meeting.**

Simon Parkes asked for any observations on how the meeting had gone.

Gill Ponder noted that given the number of papers on the agenda the meeting had finished early which was a positive. She did suggest having a scheduled five-minute comfort break during the meeting in future as she felt that three hours was a long time to sit still.

Helen Harris commented that the focus was on the areas that were needed and those papers that were for information were only discussed if any questions were raised.

Ian Reekie noted that this this was the first ARG Committee he had attended at the Trust and stated that he had not been bored.

Item 20 02/22 **Date and Time of the next full meeting**

The next meeting was scheduled as follows:

Thursday, 21 April 2022 at 9.30am-12.30pm via Microsoft Teams.

NLG(22)100

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7 June 2022	
Director Lead	Neil Gammon, Independent Chair of HTF Committee	
Contact Officer/Author	Lee Bond, Chief Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes of meeting held on 3 March 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 3 March 2022 and approved at its meeting on 5 May 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	☐ 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.

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **3rd March 2022 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF Trustees
	Mike Proctor	Non-Executive Director
	Gill Ponder	Non-Executive Director
	Maneesh Singh	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
	Ellie Monkhouse	Chief Nurse
	Christine Brereton	Director of People
In attendance:	Caroline Russell	Sparkle Wish
	Tony Burndred	Governor
	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin Assistant (For the Minutes)

Item 1 03/22 **Apologies for Absence**

Apologies for absence were received from: Jug Johal; Victoria Winterton

Item 2 03/22 **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 03/22 **Minutes of meeting held on 4 November 2021**

The minutes of the meeting held on 4 November 2021 were reviewed for accuracy and completion of actions and following review were agreed as an accurate record.

Item 4 03/22 **Matters Arising**

The chair was pleased to announce that he and Clare Woodard had met in person for the first time with HTF Patron, Sir Reginald Sheffield. Sir Reginald was interested in how everything worked and wanted to learn more about the Trust and HTF. The chair, with agreement from the Trustees, proposed to invite him for an informal visit and tour around the hospital grounds.

Peter Reading felt this was fantastic idea and nominated SGH to be the site of choice on this occasion to show Sir Reginald what our Trust provides, meet consultants and medical staff, thereby getting a real sense of flavour for the Trust as a whole.

Kate Wood agreed, but to exercise caution to ensure IPC guidelines were followed.

The chair also expressed Sir Reginald Sheffield's interest in sitting in on one of our Trustees meetings. All in attendance welcomed this idea.

4.1 Roles Funded by Health Tree Foundation

Clare Woodard gave a brief background explaining that an individual, currently funded by the HTF, has been asked to carry out a small part of their role outside the Trust to help implement a programme in another region. This was not part of the HTF original funding agreement. Following discussions with Kate Wood, it was agreed that the post holders will only undertake their role as agreed at the time funding was approved and that any proposed changes to the original funding application, which would significantly alter the nature of the outcomes of a role, must be submitted for approval to this committee before any such changes are implemented. Going forward, any requests received by HTF for funded staff posts, will require the line managers' signed agreement to these terms.

Peter Reading suggested an agreement to be worked up with the division and the relevant line manager to tighten the process up.

Clare Woodard to add this new process to the HTF Charitable Procedures.

Action: Clare Woodard.

Item 5 03/22 **Review of Action Log**

The action log was reviewed as follows:

6.1 (04 11 21) – Half Day Development Sessions. The chair put forward to the committee that these development days need to be arranged with maximum attendance in mind. Kate Wood to work with Clare Woodard to find suitable dates. Gillian Ponder pointed out that these will not be able to take place on the day of the July and September committees.

Action: Kate Wood and Clare Woodard.

7.1 (04 11 21) – HTF Funded Posts. Complete and to be removed from the action log.

Action: Closed.

7.1 (04 11 21) – HTF Newsletter. Clare Woodard confirmed that a newsletter will be circulated every quarter, with the aim of swiftly updating Trustees on HTF matters of the moment. It was agreed for a copy to be sent to Sir Reginald Sheffield.

Action: Closed.

Item 6 03/22 **Items for Discussion / Approval**

6.1 Health Tree Foundation Terms of Reference

The chair drew trustees' attention to page four 4 of the TOR, under 5.1 core membership, and posed the question of whether two independent trustees were required due to the committee only having one in attendance (the chair, Neil Gammon) for quite some time now.

When an independent Chair was appointed, it was viewed as a 'halfway house' between no independent trustees and full charity independence. It was thought that someone from a business or education background could become a further independent trustee to offer specialist help or advice. However, nothing further had taken place in this regard and Clare Woodard wondered if the current situation should be retained for now?

Ellie Monkhouse felt things have been working well so far without the need for a second independent trustee.

Peter Reading agreed and touched upon the modest scale of the charity, adding the Trust Board are all Trustees and with several NEDs involved, it was viewed that there are enough voices to make educated decisions.

Gill Ponder took a different view and thought that a second independent trustee may be quite beneficial to the charity as it is good to link in with other businesses to network and raise more funds. Gill used Local Lions as an example where the HTF charity could be the beneficiary.

Clare Woodard noted that the HTF already have strong connections with Local Lions.

The chair highlighted that HTF is moving forward with further networking especially now things are starting to get back to 'normal' since covid. Clare Woodard confirmed one planned example of the charity being able to network is having a stall for one of the most popular summer events in Cleethorpes: The Armed Forces Day.

Michael Proctor commented he was happy with just one independent trustee.

All agreed to amend the TOR to read one independent trustee, but to keep mindful of a potential associate specialist trustee role for the future.

Action: The Chair to highlight to the Trust Board.

6.2 Legacy received from Elizabeth Fairchild

The Chair asked members to refer to the suggestions within the report, which listed possible ways in which the Fairchild Legacy could be spent. He then asked for Trustees' views.

Kate Wood expressed her concern around the money being lost if the Scunthorpe site is to be re-built in 10 years' time and felt 'pick and shift' equipment may be more beneficial to the Trust.

Michael Proctor voiced that he was grateful for this legacy money, adding that 10 years is probably sufficient time for patients to benefit from the investment. He noted the absence of any Fairchild family (who would be interested in how the legacy was spent) and concluded that he is content to be led by clinical colleagues' views.

The Chair confirmed that all enquires to find any relatives have drawn a blank.

Ellie Monkhouse stated a lot of investment has been put into capital lately and she felt that it was time for the community to reap the benefits of such a legacy. She added, Dementia affects everyone, and it would be a huge kite-mark moment for the Trust if we were deemed to be a "dementia friendly" Trust, making a difference to people's lives. She was in favour of the improved dementia and disability facilities on wards and across the hospital site, as well as looking into employing an Admiral Nurse for a year. Admiral Nurses are specialist dementia nurses who are supported and developed by Dementia UK. Ellie Monkhouse did not want to see this legacy being used for another CT scanner.

Peter Reading commented that any decision on a new hospital at SGH has been delayed and funding is not guaranteed. With this is mind, he questioned whether we delay the decision for the funding, however he is keen to see local people benefit as soon as possible. He added that after discussions with A&E staff, they would love to have a CT scanner on each site but agreed with Ellie Monkhouse regarding this funding being used for something else more exciting. Peter Reading admitted he has changed his mind on this from previous discussions, however he would like to see this money have a positive impact on the vulnerable and has been swayed towards the dementia option.

Michael Proctor and the chair agreed to mark the legacy in some way.

Maneesh Singh questioned why only 8 suggestions had been received.

The chair advised Trustees that HTF colleagues advertised the legacy funding to ask for suggestions and those submitted were group suggestions made by departments, not just one person.

Maneesh Singh was not in favour of the idea of funding a new CT scanner, due to the ongoing costs of running and staffing the machine and he proposed to spend a little more time gaining more ideas from staff.

Discussion took place around delaying the decision for this legacy; however, the majority of the members were happy to support the decision making now and firm up the ideas already put forward.

The chair concluded the discussion by requesting that Ellie Monkhouse works with Clare Woodard to capture the full picture around the dementia option and add it to the agenda for the committee meeting in May 2022.

Action: Ellie Monkhouse / Clare Woodard.

6.3 Wish Ref 040/21 – Children's Development Centre Sensory Room (Sparkle Wish)

The chair welcomed Caroline Russell and asked whether she would like to add anything further to the wish that she had submitted.

Caroline Russell informed the members of historically having a sensory room which was a huge benefit for achieving therapy targets, a soothing place to deliver bad news and a place for staff and patients to de-stress. The room was 15 years old and suffered flood damage and has been inaccessible for a considerable amount of time. She expressed her enthusiasm to get this room back up and running and confirmed she had gained all quotes for the repairs.

Kate Wood fully supported this wish and questioned whether there were any insurance monies which could be gained.

Lee Bond added that it may not have been in the best interest for the Trust to make a claim at the time of the damage occurring.

The chair, along with the other members, all strongly agreed for the HTF to fund this wish as it will bring great benefit to both patients and staff.

The chair praised Caroline Russell for all her effort and work with this and thanked her for attending.

Item 7 03/22 Updates from Health Tree Foundation

7.1 HTF Update Report

Clare Woodard was pleased to inform Trustees that a lot of work is going on, with the fundraising and appeals reaching closer to their targets.

The Seaview Street Cancer Shop, who are major supporters of the cancer services on the DPOW site, have an additional £20,000 to donate to the HTF. Plans are being put in place to have press visit to celebrate the shop manager and her tireless volunteers. The chair encouraged members of this committee to go and visit the shop to thank the volunteers in person.

Due to a decrease in wishes being submitted by staff, the HTF colleagues are planning to hold a series of small "Road Shows", visiting the wards, staff rooms and other staff areas to encourage and provide help with submitting wishes.

Clare Woodard expressed how happy she and the teams are to be back up to full capacity and to be able to be on-site, visiting various areas and fund raising.

Ellie Monkhouse took the opportunity to thank the HTF for helping the Trust to gain the RITA Award and highlighted how pleasant it is to see them being used by patients. The ambition is to have these on each ward.

Contactless card machines have been ordered and will be up and running across the sites within the new A&Es which will hopefully increase donations.

Lauren Henry is a new member of the HTF who has settled in well with huge enthusiasm to complete the list of "Sparkle" jobs.

Kate Wood queried whether work is taking place for the pond area at DPOW. Clare Woodard confirmed that they are actively looking for volunteers at the moment.

Item 9 03/22 **Finance Update**

9.1 Finance Report – January 2022

Paul Marchant presented the report and highlighted the key points, including:

- Income for the 10 months to January 2022 was £730k which was £22k ahead of the plan.
- The final amount received from the Elizabeth Fairchild legacy was £326k which is for the benefit of SGH general funds.
- Full year income is forecast at £800k compared to the full year plan of £850k.
- Expenditure for the 10 months to January was 719k which was £379k underspent against the plan.
- Full year expenditure is forecast at £850k compared to the full year plan of £1,260.

9.2 HTF Financial Plan 22/23

Clare Woodard & Paul Marchant presented the proposed financial plan for the 22/23 year, highlighting the key points as follows:

- Planned income for 22/23 of £920k (plan 21/22 £850k)
- Planned expenditure for 22/23 of £1,220k (plan 21/22 £1,260k)

Following a discussion of the plans, it was agreed that more ambitious figures be set for income and expenditure. Clare and Paul agreed to review the figures and present a revised report to the next meeting.

Action: Clare Woodard and Paul Marchant

9.3a Annual Report and Accounts 20/21

Paul Marchant presented the 20/21 Annual Report and Accounts. These had been approved by Neil Gammon and Peter Reading on 24th January 2022 and had been submitted to the Charity Commission by the end of January deadline. This was noted by Trustees.

9.3b Letter of Representation

This had been signed by Peter Reading on 24th January 2022 as part of the approval of the Annual Report and Accounts. This was noted by Trustees.

9.3c Auditors Completion Report

Paul Marchant presented the Audit Completion Report issued by Mazars. This confirmed approval of the financial statements and the auditors issued an unqualified and unmodified audit opinion. This was noted by Trustees.

Item 10 03/22 Any Other Business

Clare Woodard mentioned that a request had been submitted to fund a research post within the Pink Rose Suite and wanted to gather thoughts.

Ellie Monkhouse urged Clare Woodard to proceed with caution and to speak to Maria Briggs to gain more information and bring back the findings to the next meeting.

It was shared that although this would be a great idea, the Trust has other pressing matters and resources which it needs to focus on, and it was felt that HTF funds could be better spent.

To celebrate the Queen's Platinum Jubilee the HTF are handing out jubilee packs to staff across all sites. This news was well received by Trustees.

Ellie Monkhouse shared the idea of having a vintage afternoon tea take place at the Trust. Kate Wood agreed and nominated the extra bank holiday as the day to hold it, to thank all the staff working on that day. It was thought that one session could be held in the morning and then relocated for an afternoon session to ensure the event involves as many staff as possible.

Three trees, one on each site, are going to be planted week commencing 21st March to mark the first lockdown due to covid and to acknowledge the impact that the past two years had had on NLAG staff. Clare Woodard hoped that members would be able to attend the small planting ceremony if on site.

Item 11 03/22 Matters for Escalation to the Trust Board

- HTF Terms of Reference
- Annual Accounts 20/21
- HM The Queen Platinum Jubilee Event.

Item 12 03/22 **Private Agenda Item**

12.1 The chair confirmed that the Trust went out to tender on Monday with bids to be received by 23rd March 2022, and thanked Paul Marchant and associated colleagues for the work involved with this process.

It was agreed that Neil Gammon, Paul Marchant, Lee Bond and Gill Ponder would form the tender assessment panel.

Item 13 03/22 **Date and Time of the next meeting:**

Thursday 5th May 2022
1.00pm – 3.30pm
Via MS Teams

Attendance Record:

Name	May 2021	July 2021	Sept 2021	Nov 2021	Jan 2022	March 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)		✓
Christine Brereton	✓	-	✓	Apols (Rep)		-
Paul Marchant	✓	✓	✓	✓		✓
Andy Barber	Apols	-	Apols	-		-
Victoria Winterton	✓	✓	✓	✓		Apols
Clare Woodard	✓	✓	✓	✓		✓
Adrian Beddow	✓	Apols (Rep)	✓	Apols (Rep)		-
Ian Reekie (Governor)	Apols (Rep)	Apols	Apols	-		
Tony Burndred						✓
Total	**13**	**8**	**9**	**10**		**10**

NLG(22) 101

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7/6/2022	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up – June 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 as well as providing updates on media and social media activity. It covers the period 18 March 2022 to 20 May 2022 and also 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.
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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**
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5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

June 2022

Kindness • Courage • Respect

June update 2022 – covering 18 March to 20 May

Contents

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've already done** • Created a regular drumbeat for internal communications – Monday Message, Weekly Wednesday News, Building our Future on Thursdays and #ThumbsUpFriday • Put in place a new Thank You System for staff to easily share compliments boosting morale • Created a safe space for staff to raise concerns via the Ask Peter forum • Set up a staff Facebook group to reach staff with no access to the Hub/emails (3.7k members)
What we're working on • How we can work more closely with our local media, providing positive news stories • Introduce more video content where relevant • Reviewing our social media channels	**What we're working on** • Targeted line management communication • Work with senior leaders on their approach to engagement and communication • Re-invigorating the way we share compliments on social media – swapping #ThankYouTuesday for #ThankYouNHS • Introducing a new Team Brief Live approach later in June 2022 • Supporting the People division with the Health and Wellbeing and Culture Transformation work.

Supporting the Trust's priorities

Trust Priority 2 - Quality and Safety:

Prior to the **Quality Improvement** Conference, we promoted the event to attract attendees and supported the team by creating graphics, materials to print and a special edition of the staff magazine to hand out to attendees.

On the day, we photographed the event and live-Tweeted – resulting in our top Tweet in April with 1064 impressions. Follow-up comms were also shared post-conference.

A special edition of the staff magazine was produced around **end-of-life care**
The 20-page edition covered the latest news and developments from the team, including an update on the rollout of the Bluebell principles.

Unfortunately, the Hub only allows us to track page views, not document views so we can't see how many staff have accessed this.

The CQC hub page and staff guide are continually updated as part of **CQC preparation.** We've had more than 4,200 hits on the CQC page since last August

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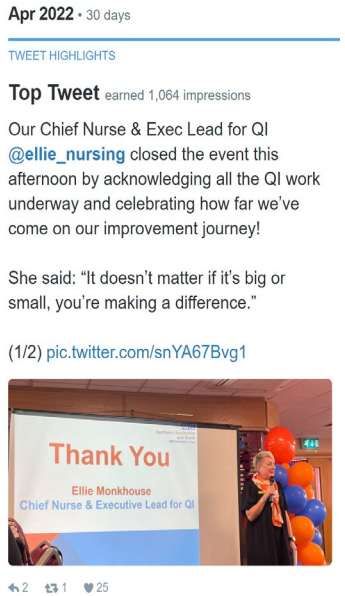
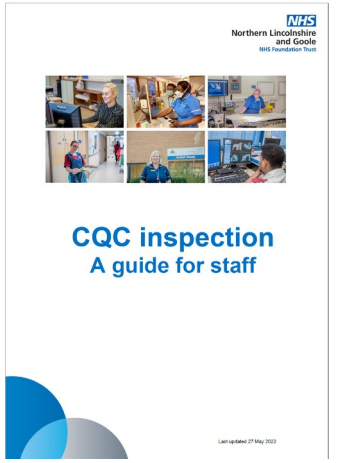




Supporting the Trust's priorities

Trust Priority 4 - Reducing health inequalities

We continue to support the ongoing work surrounding Tobacco and Alcohol dependency. This work is ongoing, but upcoming plans include internal comms detailing the enhanced staff offer, training and new referral processes, plus external comms to patients and the public to outline the support available to them when coming into hospital. There will also be opportunities to work with the media which we'll explore once fully underway.

Trust Priority 8 – Capital Investment

During this period, the ongoing works have featured in nine media reports (covering the opening of the DPoW car park, approval of the Final Business Case for our IAAU and SDEC units and the brief hand-back of the Scartho Baths car park for the duration of the annual fair).

For both staff and the general public, social media – and Facebook in particular - remains their preferred method of engaging with us. Our social media posts between February to April reached a combined audience of more than 181,000, with strong levels of two-way engagement.

We also saw a 200% increase in questions related to the works posed by staff on Facebook and a 55% increase via Ask Peter. Topics included solvent smells; noise from demolition works; parking and patient way-finding.

Trust Priority 10 - Green agenda

We continue to promote Green initiatives across the Trust including the Arrive and Drive and Sustainability Day at Grimsby hospital, an internal campaign around getting staff to reduce internal mail and how much they print.

Key Campaigns

Campaigns and awareness weeks

Hepatitis C – Liver Roadshows
Our social media campaign and press release advertising liver roadshows resulted in 331 people tested for Hepatitis C in the community, with four positives identified.

Deaf Awareness Week
Throughout Deaf Awareness Week we gave advice on effective communication techniques, how to spot the signs of hearing loss and what to do if you have concerns. We promoted the support available to patients with hearing loss when accessing our services and the services provided by our Audiology team including how to access them. Compared to the previous week visits to the Audiology pages on the external website during the week increased by more than 55%.

Mental Health Awareness Week
Mental Health Awareness week was the launch pad for a long-term communications programme around the introduction and implementation of the Trust's first Mental Health Strategy. Between May 9 and 15, we shared daily content with our staff which introduced the strategy and explained its importance within an acute trust setting.
The number of unique visitors to the Mental Health hub site during the awareness week was 6.25% higher than we saw in the whole of April (51 during the week compared to 48 in the whole of April).

Other awareness days, weeks and months promoted: International Clinical Trials Day, World TB Day, World Health Day, Dying Matters Awareness Week, Maternal Mental Health Awareness Week, Earth Day, International Day of the Midwife, International Nurses' Day and Dementia Action Awareness Week.

A simple test could save your liver from Hepatitis C

Improving reputation through external communications

Media coverage

There were 94 stories about the Trust in the media during this period. 61% of media coverage was positive or neutral in tone. **Coronavirus** continues to be the top theme on media coverage, followed by **care issues.**

We issued 9 news releases, the most covered was our £24.86 million Acute Assessment Unit plan being approved.

National media coverage of note: The Trust's ambulance handover performance was mentioned in the Daily Mail and the Independent and the Nursing Times featured one of our Clinical Nurse Specialists in an article on bone marrow
The Medicine division has generated the most news releases and Family Services division have had the most positive coverage.

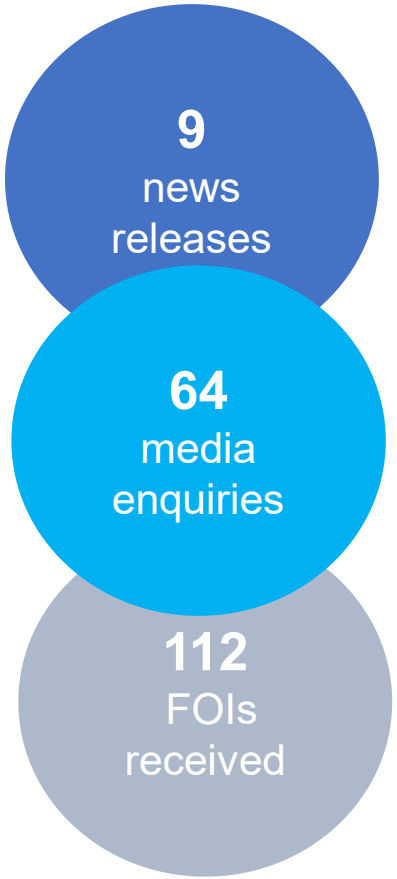
Media enquiries

64 media enquiries were handled in this time, 95% were dealt with within the requested timescale.

The top theme for media enquiries was 'other' (due to many enquiries following a fire at United Lincolnshire NHS Trust) followed by questions on coronavirus. 5 came in on the back of proactive news releases. The main reason journalists got in touch was to put in an information request. 6 statements were issued in this period

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 112 submitted in this period – of these 77 are closed, 23 are still in progress and 12 are awaiting a response from the requester.



Improving reputation through external communications

Social media

Followers update for the Trust's corporate accounts

12,870 on the Trust's Facebook page (up 232 from the last report)
5128 5,050 followers on Twitter (up 78)
We are rated 4.6 out of 5 stars on reviews on Facebook

Sentiment

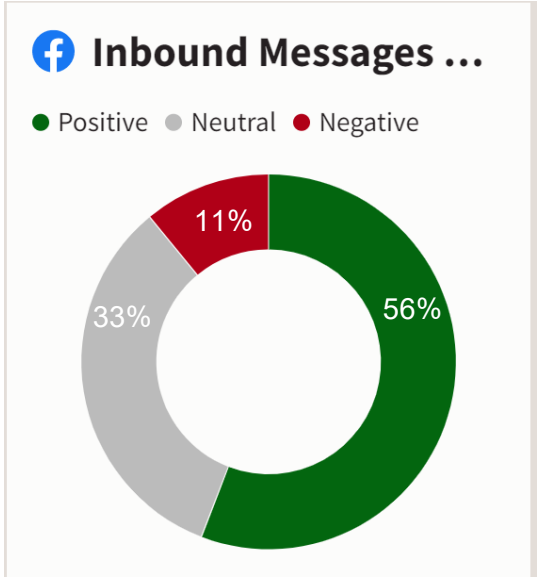
The majority of inbound messages to our corporate social media pages are either positive or neutral:
94% on Twitter and 89% on Facebook

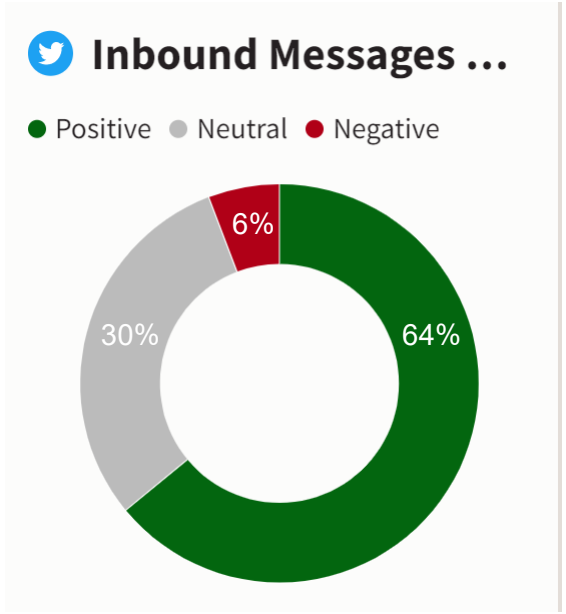
On Facebook this includes comments, posts and private messages

On Twitter this is taken from mentions and direct messages received

"The Urology team have been fantastic, so caring and kind."

"Cardiology staff were so friendly, caring and supportive."





Improving reputation through external communications

The top Tweet and top Facebook post in this period were around our celebration of International Nurses' Day and International Day of the midwife

Top Tweet
2,718 impressions

Top Facebook post
13,902 reach, 732 reactions, comments or shares

Thumbs up Friday and #ThankYouTuesday

30+
ThumbsUp Fridays

25+
Thank You Tuesdays

Improving reputation through external communications

Health Tree Foundation: We continue to support the Trust's charity and have helped them promote upcoming events that people can take part in to raise money including marathons and a sky dive. The Scunny Bikers Easter donation was the most covered press release. We are also currently running a campaign, internally and externally, to promote the Circle of Wishes; encouraging more people to submit a wish.

THE HEALTH TREE FOUNDATION
Your hospital charity

Website – www.nlg.nhs.uk

Key stats:

- 78,901 visits and 217,955 page views – this is consistent with the last report
- 72% of visitors were new users
- 97% of users were in the UK
- Safari was the top browser used to access the site followed by Chrome
- 72% of users accessed the site via a mobile or tablet.
- More men accessed the website than women
- 25 - 34 was the most popular age category
- 78% of people came to the website via a search, 16% direct, 4% from social media (mainly Facebook) and 2% 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 a plea for people to return their NHS equipment (issued in November), Graham Jaques' retirement and the opening of the new decked car park at Grimsby.

79,000
Page visits

218,000
Page views

Safari
Top browser

Improving staff morale and engagement

Keeping staff informed

Wednesday Weekly News

We are unable to track how many people read this all-staff email, but we are able to access link clicks. The top links in this period were for the new Stagecoach bus timetable, the new ward contact info on the Hub, IT security updates and information on how to support staff during Ramadan.

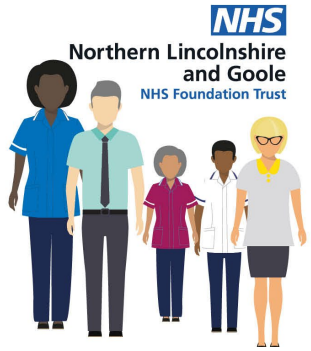
Monday Message

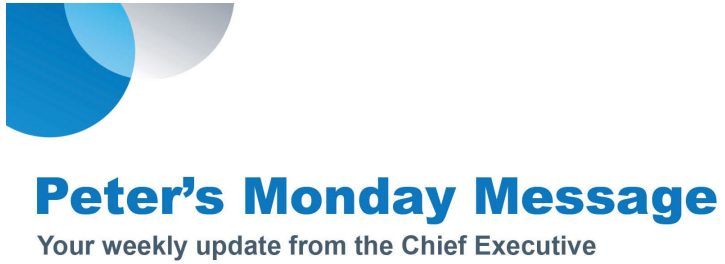
Messages have come from the Chief Executive, Chief Nurse, Medical Director and Chief Operating Officer.
Topics have included:

- Mental health awareness week
- Update on new Trust priorities
- Ockenden report
- Progress since the last CQC report
- Progress against last year's Trust priorities
- Update following the Trust Board meeting

Senior Leadership Briefing

76 senior leaders attended the April SLC and 88 in May. Updates included the Trust priorities for the year ahead, our Health and Wellbeing plans and changes to CSS division.





88
Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Routes for speaking up

Staff closed Facebook group stats

- 3,725 total members
- 885 posts
- 4,477 comments
- 12,783 reactions

The most popular post was a visit to ward C6 by the Grimsby Town mascot

Ask Peter .

291 Ask Peter's were received in this period (up 118 from last year's 173)
Hot topics include: National Living Wage; Moving and Handling training; parking; Agenda for Change bandings; nursing apprenticeships; Dictate IT 3; Park and Ride; staff morale; bank/agency staff and heating. In this period, we have redacted two questions. We have also implemented a new section on the Hub which provides ward move information, and contact details for ward managers as a result of feedback via the forum.

Staff Thank Yous

Since the 'Thank you' system launched in January staff have
sent more than 650 thank yous 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

3,725
Members of the staff Facebook group

291
Ask Peter questions

650
Staff Thank Yous

NLG(22)102

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 February 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 (February 2022 – NLG(22)021).	
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	☐ 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
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4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
-	-	-

Action Required

The Trust Board is asked to note the report.

Directorate of Corporate Governance

FINANCE & PERFORMANCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT124
Version:	1.5
This version issued:	
Result of last review:	Responsibility for Digital and Cyber Security~~services~~ and Service Strategy removed from the F&PC and moved to other committees
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	
Owner:	Helen Harris, Director of Corporate Governance
Document type:	Terms of Reference
Number of pages:	13~~10~~ (including front sheet)
Author / Contact:	Helen Harris, Director of Corporate Governance

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

The Trust has established the Finance and Performance Committee, as a formal sub-committee of the Trust Board. This Committee is responsible for oversight, challenge and assurance, on behalf of the Trust ~~strategies,~~ plans and performance against key operational targets. This will include the management of financial resources within parameters set by regulators.

2.0 Purpose

2.1 The Committee's oversight remit will extend to all critical drivers of financial and operational performance including operational and financial planning, expenditure against capital programme, contracting, financial savings programmes and recovery plans, performance against constitutional standards~~service strategy~~, ~~Digital Services,~~ and estates, ~~and~~ facilities and sustainability.

2.2 The Committee will report the outcome of each meeting to the Trust Board, raise any concerns and make recommendations for action to the Trust Board across this remit.

2.3 To make any recommendation on changes to the Forecast Outturn to the Trust Board.

3.0 Authority

3.1 The Committee may take the following actions on behalf of the Trust Board (subject to the "Reservation of Powers to the Board and Delegation of Powers"):

3.1.1 Approve Trust strategies and policies that fall within the remit of the Committee.

3.1.2 Scrutinise operational and financial plans, and the effectiveness of delivery against those plans.

3.1.3 Scrutinise management arrangements and structures put in place to support financial and operational performance management.

3.1.4 Recommend appropriate corrective and other actions to mitigate identified risks and to ensure compliance with financial and other operational performance targets.

3.2 The Committee is responsible for oversight as to whether the Trust has in place appropriate arrangements to effectively manage financial and operational performance within any required parameters. The Committee is required to provide appropriate assurance to the Trust Board in this regard.

4.0 Accountability & Reporting Arrangements

4.1 The Finance and Performance Committee, appointed under and subject to the Standing Orders of the Trust, is a sub-committee of the Trust Board, and will submit copies of its minutes for inclusion on the Trust Board agenda. The

Trust Board will also receive details of the outcome of the annual evaluation of performance of the Committee.

4.2 The Committee will ensure that significant issues are escalated to the Trust Board via monthly 'highlight' reports with recommendations for action where appropriate.

4.3 Executive and Non-Executive/Associate Non-Executive Committee members will be expected to ensure appropriate cross over with the work of other Trust Board sub-committees, to avoid adoption of incompatible strategies or plans~~,~~ and eliminate duplication of workload.

4.4 The Committee will receive updates on a regular basis, in any appropriate format, regarding key drivers of financial and operational performance, including, but not exclusively:

- Contracting and income recovery
- Expenditure against capital programme
- ~~Service strategy~~
- Operational and financial planning
- Savings and improvement programmes
- Performance against constitutional standards
- Service recovery and improvement plans, including priority areas of waiting lists, reducing long waiting times and improving ambulance handover times
- ~~Digital Services strategies and plans~~
- Estates~~, and~~ Facilities and Sustainability strategies and plans

4.5 Where relevant, the Committee will seek assurance on relevant matters directly from operational staff, requiring attendance at meetings as required.

4.6 The Committee will agree an Annual Work Programme/Cycle of Business, which will be reviewed at each Annual Evaluation of the Committee.

5.0 Responsibilities

On behalf of the Trust Board, the Committee will:

5.1 Financial and Operational Performance

5.1.1 Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.

5.1.2 Review, interpret and challenge in-year financial and operational performance.

5.1.3 Oversee the development and delivery of any corrective action plans and advise the Trust Board accordingly.

5.1.4 Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Trust Board.

~~5.1.4~~5.1.5 Assurance on Procurement processes and functions

~~5.1.5~~5.1.6 Refer issues of quality or specific aspects of the Quality and Safety Committee's remit, and maintain communication between the two committees to provide joint assurance to the Trust Board. Refer issues relating to other Committees' Terms of Reference to those Committees for assurance to the Board

5.2 Estates, Facilities and Sustainability ~~Estates Strategy and maintenance programmes~~

5.2.1 Review the delivery of the Trust's estates strategy and planned maintenance programmes as agreed by the Trust Board.

5.2.2 Consider initiatives and review proposals for land and property development and transactions prior to submission to the Trust Board for approval.

~~**5.3 Digital Strategy, Performance and Development**~~

~~**5.3.1** Review the delivery of the Trust's Digital Strategy and planned development programmes as agreed by the Trust Board.~~

~~5.4~~5.3 **Capital and Other Investment Programmes and Decisions**

~~5.4.1~~5.3.1 Oversee the ~~development, management and~~ delivery of the Trust's annual capital programme and other agreed investment programmes, including expenditure against the annual capital programme.

~~5.4.2~~5.3.2 Evaluate, scrutinise and approve the financial validity of individual significant investment decisions (that require Board approval), including the review of outline and full business cases, up to a value of £1~~2~~5 million.

~~5.4.3~~5.3.3 Business cases that require Board approval will be referred to the Committee following initial review by the Trust Management Board or Capital Investment Board.

~~5.5~~5.4 **Cost improvement plans**

~~5.5.1~~5.4.1 To oversee the delivery of the Trust's cost improvement plans and the development of associated efficiency and productivity programmes.

~~5.6~~5.5 **Business Development Opportunities and Business Cases**

~~5.6.1~~5.5.1 Evaluate emerging opportunities on behalf of the Trust Board.

~~5.6.2~~5.5.2 Consider the merit of developed business cases for new service developments and service disinvestments prior to submission to the Trust Board for approval.

~~5.7~~5.6 Review the Board Assurance Framework on a quarterly basis, giving consideration to the assurance provided, whether the key elements are appropriate in light of any concerns about which the Committee may be aware, and whether the underpinning risks provide sufficient assurance that the strategic risk is being appropriately managed, and undertake deep dives as per the committee's workplan.

~~5.8~~5.7 Recommend appropriate responses and mitigation for risks linked to financial and operational performance, utilising the Trust Risk Register and associated assurance processes such as the Board Assurance Framework.

~~5.9~~5.8 To review and approve strategies and policies relevant to the work of the Committee.

~~5.10~~5.9 The Committee will agree an appropriate annual workplan (Appendix A), and monitor progress in delivering this plan through the year.

6.0 Membership

6.1 Core Membership

6.1.1 The Committee will comprise three Non-Executive Directors/Associate Non-Executive Directors.

6.1.2 Associate Non-Executive Directors to be included as core members of the Committee and to be counted towards quoracy and can be counted towards voting rights (where applicable).

6.2 Executive Directors in Attendance:

- Chief Financial Officer
- Chief Operating Officer
- Director of Estates~~, &~~ Facilities and Sustainability
- ~~Chief Information Officer~~

6.3 Other Persons Attending Meetings

6.3.1 Other persons will attend as agenda items dictate or where a pre-existing or externally driven reporting requirement exists.

6.3.2 All Non-Executive Directors/Associate Non-Executive Directors who are not members of the Committee can attend as desired but will not form part of the permanent membership of this committee.

6.3.3 The Chief Executive and Chair have a right of attendance and speaking rights at all meetings of the Committee and may be included in the quoracy subject to agreement by the Chair.

6.3.4 An invitation to join the committee as an attendee will be extended to a Governor to be identified by the Lead Governor.

6.3.5 Executive Directors may on occasion invite other senior officers to attend the Committee, with the approval of the Committee Chair, to present specific items, or for developmental purposes.

6.3.6 The Committee may, from time to time and as the agenda dictates, require attendance from other Senior Officers of the Trust not mentioned above.

6.3.7 The Director of Corporate Governance may be in attendance at meetings as the agenda dictates.

7.0 Procedural Issues

7.1 Frequency of Meetings

Meetings will normally be held monthly.

7.2 Chair

One of the Non-Executive Director or Associate~~d~~ Non-Executive Director members of the Committee will be appointed as Chair. One of the other Non-Executive Director~~s~~/Associate Non-Executive Director~~s~~ shall deputise in his/her absence.

7.3 Secretary

The Chief Operating ~~Financial~~ Officer's Executive ~~Personal~~ Assistant will act as Secretary to the Committee, preparing agenda papers in conjunction with the Chair and Chief Financial Officer. They will also check minutes and the action log before they are sent to the Chair for approval and draft the highlight report to the Board, which will be approved by the Chair before submission.

7.4 Attendance

7.4.1 Attendance is required for a minimum of 75% of all committee meetings.

7.4.2 Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies appointed can attend up to 25% of all meetings.

7.4.3 Nominated deputies are:

7.4.3.1 Chief Financial Officer – Deputy Director of Finance

7.4.3.2 Chief Operating Officer – Deputy Chief Operating Officer

~~7.4.2.0~~7.4.3.3 Director of Estates, Facilities and Sustainability – Deputy Director of Estates and Facilities

~~7.4.3~~**7.4.4** Joint Trust roles, such as the Chief Financial Officer or any such role, the attendance required is 50% of Committee meetings with appointed deputies covering the remainder of meetings.

7.5 Quorum

7.5.1 The Committee will be deemed to be quorate when there are four members, two of whom will be Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors, one of whom must be either the Chief Financial Officer or the Chief Operating Officer (or their deputies).

7.5.2 Formally appointed deputies will be counted towards quoracy.

7.5.3 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

7.6.1 Minutes of meetings will be circulated with the agenda papers to all members well in advance of each meeting but no less than seven calendar days before each meeting. In addition to the circulation of minutes, the 'action log' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within timescale.

7.6.2 Agenda items for consideration to be submitted 12 calendar days before the meeting.

7.6.3 Submission of papers to members should take place seven calendar days before the meeting. Late papers may be submitted at the discretion of the Chair.

7.6.4 Minutes of meetings of the Finance and Performance Committee will also be submitted to the Audit, Risk and Governance Committee and the Trust Board.

7.6.5 The Chief Financial Officer's Executive Personal Assistant will maintain a record of attendance which must be presented at each committee meeting and included in the annual evaluation exercise.

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the chair will clarify what members are being asked to vote on – the 'motion'. Subject to meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

7.7.4 Only the core members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at board level.

7.8 Monitoring, Compliance & Effectiveness

7.8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Finance and Performance Committee will undertake an annual evaluation of its performance and attendance levels.

7.8.2 A performance evaluation tool, which reflects the requirements outlined within this Terms of Reference, has been developed for this purpose. As part of this evaluation, the committee will formally review the:

- Performance against core duties
- Completion of the actions outlined in the action log
- Effectiveness of the Annual Work Programme

7.8.3 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed, and implementation will be monitored by the Committee.

7.8.4 The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

7.9 Review

These Terms of Reference will be reviewed every year at the time of the annual performance review of the committee or sooner should the need arise.

8.0 Equality Act (2010)

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

8.2 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.

8.3 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.

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Committee Name
Committee Workplan Template

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	20xx									20xx		
								Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
SECTION HEADING																			
SECTION HEADING																			

Agenda Number: 7.3

Name of the Meeting	**Quality & Safety Committee**
Date of the Meeting	Tuesday 24 May 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Nursing Assurance Report**
Executive Summary (to include recommendations)	CHPPD was 8.3 in March. The latest model hospital data for February 2022 indicates a national median of 8.1 and recommended peer median of 8.4. Central delivery suit, Ward 19, 26, C3 and Clinical Decision Unit had a substantive RN/RM fill rate below 50% on day shift. Approximately 67 unestablished escalation beds have been open since before Easter to manage non-elective operational pressures. At times of increased operational pressures, beds have also been utilised on the Discharge Lounge DPoW and SDEC SGH. Vacancies on the inpatient wards in March for Registered Nurses showed a decrease of 1.5 WTE. Healthcare Assistant vacancy showed an increase of 4.9 WTE. There are a total of 125.57 WTE (7.41%) Registered and 98.10 WTE (11.58%) Unregistered vacancies across the Trust. Recruitment and retention work are a priority. In Community there is a slight decrease overall in the nursing vacancies for March 2022 to 13.8wte with a slight increase in the Registered Nurse vacancy rates in month from 13.0wte in February 2022 to 13.2wte in March 2022. A total of 93 staffing red flags (71 reported on Safecare Live and 22 red flags on Ulysses) in March. This was an increase compared to 82 in February. The CN Safe Staffing establishment review report was presented to the Trust Board in December 2021. The Board gave support for the recommendations and priority areas have been funded for 2022/23 therefore recruitment can commence. The Midwife: Birth ratio remains 1:24 in March and has been maintained between 1:22 - 1:25 over the last 12. Maternity staffing and Red Flag incidents continue to be monitored on a daily basis. For the fourth month all the maternity wards have fill rates <95 %. Staffing shortfalls have been experienced across both sites and in the community due to COVID19 absence, sickness and vacancies. Escalation processes are in place. The total number of falls reported in March 2022 has decreased. The largest decrease was reported at the Grimsby site. There has been an increase in the number of pressure ulcer incidents reported in March 2022. The highest increase was in the number of category 2 pressure ulcers reported. Ward B3 has triggered as a higher reporting ward for the fourth consecutive month. It should be noted that there ward has reported no

	category 3, 4 or unstageable pressure ulcers in March 2022. Lead Patient Safety nurse has been undertaking educational support. Ward C2 has triggered for the third consecutive month with an increase in the number of reported category 3 and unstageable pressure ulcers in March 2022. Weekly support is in place for C2. In Community pressure ulcers has not reduced however the majority of reported pressure ulcers overall are category 2 and preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. New formal complaint numbers have increased slightly during March to 34, with continued complexity seen in the issues raised. In March there were 88 ongoing open complaints The new PALs in March rose again to 223, an upward trend is now clearly visible. Due to the impact from restricted visiting, communication is featuring in the concerns, and as the Trust reviews and reopens visiting these concern numbers will be monitored. In March the Trust declared 14 mix sex breaches with the theme for all of these being the Trust had declared OPEL 4 on all occasions. x8 15 steps visits were undertaken place. 6 Visits were cancelled due to significant pressures 3 Outpatient Areas achieved Outstanding. Outpatients Department at GDH receiving this rating for the 2nd time. Ward 22 at SGH required intensive support. The trust had a C.difficile objective of no more than 33 cases and ended the year on 20 reported cases which is 40% within the allocated trajectory and 29% reduction to last year. In summary this was the lowest number of cases for a District Hospital in the region and one of the lowest in the UK. The Trust has not reported any cases of Hospital Onset MRSA bacteraemia cases this financial year. The number of covid-19 cases detected is slowly receding and the majority of patients detected with the infection are asymptomatic. The trusts 3rd QI collaborative has commenced with a focus on Pain Assessment / Re-assessment. The “expert panel” has been formed and are currently working through the process to understand the key problems using QI tools. The panel have also scoped the first 5 wards of focus these are C2, C3, B2, B3 and B7 of which all have been agreed with Divisional HoN.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ✓ Other: Click here to enter text.

Which Trust Priority does this link to	☐ 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 Objective(s) does this link to	✓ To give great care ✓ To be a good employer ✓ To live within our means		☐ To work more collaboratively ✓ To provide good leadership ☐ Not applicable
Which Trust Strategic Risk(s) in the Board Assurance Framework does this link to (*please see descriptions on page 2)	✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4	☐ 1 - 1.5 ☐ 1 - 1.6 ☐ 2 ☐ 3 - 3.1	☐ 3 - 3.2 ☐ 4 ☐ 5 ☐ Not applicable
Which CQC Key Line(s) of Enquiry (KLOE) does this link to	✓ Caring ✓ Responsive	✓ Well Led ✓ Effective	✓ Safe ☐ Not applicable
Financial Implication(s) (if applicable)			
Recommended Action(s) Required:	✓ Approval ☐ Information ☐ Discussion ☐ Assurance		☐ Review ☐ Onward distribution: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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 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.

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: 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.

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: 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.

Strategic Objective 1 – 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.

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: 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.

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: 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).

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: 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.

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: 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.

Strategic Objective 3 – 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.

Strategic Objective 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.

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

Assurance Report May 2022 (March data)

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018).

Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Oversight continues to be provided to the Quality and Safety Committee on nursing and safe staffing. The changes to ward configurations and zoning throughout the pandemic has made it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons.

As we continue to reset ward configurations and utilise escalation bed during the surge in non-elective activity, any data should be viewed with caution and for this reason we continue to review individual metrics and apply professional judgement. In line with the document published in February 2021, Deployment and Assurance of Clinical Nursing Workforce during Covid19 emergency, quality impact assessments are undertaken with final sing-off by the Chief Nurse prior to additional wards being opened.

The Nursing Metrics Review Panel is chaired by the Chief Nurse, meets monthly and is attended by the senior nursing team for the organisation. The panel review the information provided by the nursing dashboard and commission any work required to investigate and support any areas of concern.

2.0 Safe Staffing

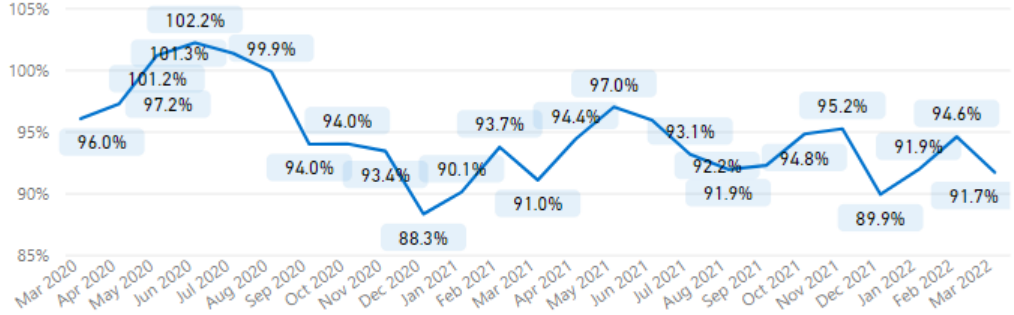
2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

The information presented shows data on inpatient wards only.

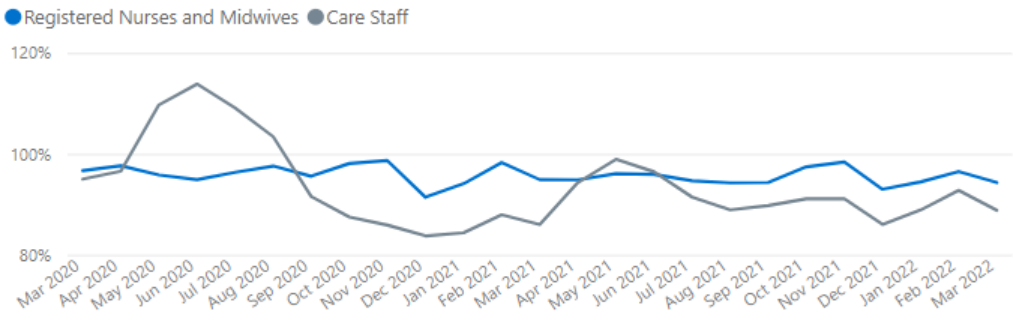
Shift Fill Rates Summary Mar 2022

Overall	Registered Nurses and ...	Care Staff	Nursing Associates
91.7% ▼ -2.9%	94.3% ▼ -2.2%	88.8% ▼ -4.0%	28.1% ▼ -13.2%

Overall Fill Rate



Fill Rate by Staff Group



Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPoW	90.3%	-4.4%	94.8%	
Mar 2022	GDH	115.8%	9.4%	106.4%	
Mar 2022	SGH	90.7%	-2.3%	93.0%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Medicine	90.7%	-5.4%	96.1%	
Mar 2022	Surgery & Critical Care	98.9%	2.4%	96.6%	
Mar 2022	Women & Children's	86.1%	-2.1%	88.2%	

Shift fill rates are reported against ward establishments. During the pandemic, our wards and bed bases have undergone extensive changes and moves, this has involved ward changes of specialty as well as demographic and bed base. Establishments have been reviewed consistently during this time and staffing reviews take place at intervals throughout the day, including a trust wide review of SafeCare Live information at 10am. At each ward reconfiguration, the Chief Nurse has reviewed the establishment based on a set of principles as we have been unable to apply the robust process that would normally be undertaken.

The Chief Nurse undertook an establishment review in 2021 with collection of the Safer Nursing Care Tool data during April and May once the bed base was reset. Meetings were held with ward and department managers so that recommendations could be made. The report was presented to the Trust Board in December 2021. The Board agreed to continue to fund the very high/ immediate risk recommendations through the use of temporary staffing. The ability to fill these shifts has been a concern due to the availability of bank and agency staff and continues to be monitored. The Board gave support for the recommendations and priority areas have been funded for 2022/23 therefore recruitment can commence.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard. The combined fill rate has decreased to 91.7% below the 95% target. HCA fill rate remains a concern at 88.8% which is a 4% reduction form last month. Fill rate within Family Services is the lowest at 88.8% and is a concern due to the number of midwife vacancies and sickness.

Securing temporary staffing through the bank and agencies remains challenging as it has throughout the latter stages of the pandemic. Incentive payments for bank staff were introduced in November for the winter and ended on 30.04.22.

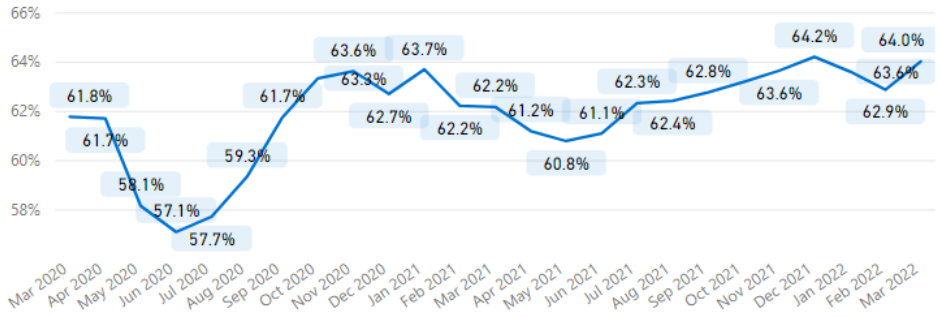
A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse and Midwife to HCSW ratio for the Trust has been above 60% for the last year. Medicine had the lowest RN ratio in March at 58.3%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

RNMW Ratio Summary Mar 2022

RNMW Ratio

64.0% ▲ 1.1%

RNMW Ratio



RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPoW	61.9%	0.9%	61.0%	
Mar 2022	GDH	59.1%	2.0%	57.1%	
Mar 2022	SGH	67.1%	1.3%	65.7%	

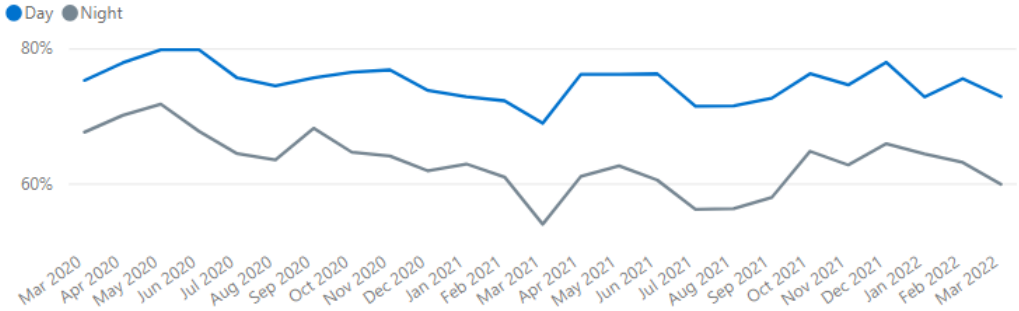
RNMW Ratio by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Medicine	58.3%	1.4%	57.0%	
Mar 2022	Surgery & Critical Care	71.9%	0.7%	71.2%	
Mar 2022	Women & Children's	69.8%	1.0%	68.7%	

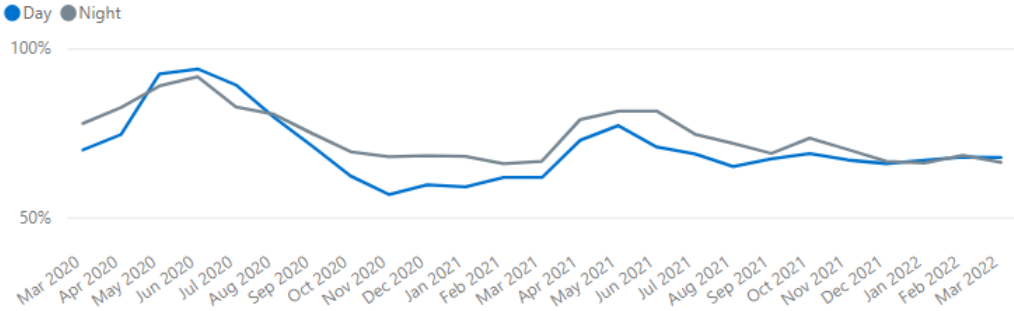
Substantive Fill Rates Summary Mar 2022

RNMW - Da	RNMW - Night	Care Staff - Day	Care Staff - Night
72.8% ▼ -2.7%	59.9% ▼ -3.2%	67.7% ▼ -0.1%	66.2% ▼ -2.1%

Registered Nurses and Midwives Substantive Fill Rate %



Care Staff Substantive Fill Rate %



RNMW - Day Substantive Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPoW	76.3%	-5.2%	81.5%	
Mar 2022	GDH	79.9%	-2.5%	82.4%	
Mar 2022	SGH	68.2%	-0.0%	68.2%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Medicine	67.2%	-5.5%	72.7%	
Mar 2022	Surgery & Critical Care	82.8%	3.5%	79.4%	
Mar 2022	Women & Children's	74.4%	-2.5%	76.9%	

Wards with Substantive Fill Rate Below 50% **Mar 2022**

Staff	Registered Nurses and Midwives	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Central Delivery Suite	49.2%	▼ -12.7%
Ward 26 SGH	47.2%	▼ -1.2%
Ward C3	43.3%	▼ -17.5%
Ward 19	42.4%	▼ -22.1%
Clinical Decisions Unit	42.2%	▼ -58.8%

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD C6 DPoW	47.5%	▼ -27.5%
STROKE UNIT DPoW	46.5%	▼ -2.2%
Ward C3	43.6%	▼ -17.5%
Amethyst	42.9%	▼ -0.1%
WARD C5 DPoW	39.4%	▼ -0.1%
WARD 23 SGH	38.3%	▲ 0.7%
Clinical Decisions Unit	34.5%	▼ -85.0%
WARD 24 SGH	32.3%	▼ -0.6%
WARD 17 SGH	25.5%	▼ -2.0%
WARD 22 SGH	22.8%	▼ -2.7%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Ward C3	48.7%	▼ -34.4%
ICU SGH	48.6%	▲ 7.9%
LAUREL WARD DPoW	45.6%	▲ 7.8%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD 22 SGH	47.3%	▼ -8.7%
Ward C3	46.7%	▼ -33.0%
WARD 17 SGH	45.2%	▼ -13.8%
Ward 26 SGH	44.0%	▼ -2.9%
WARD B7 DPoW	41.9%	▼ -24.1%
WARD 23 SGH	41.8%	▼ -13.9%
Ward 19	22.6%	▼ -4.1%

Substantive versus temporary staff fill rate is monitored and a slight decrease in substantive staff fill rate is seen for RN days and nights and care staff at night. This is likely due to the increase of staff absence seen from the latest Covid surge.

Five wards had a substantive RN/RM fill rate below 50% on day shift. This is a combination of sickness and vacancies. Night shifts continue to be the shift with the lowest substantive fill rate for RNs/RMs with 10 wards less than 50%.

Scunthorpe wards continue to have the lowest fill rate on nights. These wards have several agency staff blocked booked, many who have worked in the trust for a number of years and are experienced nurse familiar with the Trust policies and procedures.

The information below demonstrates the high level of sickness in the areas with the lowest substantive fill rate

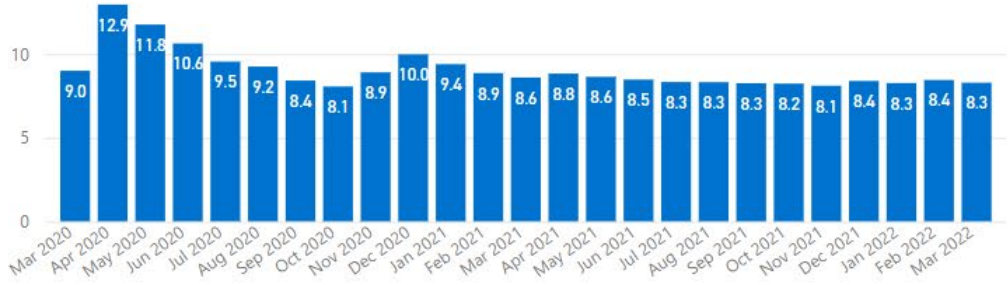
Monthly Sickness %

Unit	Sickness %
208 SGH Maternity Central Delivery Suite (2670)	4.23%
208 SGH Maternity Ward 26 (2681)	13.79%
208 DPOW Medical Ward C3 (Shortstay) (2410)	5.44%
208 SGH Surgical Ward 19 (2551)	7.27%
208 SGH Medical Ward (AAU YB) (2610)	12.30%
208 DPOW Medical Ward C6 (2406)	5.03%
208 DPOW Medical Ward Stroke Unit (2411)	8.24%
208 DPOW Medical Ward Amethyst (2409)	15.74%
208 DPOW Medical Ward C5 (2401)	6.34%
208 SGH Medical Ward 23 (Shortstay) (2605)	4.35%
208 SGH Medical Ward 24 (AAU YA) (2602)	4.00%
208 SGH Medical Ward 17 (2604)	7.79%
208 SGH Medical Ward 22 (2601)	10.46%

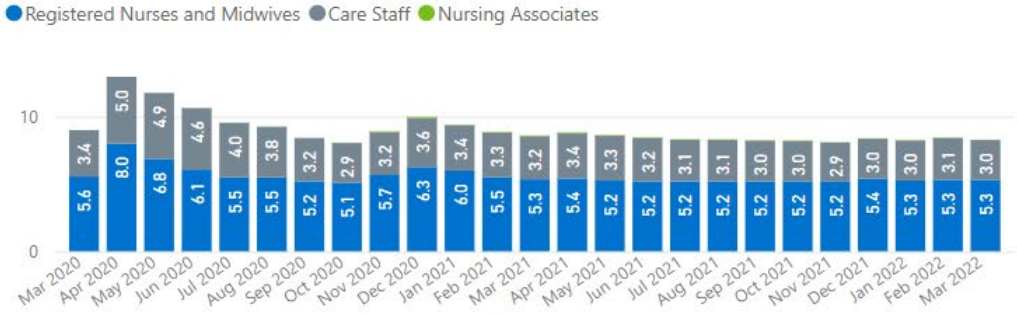
CHPPD Summary Mar 2022

Overall	Registered Nurse...	Care Staff	Nursing Associates
8.3 ▼ -0.16	5.3 ▼ -0.01	3.0 ▼ -0.14	0.0 ▼ -0.01

Overall CHPPD



CHPPD by Staff Group



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPoW	8.3	! -0.2	8.5	
Mar 2022	GDH	7.6	! -0.8	8.4	
Mar 2022	SGH	8.4	✓ 0.0	8.4	

CHPPD by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Medicine	7.3	✓ 0.0	7.3	
Mar 2022	Surgery & Critical Care	8.7	! -0.9	9.6	
Mar 2022	Women & Children's	12.0	✓ 0.2	11.8	

Wards with CHPPD Below 6.0 **Mar 2022**

Staff	Registered Nurses and Midwives		Care Staff		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
Ward 26 SGH	4.4	▲ 0.45	1.6	▲ 0.05	**6.0**	**▲ 0.50**
Amethyst	3.3	▲ 0.07	2.6	▼ -0.05	**5.9**	**▲ 0.01**
WARD 22 SGH	3.3	▲ 0.08	2.5	▼ -0.18	**5.7**	**▼ -0.10**
WARD C2	2.8	▲ 0.02	2.6	▼ -0.05	**5.4**	**▼ -0.03**
WARD B4 DPoW	0.3		0.2		**0.6**	

The Care Hours per Patient Day (CHPPD) data is reported monthly and is included in the Trust's NHS Digital return. CHPPD is the total hours per day of Registered Nurses (RN), Midwives (MW) and care staff divided by the number of patients in the ward/department at 23.59 hours each night. This provides a score of the average care hours per patient per day. There are many factors that can affect the care hours required, for example, the proportion of single rooms.

The graphs above shows the trend for the CHPPD which has seen no significant change since the increase seen in the first wave of Covid when bed numbers were reduced to support management of the pandemic and increased patient acuity, and the workforce was being supported by third year student nurses on paid placements.

CHPPD was 8.3 in March. The latest model hospital data for February 2022 indicates a national median of 8.1 and recommended peer median of 8.4. It remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 24 months.

2.2 Escalation Beds

It is still not possible to obtain accurate escalation bed data against established beds from WebV or the Sitrep reports. Escalation beds which are not established are open on C3 (n5), B2 (n8), ward 24 (n6), IAAU (n12), ward 19 (n12 D2A), Laurel (n12 D2A), SGH gynae (n3 D2A), Ward 3 Goole (n9 D2A) – total 67 beds . In addition to these, at times of increased operational pressures, beds are utilised on the Discharge Lounge DPoW and SDEC SGH. This has an impact on staffing across all areas as there is no establishment overnight on the Discharge Lounge or SDEC.

2.3.1 Maternity Staffing

The Chief Nurse undertook a desktop maternity staffing establishment review in early March 2021 and the increases in establishments identified were included in the Trust's Ockenden Immediate and Essential Actions submission. An establishment review using Birthrate Plus workforce planning tool has been undertaken and the final report is expected in May. A desktop review with ward managers is being planned for the end of May

2.3.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD — Mar 2022

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.9%**	**▲ 0.4%**	**82.5%**	**▲ 0.7%**	**13.0**	**▲ 2.25**
Registered Nurses and Midwives	91.8%	▲ 3.9%	80.4%	▲ 3.0%	8.2	▲ 1.71
Care Staff	92.1%	▼ -5.4%	86.1%	▼ -2.9%	4.9	▲ 0.54
Central Delivery Suite	**76.0%**	**▼ -13.8%**	**60.9%**	**▼ -10.0%**	**29.2**	**▲ 2.91**
Registered Nurses and Midwives	73.0%	▼ -15.3%	55.9%	▼ -10.4%	22.6	▲ 1.82
Care Staff	88.1%	▼ -7.5%	81.8%	▼ -8.3%	6.6	▲ 1.09
Jasmine & Honeysuckle	**85.8%**	**▼ -5.9%**	**71.8%**	**▼ -3.9%**	**11.7**	**▼ -2.42**
Registered Nurses and Midwives	81.7%	▼ -8.4%	66.9%	▼ -9.4%	7.4	▼ -1.83
Care Staff	94.1%	▼ -0.8%	81.5%	▲ 7.3%	4.2	▼ -0.59
Ward 26 SGH	**74.6%**	**▲ 1.0%**	**49.5%**	**▼ -0.2%**	**6.0**	**▲ 0.50**
Registered Nurses and Midwives	75.1%	▲ 2.4%	48.8%	▼ -1.7%	4.4	▲ 0.45
Care Staff	73.3%	▼ -3.0%	51.6%	▲ 3.9%	1.6	▲ 0.05
Total	**82.9%**	**▼ -4.4%**	**67.5%**	**▼ -3.2%**	**11.3**	**▲ 0.26**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	62.7%	▲ 2.8%
Central Delivery Suite	77.4%	▼ -1.7%
Jasmine & Honeysuckle	63.7%	▼ -2.0%
Ward 26 SGH	73.5%	▲ 1.5%
Total	**68.2%**	**▼ -0.1%**

For the fourth month all the maternity wards have fill rates <95 %. Staffing shortfalls have been experienced across both sites and in the community due to COVID19 absence, sickness and vacancies. Operational staffing meetings are held three times per day with review of issues and escalation of any risks that can't be mitigated, with senior oversight in the 10.00-hour safe staffing meeting. Proactive requests for bank staff / agency staff are made as required. Escalation processes and plans are in place with daily oversight from the senior midwifery team.

Recruitment is ongoing and vacancies are reviewed regularly and taken to the weekly establishment review meeting. There is a rolling advert for rotational midwifery posts and international recruitment of midwives is being explored.

2.4 Staffing Indicators

2.4.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies Summary Mar 2022

Vacancies - Total

98.5 ▲ 3.4

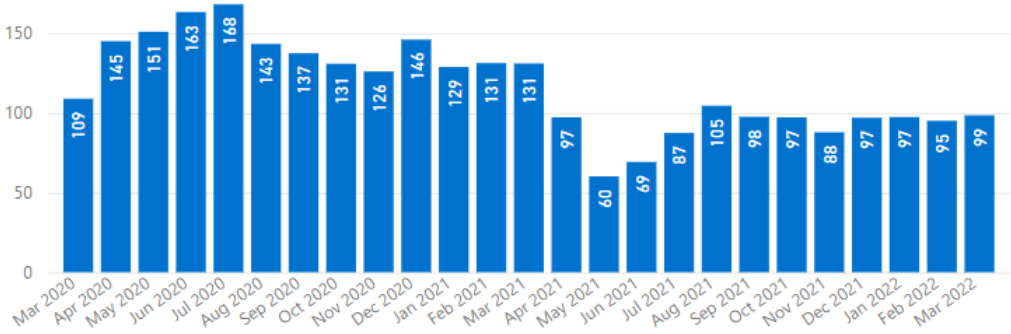
Vacancies - Qualified

53.1 ▼ -1.5

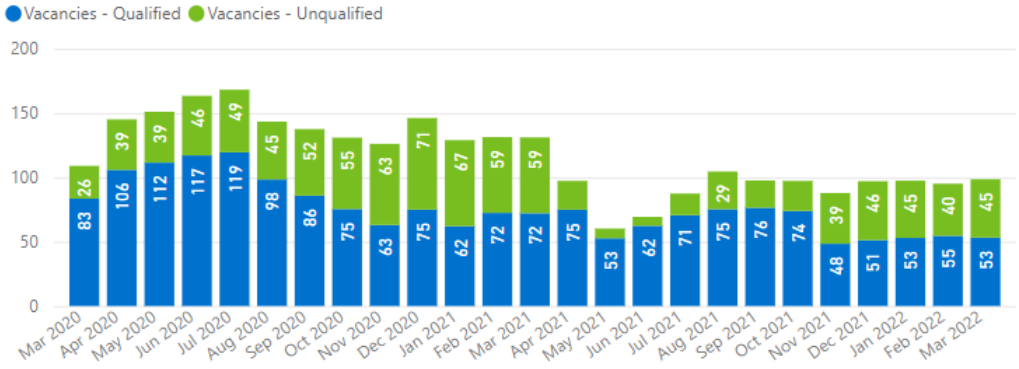
Vacancies - Unqualified

45.4 ▲ 4.9

Vacancies



Vacancies by Staff Group



Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPOW	12.6	-3.1	15.7	
Mar 2022	GDH	16.7	-0.6	17.3	
Mar 2022	SGH	23.9	2.3	21.5	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Community & Therapies	2.4	0.4	2.1	
Mar 2022	Family Services	15.7	-1.6	17.3	
Mar 2022	Medicine	32.8	3.6	29.3	
Mar 2022	Surgery	2.2	-3.8	6.0	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPOW	18.0	-3.2	21.2	
Mar 2022	GDH	-1.1	1.0	-2.1	
Mar 2022	SGH	28.4	7.1	21.3	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Community & Therapies	0.4	0.0	0.4	
Mar 2022	Family Services	2.8	1.2	1.6	
Mar 2022	Medicine	34.7	-1.8	36.5	
Mar 2022	Surgery	7.5	5.5	2.0	

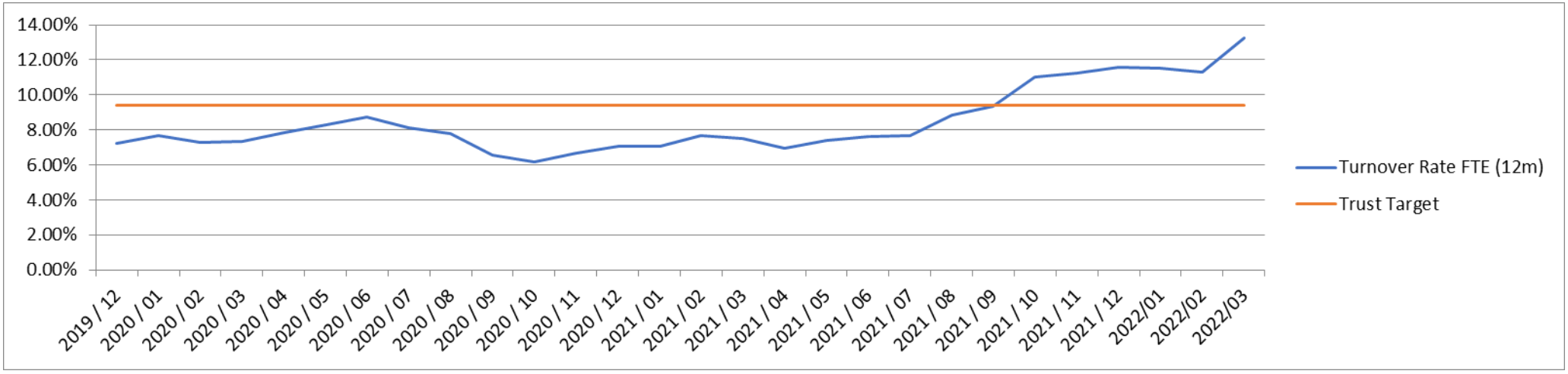
Vacancies on the inpatient wards in March for Registered Nurses showed a decrease of 1.5 WTE (B4 Registered Nursing Associates and B4 overseas Pre-registration nurses are included in the monthly ward established RN position).

Healthcare Assistant vacancy showed an increase of 4.9 WTE. Active recruitment continues to recruit to the HCA Pool to ensure swift recruitment to replace any leavers.

There are a total of 125.57 WTE (7.41%) Registered Nurse and 98.10 WTE (11.58%) Unregistered vacancies across the Trust.

As can be seen from the graph below, HCA turnover has increase to 13.35%. Work has been initiated to explore the reasons for this with individuals. Retention work continues and as part of this the HCSW induction programme has been refreshed, career clinics have been established and workshops are planned.

HCA turnover Dec 2019 – March 2022



The overseas Pre-registration nurses who have joined the Trust continue to progress through their OSCE preparation and induction programme.

Cohort	Start date	Number of Pre-registration nurses	OSCE 1st attempt pass rate	OCSE 1st resit pass rate	OCSE 2nd resit pass rate
1	Oct 2020	20	58%	100%	NA
2	Dec 2020	19 (+ 1 shielding)	42%	91%	100%
3	Feb 2021	10	100%	NA	NA
4	Mar 2021	25	84%	75%	100%
	Apr 2021	3	100%	NA	NA
5	July 2021	7	100%	NA	NA
6	Sept 2021	10	100%	NA	NA
7	Oct 2021	5	80%	100%	NA
8	Nov 2021	13	85%	-	-
9	Dec 2021	18	44%	90%	100%
10	Jan 2022	5	60%	100%	-
11	Feb 2022	14	-	-	-
12	Mar 2022	15			
TOTAL		**165**	59%	90%	100%

The NMC have recently restructured the OSCE Test of Competence. The December and January cohorts took a mixture of the old and new OCSE. The success rate across the country was predicated to drop initially by NHS England whilst Trusts became familiar with the new OSCE process.

The last quarterly NMC figures (Oct-Dec 2021) show an overall pass rate of 65%, **including resits**. The lower number of candidates taking the new OSCE is due to the fact that most applicants currently taking OSCE are still eligible to continue with the legacy OSCE during the transition period until 31.07.22. The legacy OSCE pass rate for Q3 was 76%.

Funding has been secured from NHSE/I to support recruitment of an additional 120 international nurses before December 2022 (£3k per nurse). A risk associated with the ability to continue to support international nurse recruitment includes approval of the business case for substantive recruitment of CPD nurses to support OSCE prep and induction as temporary funding from NHSE/I ends. From April 2022, the remining CPD nurse will only be able to support cohorts of 12 nurses every other month until her contract ends in October. Without the business case being funded it is anticipated that 41 of the proposed 120 international nurses can be recruited and supported.

Additionally, there is a risk with the ability to appoint nurses from non-red list countries who are ready to relocate within timescales. The red list counties include African countries including Ghana, Niger, Nigeria which are countries from which most of our future pipeline is made up. They have applied directly and have not been actively recruited so can be appointed. NHSE/I funding can now be used to support the recruitment of nurses from red list countries (where no active recruitment) however this position is temporary.

A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

2.4.2 Staffing Incidents

The information presented below shows data on inpatient wards only.

Staffing Incidents Summary Mar 2022

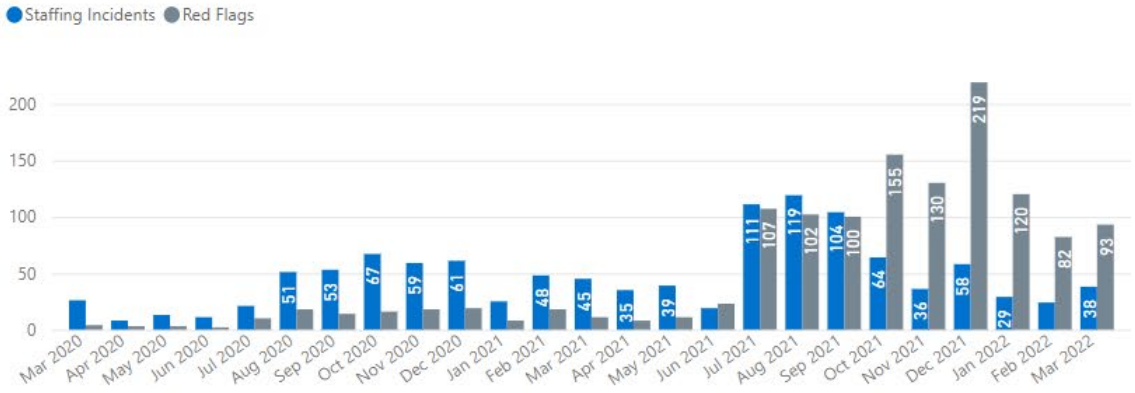
Staffing Incidents

38 ▲ 14

Red Flags

93 ▲ 11

Staffing Incidents and Red Flags



Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - Rainforest	0	0	13	▲ 2
DPOW - Maternity	8	▲ 3	3	0
SGH - CDS	9	▲ 1	1	▼ -3
SGH - Ward 26	3	▼ -2	7	▲ 1
DPOW - B6	1	▲ 1	7	▲ 4
DPOW - Laurel	4	▲ 4	4	▲ 4
SGH - Ward 16	0	0	7	▲ 6
SGH - Stroke SGH	1	0	5	▲ 4
SGH - Ward 23 Short Stay	1	▲ 1	5	▲ 3
DPOW - C2	0	0	5	▼ -1
SGH - ICU	0	0	5	▼ -2
SGH - SDEC Medicine SGH	2	▲ 1	3	▲ 3
SGH - Ward 28	2	▲ 2	2	▲ 2
DPOW - C3 Short Stay	0	▼ -1	3	▼ -6
GDH - Ward 3	0	0	3	▲ 3
SGH - Ward 18	1	▲ 1	2	▲ 2
SGH - Ward 22	0	▼ -1	3	0
SGH - Ward 24 Assessment Unit	1	0	2	▲ 1
DPOW - A1	0	0	2	▲ 1
DPOW - B3	1	▲ 1	1	▲ 1
DPOW - Stroke DPW	0	0	2	▼ -7
SGH - Disney	1	▲ 1	1	▲ 1
SGH - NICU SGH	1	▲ 1	1	▲ 1
DPOW - Amethyst	0	0	1	▼ -4
DPOW - B2 Assessment Unit	1	▲ 1	0	▼ -2
DPOW - C1 Glover	0	0	1	0
DPOW - ITU	0	0	1	▲ 1
DPOW - NICU DPW	0	0	1	0

38 nurse staffing incidents were reported in March on the Ulysses system compared to 23 in February.

2.4.3 Red Flags

A total of 93 staffing red flags were reported (71 on Safecare Live and 22 on Ulysses) in March. This was an increase compared to 82 in February however 122 were reported in January.

Red Flags on SafeCare Live

Red Flag Type, Ward	No. Red Flags
Below Safe Staffing Levels	56
PAU DPoW	7
Ward 16 SGH	7
Rainforest DPoW	6
B6 DPoW	6
C2 DPOW	5
Ward 26 SGH	4
Ward 23 new SGH	3
Ward 27 SDEC SGH	2
Ward 3 GDH	2
ICU - SGH	2
Ward 22 SGH	2
Ward 24 new SGH	2
Stroke Unit DPOW	2
C1 Glover DPOW	1
Laurel Ward DPoW	1
Ward 18 SGH	1
Stroke Unit SGH	1
Amethyst Ward DPoW	1
Nicu DPoW	1

Red Flag Type, Ward	No. Red Flags
Less than 50% substantive staff on shift	6
Stroke Unit SGH	2
C3 Short Stay DPoW	1
Ward 22 SGH	1
Ward 19 Ringfenced SGH	1
Ward 23 new SGH	1
Co-ordinators Non Supernumerary	4
ICU - SGH	3
ITU DPoW	1
Trained Nurse less than 12mths qual left in Charge	3
A1 Yellow B IAAU DPoW	1
Ward 29 SGH	1
Laurel Ward DPoW	1
More than 50% Staff under 12months Qualified	2
C3 Short Stay DPoW	1
A1 Yellow B IAAU DPoW	1
Area outside of normal Footprint	1
Ward 27 SDEC SGH	1
Covid-19 +ve pts on Ward	1
C3 Short Stay DPoW	1
Less than two trained nurses on a Clinical Area	1
Stroke Unit SGH	1

Red Flag Type, Ward	No. Red Flags
Less than 50% substantive staff on a shift	8
Ward 28	2
B2 Assessment Unit	1
B6	1
Disney	1
SDEC Medicine SGH	1
Stroke SGH	1
Ward 23 Short Stay	1
Below safe staffing levels following escalation	5
Ward 26	3
CDS	1
Maternity	1
Not Completed	3
NICU SGH	1
Ward 3	1
Ward 18	1
Delay of 2 hours or more between admission for induction and beginning of process	2
Maternity	2
Unplanned Services - Shortfall of more than 25% in registered professionals' time available compared	1
Laurel	1
Trained nurse less than 12 months qualified, or still in preceptorship left in charge	1
Laurel	1
Delay of more than 30 minutes to provide acute pain relief	1
ECC DPW	1
Less than 2 trained nurses on a clinical area	1
B3	1

Red Flags on Ulysses

Rainforest/ PAU, ward 16 and B6 have the highest red flags for March with most concerns regarding safe staffing levels. There wards are not triggering on other workforce metrics and are being monitored.

3.0 Community Nursing

Community Nursing Assurance Dashboard — Mar 2022

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Activity			Safety & Quality							Staffing	Infection Control	Friends & Family	End of Life Care
Team	Contacts Actual	Contacts Planned	Contacts Telephone	Red Flags	Falls - Total	Community Acquired PU - Total	Complaints	Weekly Assurance Tools	Caseload Reviews	Caseload	Vacancies - Total	Hand Hygiene %	FFT Recommended Rate %	Deaths with Care in Last Days of Life %
West Network	3,020.0 ↗		93.0 ↘	2.0 ↘	1.0 ↗	14.0 ↗					1.1 ↗			
East Network	3,251.0 ↗		107.0 ↗	1.0 ↘	0.0	12.0 ↗					5.2 ↗			
South Network	4,304.0 ↗		148.0 ↗	2.0 ↗	0.0 ↘	13.0 ↘					3.1			
Unscheduled Care Team (UCT) (incl rapid response)	434.0 ↗		89.0 ↗	0.0	0.0	0.0					2.2			
Macmillan Health Care Team	1,651.0 ↘		19.0 ↘	0.0 ↘	0.0	0.0					2.4 ↗			
Specialist Palliative Care Nurses (SPC)				0.0	0.0	0.0					0.0			
Palliative Care				0.0	0.0	0.0					-1.0			
Palliative Care (incl specialist nurses)	343.0 ↗		237.0 ↗											
Single Point of Access (SPA)				1.0 ↗	0.0	0.0					0.3			
Continence Team	226.0 ↘		99.0 ↗	0.0	0.0	0.0					0.2 ↗			
Tissue Viability Team	187.0 ↗		7.0 ↘	0.0	0.0	1.0 ↘					1.6			
Long Term Conditions / Complex Care Matrons (Comm Matrons)	432.0 ↗		254.0 ↗	0.0	0.0	0.0					1.1			
Intermediate Care Services (ICS) + Core Therapy	936.0 ↗		17.0 ↗	0.0	0.0	6.0 ↗					-0.7			
Discharge Liaison Team				0.0	0.0	0.0					0.0			
Locality Co-ordinators				0.0	0.0	0.0					-0.1			
Evening / Night Service				0.0	0.0	0.0					-1.8 ↘			
Chronic Wound Team	395.0 ↗		49.0 ↗	0.0	0.0	1.0 ↗					0.2			
DN Students				0.0	0.0	0.0					0.0			
Community Nursing														18.8 ↘

3.1 Community Nursing Workforce

Team	Vacancies - Qualified	Vacancies - Unqualified	Total
East Network	7.1	-1.8	5.2
South Network	3.4	-0.3	3.1
Macmillan Health Care Team	0.0	2.4	2.4
Unscheduled Care Team (UCT) (incl rapid response)	0.1	2.2	2.2
Tissue Viability Team	0.2	1.4	1.6
West Network	1.1	0.0	1.1
Long Term Conditions / Complex Care Matrons (Comm Matrons)	1.1	0.0	1.1
Single Point of Access (SPA)	0.5	-0.2	0.3
Chronic Wound Team	0.1	0.1	0.2
Continence Team	0.2	0.0	0.2
Specialist Palliative Care Nurses (SPC)	0.0	0.0	0.0
Discharge Liaison Team	0.0	0.0	0.0
DN Students	0.0	0.0	0.0
Locality Co-ordinators	-0.1	0.0	-0.1
Intermediate Care Services (ICS) + Core Therapy	0.1	-0.8	-0.7
Palliative Care	-1.0	0.0	-1.0
Total	**13.2**	**0.7**	**13.8**

Vacancies

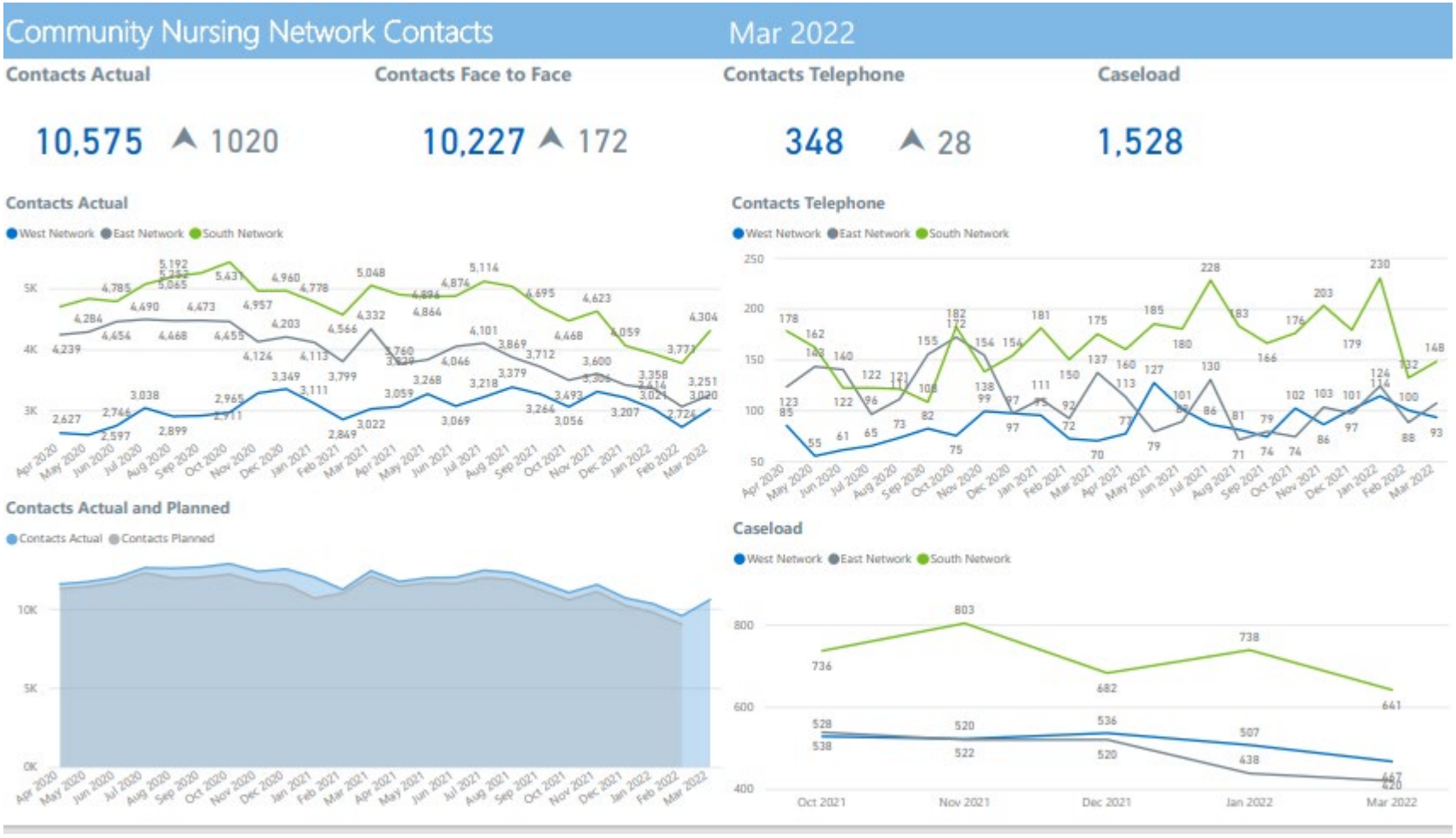
There has been a slight decrease overall in the nursing vacancies for March 2022 to 13.8wte with a slight increase in the Registered Nurse vacancy rates in month from 13.0wte in February 2022 to 13.2wte in March 2022. Most of these vacancies are in the community nursing networks with East Network having the highest Registered Nurse vacancy rate of 7.1wte, South Network 3.4wte and West Network 1.1wte. The funding for an additional 12 Registered Nurses has been approved; these are currently advertised and are being promoted widely as part of a dedicated recruitment campaign for Community Nursing. 2.0wte Band 5 Registered Nurses have a confirmed start date and 3.4wte Band 5 Registered Nurses are in the recruitment pipeline for the nursing networks. Vacancies remain which links to risk 2921 and 2922 on the risk register, this is mitigated currently by using bank and staff undertaking extra hours.

The unregistered vacancy is showing a decrease in month from 0.9wte in February 2022 to 0.7wte in March 2022.

Sickness Absence

There has been an increase in the absence rate of Registered Nurses from 9.15% in January 2022 to 11.481% in March 2022, this remains over double the target of 4.10% and this absence is being seen in a number of services. In particular, the nursing networks have seen a high level of sickness absence throughout March which is being managed by the Team Leaders and Matrons. Long terms sickness reviews are also being managed proactively by Team Leaders and Matrons with support from HR. Other services in community and therapies continue to support the nursing networks to mitigate the risk and to ensure patient safety.

Community Nursing Network Contacts



Activity remains high, particularly in the nursing networks, with a notable increase in both face to face and telephone contacts during March 2022.South Network has had the most contacts, but this is proportionate to the caseload size in comparison with the other 2 networks. There continues to be ongoing concerns with moving and cancelling visits within community nursing due to capacity, this is undertaken in line with the Essential Visit Guidance for Community Nursing Network Teams. Ongoing quality improvements within the networks has seen a significant decrease in the number of unallocated visits at the beginning of the day this is related to changes to working in postcode locations, implemented within Malinko.

The team continue to work with Malinko to set up reporting following implementation across the networks which includes the review of quality of data entry and making changes to the SOP.

Community Nursing Red Flag incidents

Staffing red flags were updated and relaunched in June 2021; these are discussed daily at the Community Safety Huddle. The total nursing red flag incidents for March 2022 is 6 which is a decrease from the 20 reported in February 2022. 3 of these relates to a shortfall in nurse/therapy staffing in the community networks. This is not reflective of the number of staffing shortages in the networks which have been a more frequent occurrence. Communication with nursing teams continues to remind staff to submit red flag incidents when there is a shortage of staff against agreed establishment.

4.0 Maternity Dashboard and Red Flag Incidents

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Midwife to Birth Ratio	24.0	24.0	24.9	25.8	25.2	25.4	25.2	24.4	24.8	24.6	24.9	24.0
Red Flags	7.0	4.0	6.0	17.0	10.0	28.0	15.0	5.0	17.0	10.0	13.0	9.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	4.0	2.0	1.0	6.0	1.0	9.0	8.0	2.0	4.0	1.0	4.0	3.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0	0.0	0.0	1.0	3.0	5.0	1.0	1.0	1.0	0.0	0.0	2.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	1.0	1.0	0.0	0.0	1.0	1.0	1.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	2.0	0.0	1.0	4.0	3.0	5.0	4.0	0.0	3.0	2.0	4.0	2.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	1.0	2.0	4.0	4.0	1.0	8.0	2.0	1.0	8.0	2.0	5.0	2.0
In Receipt of %			12.0	13.0	13.0	14.0	15.0	11.0	9.0	10.0	23.0	9.0
CoC In Receipt of %		79.6	81.3	87.0	55.1	53.7	58.0	60.0	52.0	21.0	83.0	56.0
Continuity Team Caseload			350.0		374.0	347.0	348.0	347.0	326.0	342.0	334.0	319.0
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	96.3	92.4	91.8	89.4	91.5	88.9	90.7	92.7	90.1	92.8	91.5	95.1
Labour Co-ordinator Supernumerary Status %	100.0	98.4	96.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies			11.7	11.5	10.6	13.9	13.2	11.5	10.8	12.1	11.8	11.2
Vacancies - Registered			9.9	10.9	10.0	13.3	12.0	9.8	8.8	10.3	10.9	10.2
Vacancies - Unregistered			1.9	0.6	0.6	0.6	1.1	1.8	2.1	1.9	0.9	0.9

SGH Maternity Dashboard

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Indicator	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Midwife to Birth Ratio	22.0 ↘	22.0	23.3 ↗	23.9 ↗	24.0 ↗	23.8 ↘	24.7 ↗	23.6 ↘	24.9 ↗	24.2 ↘	23.9 ↘	23.9 ↗
Red Flags	8.0 ↘	21.0 ↗	13.0 ↘	20.0 ↗	34.0 ↗	22.0 ↘	13.0 ↘	14.0 ↗	43.0 ↗	23.0 ↘	24.0 ↗	18.0 ↘
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	6.0 ↘	10.0 ↗	0.0 ↘	1.0 ↗	3.0 ↗	5.0 ↗	0.0 ↘	0.0	9.0 ↗	1.0 ↘	3.0 ↗	0.0 ↘
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0 ↘	0.0	1.0 ↗	4.0 ↗	6.0 ↗	1.0 ↘	4.0 ↗	1.0 ↘	3.0 ↗	1.0 ↘	2.0 ↗	0.0 ↘
(c) Missed medication during an admission to hospital	1.0 ↗	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	2.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	0.0	4.0 ↗	1.0 ↘	0.0 ↘	0.0	0.0	0.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	0.0	6.0 ↗	5.0 ↘	7.0 ↗	10.0 ↗	9.0 ↘	3.0 ↘	4.0 ↗	11.0 ↗	1.0 ↘	2.0 ↗	3.0 ↗
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	1.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	1.0 ↗	0.0 ↘	1.0 ↗
(j) Community staff have been called in to work on the unit.	0.0 ↘	5.0 ↗	6.0 ↗	7.0 ↗	10.0 ↗	6.0 ↘	2.0 ↘	8.0 ↗	19.0 ↗	19.0	16.0 ↘	14.0 ↘
In Receipt of %			15.0	3.0 ↘	6.0 ↗	4.0 ↘	12.0 ↗	12.0	6.0 ↘	8.0 ↗	7.0 ↘	5.0 ↘
CoC In Receipt of %		17.0	31.0 ↗	24.0 ↘	39.1 ↗	27.3 ↘	63.0 ↗	65.0 ↗	64.0 ↘	38.0 ↘	38.0	47.0 ↗
Continuity Team Caseload			167.0	165.0 ↘	163.0 ↘	157.0 ↘	152.0 ↘	161.0 ↗	161.0	155.0 ↘	151.0 ↘	171.0 ↗
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	94.4 ↘	95.4 ↗	92.6 ↘	89.9 ↘	90.0 ↗	88.3 ↘	85.6 ↘	88.2 ↗	85.1 ↘	87.4 ↗	88.8 ↗	88.1 ↘
Labour Co-ordinator Supernumerary Status %	98.3 ↘	98.4 ↗		100.0	96.8 ↘	96.7 ↘	96.8 ↗	100.0 ↗	100.0	100.0	100.0	100.0
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies			6.1	9.6 ↗	11.3 ↗	14.0 ↗	16.9 ↗	13.6 ↘	18.3 ↗	19.3 ↗	18.3 ↘	20.5 ↗
Vacancies - Registered			5.9	9.4 ↗	11.0 ↗	12.9 ↗	15.8 ↗	12.0 ↘	15.7 ↗	16.7 ↗	15.7 ↘	17.3 ↗
Vacancies - Unregistered			0.2	0.2	0.3 ↗	1.1 ↗	1.1	1.6 ↗	2.6 ↗	2.6	2.6 ↘	3.2 ↗

Trustwide Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Midwife to Birth Ratio	23.0	23.0	24.2	24.9	24.7	24.7	25.0	24.1	24.8	24.4	24.5	24.0
Red Flags	15.0	25.0	19.0	37.0	44.0	50.0	28.0	19.0	60.0	33.0	38.0	28.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	10.0	12.0	1.0	7.0	4.0	14.0	8.0	2.0	13.0	2.0	7.0	3.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0	0.0	1.0	5.0	9.0	6.0	5.0	2.0	4.0	1.0	2.0	2.0
(c) Missed medication during an admission to hospital	1.0	0.0	0.0	1.0	1.0	1.0	1.0	0.0	0.0	0.0	1.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	1.0	0.0	2.0	0.0	1.0	1.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	1.0	5.0	1.0	0.0	1.0	1.0	1.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	2.0	6.0	6.0	11.0	13.0	14.0	7.0	4.0	14.0	3.0	6.0	5.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	1.0	0.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	3.0	0.0	1.0
(j) Community staff have been called in to work on the unit.	1.0	7.0	10.0	11.0	11.0	14.0	4.0	9.0	27.0	21.0	22.0	17.0
Continuity of Carer %	36.0	36.6	35.8	25.0	22.5	16.0	21.0	19.0	21.0	16.0	20.0	20.0
In Receipt of %	16.0	13.0	13.0	8.0	10.0	9.0	14.0	11.0	8.0	9.0	16.0	7.0
CoC In Receipt of %		42.9	44.8	64.6	50.0	44.4	60.0	63.0	56.0	47.0	67.0	39.0
Continuity Team Caseload			517.0		537.0	504.0	500.0	508.0	487.0	497.0	485.0	490.0
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	95.5	93.7	92.2	89.6	90.8	88.7	88.5	90.8	88.0	90.5	90.3	92.1
Labour Co-ordinator Supernumerary Status %	99.2	98.4	96.7	100.0	98.4	98.3	98.4	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies			17.8	21.1	21.5	28.1	30.3	25.7	29.7	32.0	30.7	32.2
Vacancies - Registered			15.8	20.3	20.5	26.4	28.1	22.4	25.1	27.6	27.2	28.2
Vacancies - Unregistered			2.0	0.8	0.9	1.7	2.2	3.4	4.7	4.5	3.5	4.1
Sickness Absence (Division) %	5.1	4.2	5.4	5.9	4.8	6.4	6.0	5.8	7.2	8.4		
New Complaints (Division)	3.0	7.0	6.0	7.0	7.0	4.0	6.0	9.0	3.0	4.0	5.0	2.0
New PALS (Division)	16.0	8.0	21.0	17.0	20.0	26.0	21.0	28.0	16.0	33.0	32.0	30.0

The maternity dashboard for March 2022 shows a reducing midwife:birth ratio of 1:24, it is expected to be less than 1:28 and so is reassuring that across both sites this is within an expected range. With respect to the NICE maternity red flags, there has been 28 for the month of March which is 10 less than the previous months. This is shown across both sites and relates to slightly improved actual v planned staffing of 92.1% which therefore has enabled less delays in case especially induction of labour and the requirement to call in community midwives to support the acuity on the units. In February 2022, there were 22 occasions when community midwives were called into the unit to work which reduced to 17 in March 2022. It is anticipated this will fall further month on month with vacancies being filled.

With respect to Continuity of Carer, we currently continue with 3 teams. The recent publication of the Ockenden report and the subsequent request that a review be undertaken to ensure that reduced midwifery staffing levels are not being compounded by continuity of carer teams the current teams may reduce. Currently however, there is an excellent provision of care by the continuity teams for the local ethnic minority groups and those living in decile 1 areas. The teams have managed to provide a total 'in receipt of' care which includes at least 70% antenatal care, intrapartum as well as 70% postnatal care for 7% of women.

Neither unit had to divert or close in the month however there is a close working relationship between each unit to support the workload as necessary. The supernumary status of the labour co-ordinator remains at 100% as well as 1:1 care in labour. Vacancies have shown a slight increase to 32.2 wte for registered and unregistered staff. Both registered and unregistered staff have increased in the month with continued efforts to recruit to the vacant posts. There has been positive international recruitment of midwives to join the service as well as a national campaign for midwives. Recruitment has also occurred with the soon to qualify student midwives which will fill some of the vacant posts although not until the autumn time. We are awaiting the appointment of a Pastoral Support Midwife which anecdotally from other trusts has supported those midwives that are struggling with the role by providing additional support and help.

There is no up to date data with respect to the sickness absence however it is monitored as per trust policy. Absence related to covid is reducing during May however it was an issue in March and April. Finally complaints and PALS saw a slight decrease and continues to be closely monitored by the Associate Chief Nurse.

5.0 Training and development

5.1 Student Placement Hours

Work has been undertaken to ensure student placement hours are accurately recorded to support returns and receipt of the correct income.

Work has commenced to determine where Non-Medical Staff Education and Training tariff income is currently allocated/ spend withing the Trust and where the costs/ spend should sit for training nursing, midwifery and AHP students.

Developments include rotational hub and spoke placements in Medicine, increased use of spoke placements such as Clinical Nurse Specialists, with an electronic booking system that students can access and use. Additionally, a first coaching placement model pilot (Ward 22 at SGH) has been completed and evaluation will follow.

5.2 Apprenticeships

Unlike all neighbouring NHS providers, the Trust does not yet offer undergraduate nursing degree apprenticeships. A business case for nursing apprenticeships has been submitted and will support retention work and dependence on expensive temporary staffing. It is anticipated that nursing apprenticeship programmes can be offered from the autumn.

The levy is being used to fund trainee Advanced Clinical Practitioner training. Two surgical trainees commenced on this route in January 2022.

5.3 Learning Needs Analysis (LNA)

The Nursing, Midwifery and AHP Learning Needs Analysis was submitted to HEE in time for the closing date with the support of the Trust training team. HEE will now assess all returns from Trusts across the region to determine what will be funded.

Final confirmation is awaited regarding what further CPD funding will be received this year; however, it is anticipated that year 3 of the government plan to support professional development of nurses and AHPs will be funded. The LNA submission will be used to inform CPD spending plans.

6.0 Quality

6.1 Reported Falls Incidents

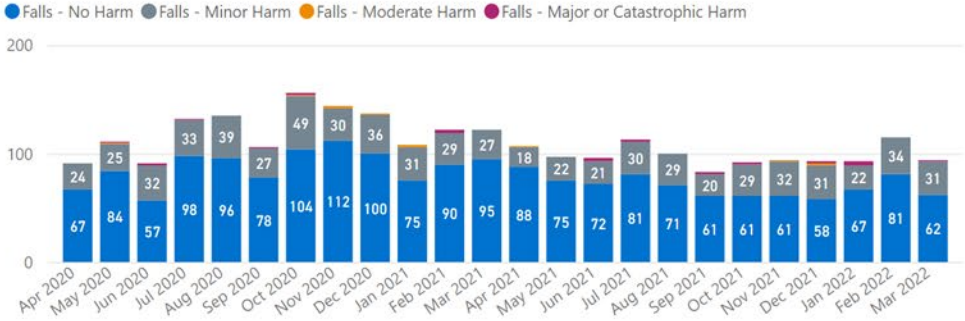
The information presented shows data for inpatient wards only and is the standard throughout the report.

Falls Incidents Summary Mar 2022

Falls - Total	No Harm	Minor Harm	Moderate Harm	Major or Catestrophic
94 ▼ -21	62 ▼ -19	31 ▼ -3	0	1 ▲ 1

Falls - Total

Falls by Category



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPOW	39	-16	55	
Mar 2022	GDH	6	-2	8	
Mar 2022	SGH	49	-3	52	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Community & Therapies	3	3		
Mar 2022	Family Services	0	-1	1	
Mar 2022	Medicine	73	-25	98	
Mar 2022	Surgery	18	2	16	

The total number of falls reported in March 2022 has decreased.

The largest decrease was reported at the Grimsby site.

One in-patient fall was reported with major harm at Scunthorpe on the Integrated Acute Assessment Unit (IAAU). The patient sustained a fracture to the neck of femur. No lapses in care were identified at the huddle and the incident has been successfully de-logged.

6.2 Falls per 1,000 Bed Days

The falls per 1000 bed days across the Trust has increased in March 2022. Caution should be used when interpreting the data as escalation beds are not included within the 1000 bed days calculation.

Falls per 1,000 Bed Days Summary Mar 2022

Falls per 1,000 bed days

4.9 ▼ -1.7

Falls per 1,000 Bed Days

Falls per 1,000 Bed Days by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPOW	4.0	-2.2	6.2	
Mar 2022	GDH	4.9	-3.2	8.1	
Mar 2022	SGH	5.9	-0.9	6.8	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Community & Therapies	7.1	7.1		
Mar 2022	Family Services	0.0	-0.5	0.5	
Mar 2022	Medicine	6.0	-2.9	9.0	
Mar 2022	Surgery	4.2	0.1	4.1	

6.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents **Mar 2022**

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - Amethyst	4	▲ 3	4	▲ 2	0	0	0	0	8	▲ 5
SGH - Ward 23 Short Stay	6	▼ -1	2	▲ 2	0	0	0	0	8	▲ 1
SGH - Ward 24 Assessment Unit	7	▲ 4	0	▼ -2	0	0	1	▲ 1	8	▲ 3
SGH - Ward 22	4	▼ -1	3	▲ 2	0	0	0	0	7	▲ 1
DPOW - A1	4	▼ -1	2	▲ 2	0	0	0	0	6	▲ 1
DPOW - B6	5	▲ 4	1	0	0	0	0	0	6	▲ 4
SGH - Ward 16	5	0	1	▼ -2	0	0	0	0	6	▼ -2

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
DPOW - HDU	12.6	▲ 5.7
SGH - Ward 18	11.7	▼ -1.3
DPOW - A1	11.4	▲ 0.7
DPOW - Amethyst	11.3	▲ 6.8
SGH - Ward 23 Short Stay	10.1	▼ -0.1

None of the areas detailed above are demonstrating any concerning trends in the number of reported falls.

The areas detailed above will be reviewed alongside other metrics at the Nursing Metrics Panel.

7.0 Pressure Ulcers

7.1 Hospital Acquired Pressure Ulcer Incidents

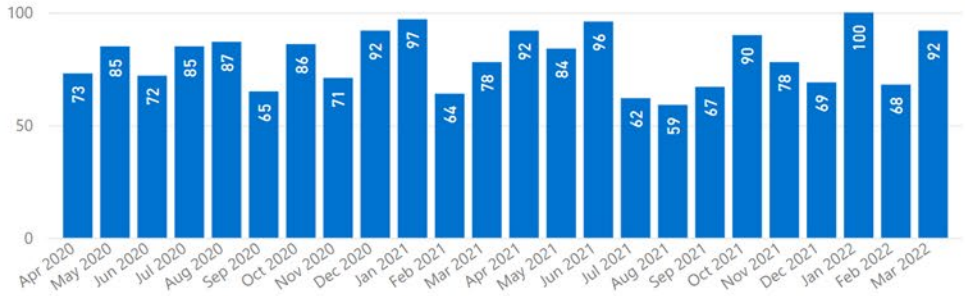
The data includes hospital acquired category 2,3,4 and unstageable pressure ulcers and is the standard throughout the report.

Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

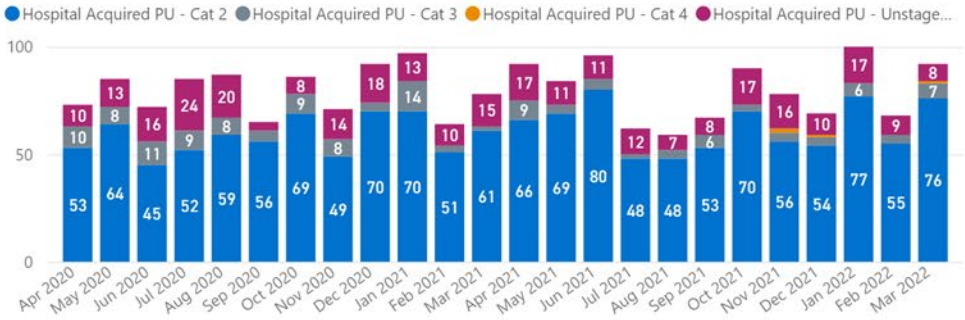
Hospital Acquired PU Incidents Summary Mar 2022

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
92 ▲ 24	76 ▲ 21	7 ▲ 3	1 ▲ 1	8 ▼ -1

Hospital Acquired PU - Total



Hospital Acquired PU by Category



Hospital Acquired PU - Total by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPOW	57	▲ 9	48	
Mar 2022	GDH	2	▲ 1	1	
Mar 2022	SGH	33	▲ 14	19	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Community & Therapies	0	◆ 0		
Mar 2022	Family Services	1	▲ 1		
Mar 2022	Medicine	67	▲ 21	46	
Mar 2022	Surgery	24	▲ 2	22	

There has been an increase in the number of pressure ulcer incidents reported in March 2022. The highest increase was in the number of category 2 pressure ulcers reported.

Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers. There has been a significant increase in the number of pressure ulcers reported at the Scunthorpe site.

The key root causes for pressure ulcers are currently under review. The Trust wide improvement plan will be reviewed and updated following this review.

7.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

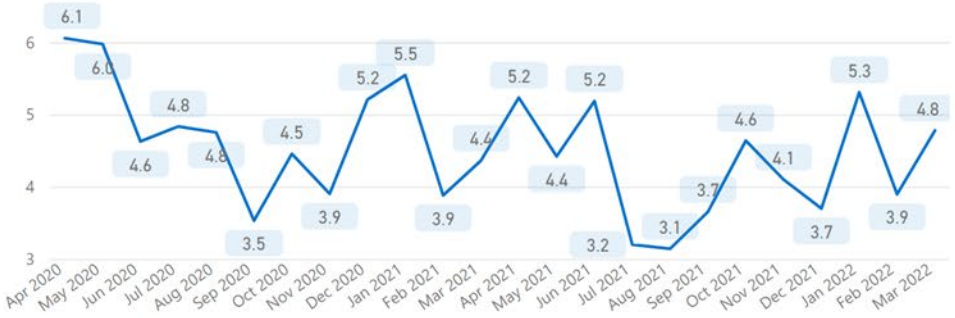
The incidence of reported pressure ulcers per 1000 occupied bed days has increased in March 2022 and remains higher at the Grimsby site. Caution should be used when interpreting the per 1000 bed days data as escalation beds are not included.

Hospital Acquired PU per 1,000 Bed Days Summary — Mar 2022

PU per 1,000 bed days

4.8 ▲ 0.9

PU per 1,000 Bed Days



PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Mar 2022	DPOW	5.9	▲ 0.4	5.4	
Mar 2022	GDH	1.6	▲ 0.6	1.0	
Mar 2022	SGH	4.0	▲ 1.5	2.5	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Mar 2022	Community & Therapies	0.0	◆ 0.0		
Mar 2022	Family Services	0.4	▲ 0.4		
Mar 2022	Medicine	5.5	▲ 1.3	4.2	
Mar 2022	Surgery	5.6	▼ 0.0	5.6	

7.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents Mar 2022

Indicator	Hospital Acquired PU - Cat 2		Hospital Acquired PU - Cat 3		Hospital Acquired PU - Cat 4		Hospital Acquired PU - Unstageable		Hospital Acquired PU - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - C2	5	▼ -3	3	▲ 3	0	0	2	▲ 1	10	▲ 1
DPOW - B3	8	▲ 3	0	▼ -1	0	0	0	0	8	▲ 2
SGH - CDU	8	▲ 7	0	0	0	0	0	0	8	▲ 7
DPOW - C1 Glover	6	▲ 3	1	▲ 1	0	0	0	▼ -1	7	▲ 3
SGH - Ward 23 Short Stay	6	▲ 6	0	0	0	0	0	▼ -1	6	▲ 5

Highest Reporting Wards - PU per 1,000 Bed Days

Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
DPOW - ITU	26.5	▲ 5.5
DPOW - C2	12.4	▲ 0.0
SGH - CDU	12.4	▲ 10.6
DPOW - B3	10.5	▲ 1.5
DPOW - C1 Glover	9.9	▲ 4.2

Ward B3 has triggered as a higher reporting ward for the fourth consecutive month. It should be noted that there ward has reported no category 3, 4 or unstageable pressure ulcers in March 2022.

Ward C2 has triggered for the third consecutive month with an increase in the number of reported category 3 and unstageable pressure ulcers in March 2022.

There are no concerning trends for any of the other higher reporting wards. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

7.4 Community (Acquired on Caseload) Pressure Ulcer Incidents

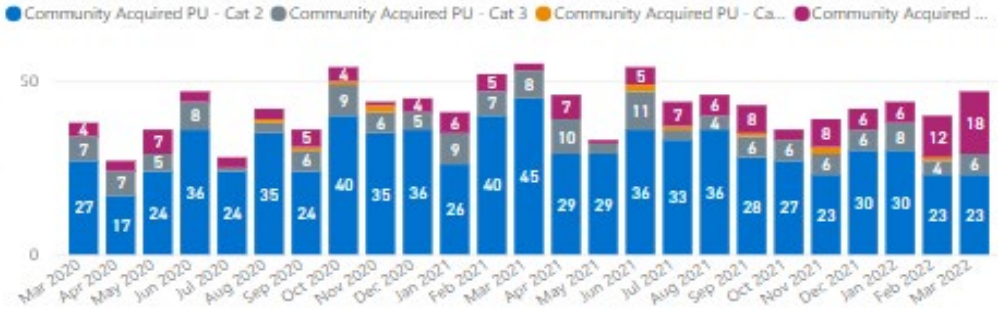
The information presented shows data on pressure ulcers acquired on community caseload. Please note this does not include category 1, suspected deep tissue injuries or moisture lesions. Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

Community (Acquired on Caseload) PU Incidents Summary — Mar 2022

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
47 ▲ 7	23	6 ▲ 2	0 ▼ -1	18 ▲ 6

PU Acquired on Caseload - Total

PU Acquired on Caseload by Category



PU Acquired on Caseload by Team — Mar 2022

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
West Network	8	1	0	5	**14**
South Network	8	3	0	2	**13**
East Network	3	1	0	8	**12**
Intermediate Care Services (ICS) + Core Therapy	3	1	0	2	**6**
Tissue Viability Team	0	0	0	1	**1**
Chronic Wound Team	1	0	0	0	**1**
Total	**23**	**6**	**0**	**18**	**47**

The incidence of pressure ulcers is not significantly reducing despite a community wide action plan; and there has been a slight increase in the number of pressure ulcers overall in month with all networks reporting similar numbers.

Nurse staffing levels due to vacancies and sickness continue to be a significant challenge in the community, particularly in the nursing networks which has not improved during March 2022, this impacts on the patient caseloads and the frequency of patient reassessments and visits.

Improving nurse staffing levels remains a key focus for Community and Therapies, including the recruitment of an additional 12 Registered Nurses; these are being advertised as part of a targeted recruitment campaign for Community Nursing. 2.0wte Registered Nurses have commenced in post during April with a significant number of the posts being allocated to the Newly Qualified Nurses due to start in September 2022.

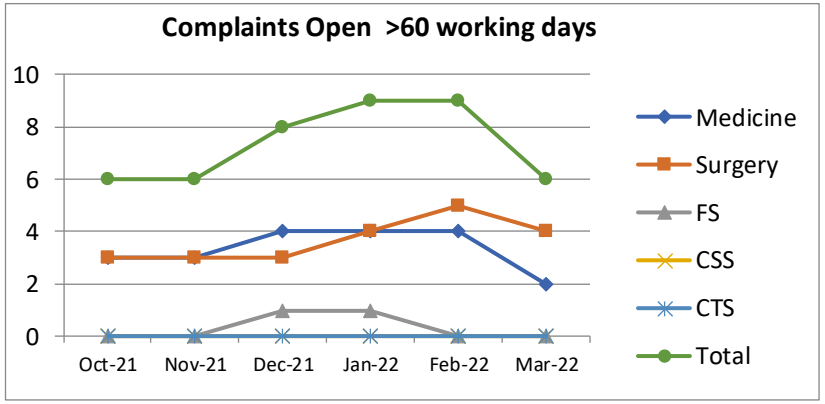
All the networks have implemented Malinko, the new electronic allocation system; whilst this system is freeing up time in terms of the allocation of workload. It has demonstrated that we do not have enough staff to meet the demand which is why the unplanned visit workload is high. However, ongoing quality improvements within the networks has seen a significant decrease in the number of unallocated visits at the beginning of the day which is related to a change to working in postcode locations within Malinko.

Most reported pressure ulcers are category 2 which is a consistent theme each month. This is suggestive that preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. The number of category 3 pressure ulcers has increased by 2 to 6, but significantly we have seen an increase this month in the number unstageable pressure ulcers from 12 reported in February to 18 reported in March 2022. These have all been validated by the Tissue Viability Nurse for Community and there are no apparent themes. There has been some recent training and education on pressure ulcers for Community Nursing staff, with a particular focus on categorization which may have contributed to this.

Themes from the review of pressure ulcers at the Pressure Ulcer Scrutiny Panel are being fed back to the community nursing network teams so actions can be taken.

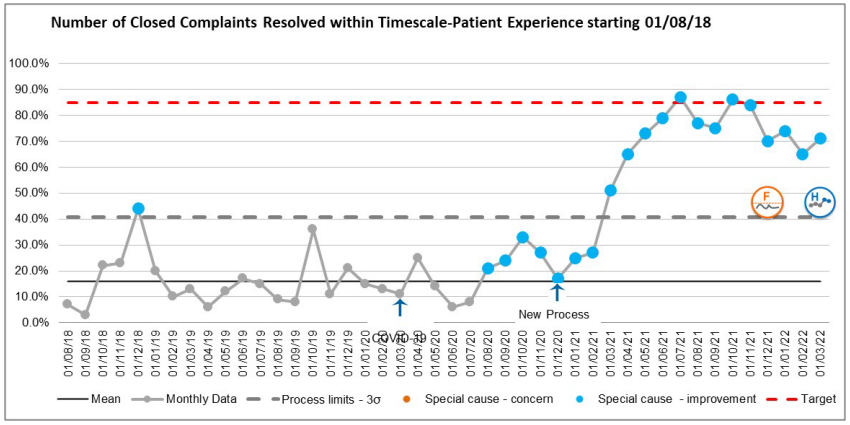
8.0 Patient Experience

New formal complaint numbers have increased slightly during March to 34, with continued complexity seen in the issues raised. In March there were 88 ongoing open complaints, 6 of those were outside of the Trust timeframe at the time of reporting, this can be seen in graph A.



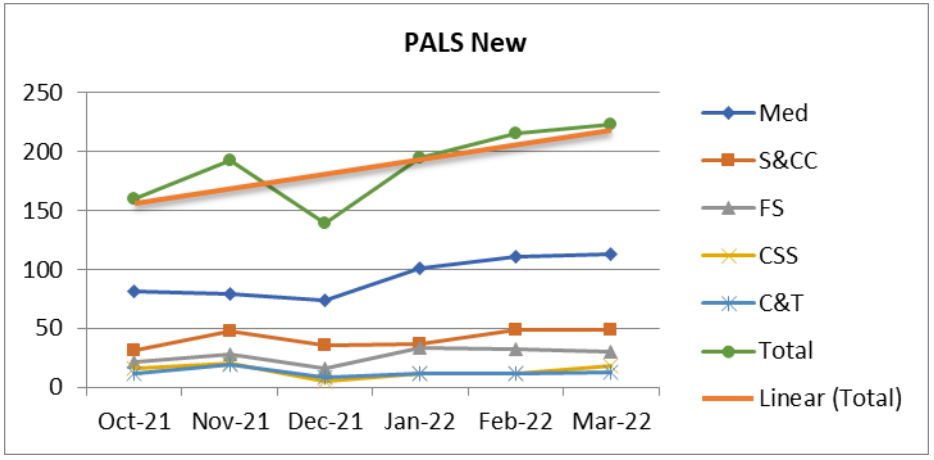
Graph A

These complaints are reviewed weekly through the central team Support and Challenge Meetings to ensure all actions are taken, centrally and divisionally, to resolve any delays .The impact of staff absence was noted on progression of complaint investigations during March and continues into April, nationally some Trusts have had to increase their timescales and manage complainant expectations , in light of this. The Trust continues to work with its 60 working day timeframe. In March 41 complaints were closed,12 of the closed complaints were over the 60 working day timescale, 2 over 100 days, 8 between 70 and 100 days and only 2 within the 60-70 range. All delays are investigated and narrative shared with divisions. An overall total of 71 % closed complaints were managed with Trust timescale, this can be seen in graph B.



Graph B

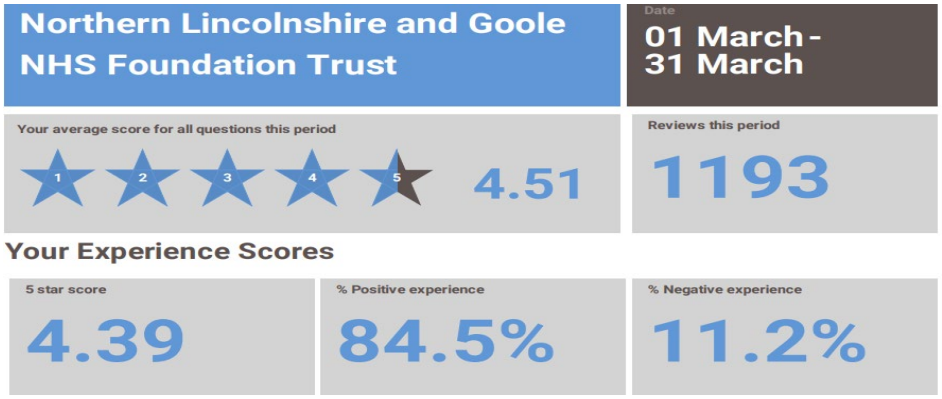
Trust wide the total number of new PALs in March rose again to 223, an upward trend is now clearly visible, and highlighted in graph C. There is impact from restrictions to visiting, especially around communication in the number of concerns, and as the Trust reviews and reopens visiting these concern numbers will be monitored.



Graph C

192 PALs were closed in March, with 48% in timescale. Whilst the compliance towards the KPI reduced this was impacted by the staffing availability due to the Covid resurgence.
Themes remained unchanged in both complaints and PALs, with communication being threaded throughout, as an overall theme.

The current summary of March FFT data submitted can be seen below:



The increase in response is related to the new survey design for ECC which has increased their response rates. Site walk rounds provided insight into visibility of FFT across the Trust and the further work that needs to be done with staff engagement. The Patient Experience Manager will be focussing on staff engagement as a priority. Procurement processes continue, and staff feedback will help form part of this.

The local INSIGHT Survey programme was unable to be completed during March due patient experience team staff absences and the Patient Contact Helpline having to be prioritised, this is being reviewed due to ongoing team availability to support.

The Volunteer Support Officer posts are now impacting on providing wellbeing and training support to our volunteer workforce. Links with Hull University Teaching Hospitals are being developed to share good practice and expand opportunities to enhance volunteering services further, including understanding additional funding routes to grow the existing team.

Visiting restrictions unfortunately had to be re-instated due to increased Covid cases and emerging Norovirus cases across the Trust. The Patient Experience team, Voluntary Services team and PALs teams all worked collaboratively to ensure families remained connected through the Patient Contact Helpline or through ward communication visits. This was further supported by the remaining Family Liaison Assistants; these roles have been extended until the end of June and the staff are being supported to explore permanent or bank opportunities within the Trust.

9.0 Mixed Sex Breaches

From 1 December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced. NHS organisations were required to submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation.

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient.

9.1 Covid-19 Recovery

All Trusts were asked to resume data submission on the number of unjustified mixing from October 2021 following a period of suspension due to Covid-19 and the need to release capacity across the NHS.

In February the Trust declared 14 mix sex breaches at both SGH and DPOW, the details can be seen below:

Site	Speciality	Date	Sex	No. that occurred	Reason
DPOW	HDU	17.03.22	F	3	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	17.03.22	M	3	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	17.03.22	M	3	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	17.03.22	F	2	OPEL 4 on site, nil bed capacity at DPOW to support step down
DPOW	HDU	17.03.22	M	2	OPEL 4 on site, nil bed capacity at DPOW to support step down
SGH	ICU	22.03.22	F	5	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	ICU	22.03.22	M	5	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	ICU	22.03.22	M	5	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	ICU	22.03.22	M	5	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	ICU	22.03.22	M	5	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	HDU	22.03.22	F	2	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	HDU	22.03.22	M	2	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	HOBs	25.03.22	M	2	OPEL 4 on site, nil bed capacity at SGH to support step down
SGH	HOBs	25.03.22	F	2	OPEL 4 on site, nil bed capacity at SGH to support step down

One action plan was commenced which contained all the actions for all 14 breaches - the theme for these was that the Trust had declared OPEL 4 on all occasions.

10.0 Safe and Secure Medications

Wards have been supported by the QI team to help to improve their Safe and Secure Storage of Medicines processes. Wards across DPOW and SGH were re-audited and all showed positive steps towards improvement. The model used was the PDSA Plan, Do, Study, Act.
2 Phases totalling 15 wards have been part of the QI collaborative to date. The annual re audit for all wards is due to take place shortly with a phase 3 QI collaborative commencing focusing on those wards falling below the 85% audit compliance target. Below are the wards involved to date and improvement in audit compliance rates.

Return on Investment from participating wards

- 30 mins staff time saved
- Cost saving across all wards **6K** of stock that could be returned to pharmacy
- No medication related incidents since the project began on some wards

Wards involved and Audit compliance rate

Ward	March 2021	March 2022
19	Closed	92%
22	64%	96%
24	62%	92%
Disney	62%	96%
Stroke	50%	76%
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%

11.0 15 Steps Challenges – March 2022

Date of Visit	Ward/Department	Rating 2022	Previous Rating
01/03/2022	Amethyst Day Case & Oncology Outpatients		N/a
08/03/2022	Day Investigation Unit DPOW		N/a
15/03/2022	Antenatal Outpatients DPOW		N/a
16/03/2022	Outpatients Department GDH		
17/03/2022	**Ward 22 REVISIT**		
22/03/2022	**Ward B3 REVISIT**		
23/03/2022	Medical Physics DPOW		N/a
24/03/2022	**IAAU-B REVISIT**		

Eight visits took place throughout March 2022, 5 outpatient areas and 3 acute ward areas all 3 of which were revisits. 6 Visits were cancelled due to significant pressures within the trust, staffing shortfalls and ward closures, allowing team members to step down and support clinically where needed.

Three Outpatient Areas achieved OUTSTANDING. Outpatients Department at GDH receiving this rating for the 2nd time.
Ward 22 at SGH required intensive support.

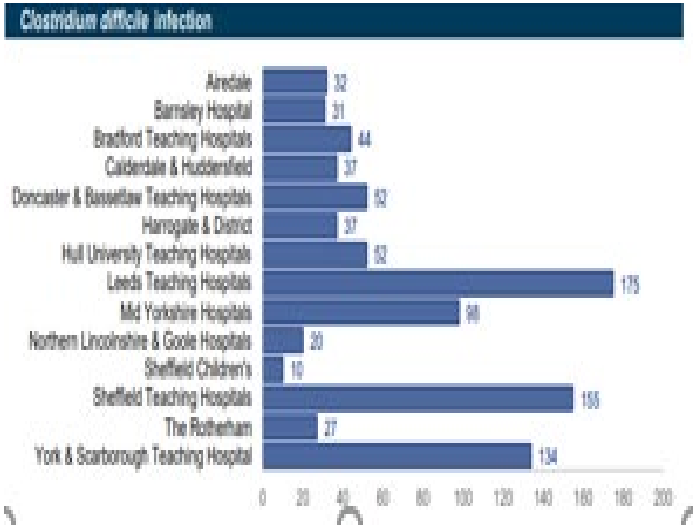
Themes for Areas of Consideration/ Action

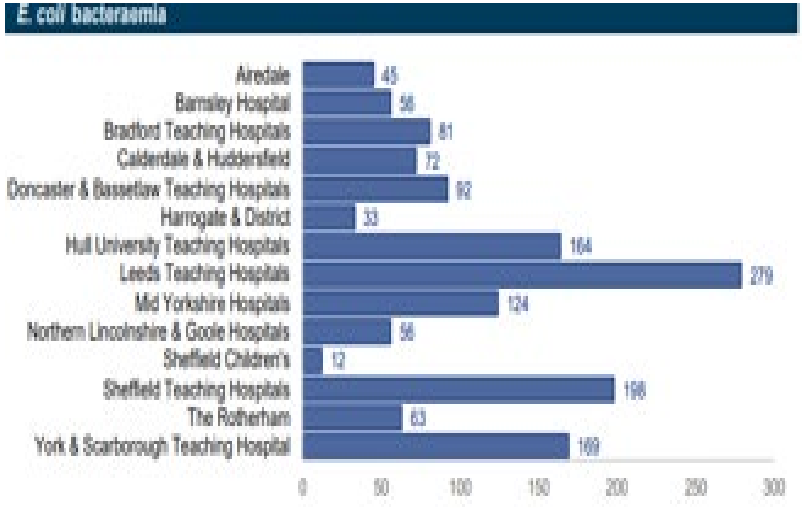
	Themes	Actions
Standard 1: Observations	• **Poor observation of Hand Hygiene between patients/procedures alongside poor use of PPE**	• Highlighted to staff the importance of peer challenging, questioning colleagues' practice where appropriate. Results of hand Hygiene audits to be monitored • Liaised with ICP for individual areas of concern • Clinicalskills.net offering support to areas of concerns through sharing of 15 Steps themes
	• **Medication stored incorrectly – not secured. Sharps not disposed of correctly.**	• Communicated with all staff re: correct disposal of sharps • Liaised with Medicines Management team to supply Abloy locks and Keys within the department for safe & secure medicines storage
	• **Notes not securely stored and managed**	• Notes trolleys ordered from NHS supply Chain for correct management of notes out on department
Standard 2: Documentation	• **Inconsistent use of Food and Fluid charts, not clear if required**	• Further education required on I.R and where to complete if tool not required, Lead Nurse to work alongside ward/dept to support
	• **Bowel charts not completed**	• Stop & Check safety huddle utilised to highlight areas of concern within documentation following Clinical Sister's documentation audits on the ward – well supported by Matron and Lead Nurse
Standard 3: Patient Feedback	Positive Feedback (minimal themes identified of concern): • Patients spoke highly of staff and were treated with privacy and dignity • Staff were approachable and informative • Patients felt involved in care • Patient knew where they were in their treatment plan/care	• None.
Standard 4: Staff Feedback	Positive Feedback (minimal themes identified of concern): • Lead Nurse gained access to Division/Ward compliance for Clinical Supervision, Mandatory training and PADR for oversight prior to area visits • PADRs complete • MT compliance good • Staff aware of incidents and evidence of learning lessons taking place within the departments and wards	• None

12.0 Infection Prevention and Control

ALERT mandatory organisms

The Trust had a C.difficile objective of no more than 33 cases and ended the year on 20 reported cases which is 40% within the allocated trajectory and 29% reduction to last year. In summary this was the lowest number of cases for a District Hospital in the region and one of the lowest in the UK. In terms of E.coli blood-stream infections we have performed very well compared to our local peers.





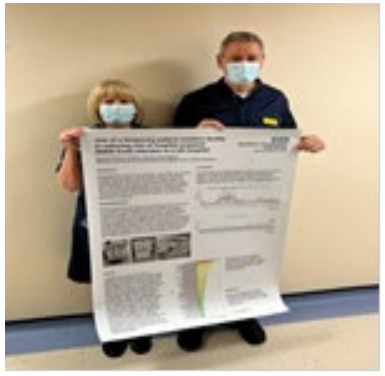
The Trust has not reported any cases of Hospital Onset MRSA bacteraemia cases this financial year. The Gram negative and C.difficile objective for 22/23 will be a significant challenge as the baseline values have been adjusted. As such the deep clean requirements will need further strengthening to continue the progress made over the years.

COVID-19

The number of cases detected is slowly receding and the majority of patients detected with the infection are asymptomatic. The national stance is now to learn to 'Live with COVID' and this has been reinforced with updated national IPC guidance to deescalate control measures to a pre-pandemic state. A paper was presented to TMB with a proposed roadmap on how the Trust would wind down control measures but ensure mitigations and controls remain in place to safeguard patient and staff safety.

OTHER

Linda Barker, on behalf of the IPC team, attended ECCMID international conference held in Portugal to present the work undertaken in the Trust utilising the Redirooms during the pandemic.



The team have recruited an associate nurse due to commence in May to replace a colleague who left in December. The Deputy DIPC will be leaving the Trust in May and the post is currently being advertised.

13.0 Quality Improvement

- The trust's first QI conference took place on the 28th of April 2022. The event had 112 attendees with regional and national presenters from NHS I/E. 95% of feedback received rated the conference as Excellent / Good. Post conference the QI team have experience an increase in engagement form areas wishes to progress improvements in their areas.
- The trust's 3rd QI collaborative has commenced with a focus on Pain Assessment / Re-assessment. The "expert panel" has been formed and are currently working through the process to understand the key problems using QI tools. The panel have also scoped the first 5 wards of focus these are C2, C3, B2, B3 and B7 of which all have been agreed with Divisional HoN.
- The QI academy continue to support QI education using the QSIR programme. 10 candidates are currently developing their QI projects to address problems from within these areas.
- Development continues to bring new QI frameworks into the organisation, such as the QI Collaboratives. These internationally evidence base QI frameworks have key uses such as a focus on process / pathway improvement.

14.0 Conclusion

During the pandemic, our wards and bed bases have undergone extensive changes and moves, this has involved ward changes of specialty as well as demographic and bed base. Establishments have been reviewed consistently during this time and staffing reviews take place at intervals throughout the day.

It is still not possible to obtain accurate escalation bed data against established beds from WebV or the Sitrep reports. Approximately 67 escalation beds have been open since before Easter to cope with non-elective operational pressures. In addition to these, at times of increased operational pressures, beds are utilised on the Discharge Lounge DPoW and SDEC SGH. This has an impact on staffing across all areas as there is no establishment overnight on the Discharge Lounge or SDEC.

The Chief Nurse safe nurse staffing establishment review was presented to the Trust Board in December 2021. The Board agreed to continue to fund the very high/ immediate risk recommendations with the use of temporary staffing. The ability to fill these shifts has been a concern due to the availability of bank and agency staff and continues to be monitored. The Board gave support for the recommendations and priority areas have been funded for 2022/23 therefore recruitment can commence.

CHPPD was 8.3 in March. The latest model hospital data for February 2022 indicates a national median of 8.1 and recommended peer median of 8.4. It remains difficult to benchmark using this data due to changes in ward demographic and acuity over the past 24 months.

The combined fill rate has decreased to 91.7% in March, below the 95% target. Fill rate within Family Services is the lowest at 88.8% and is a concern due to the number of midwife vacancies and sickness within the teams. Operational staffing meetings are held three times per day with review of issues and escalation of any risks that can't be mitigated. The Maternity Services Escalation Policy is in place and there is daily oversight from the senior midwifery team. The Birthrate Plus establishment review report is expected in May with the Chief Nurse planning desk top reviews with the teams at the end of May.

Vacancies in community nursing teams remain a concern. Risks are mitigated by using bank staff and staff working additional hours. An increase in the complexity of referrals is being seen and there continues to be ongoing concerns with moving and cancelling visits within community nursing due to capacity. However ongoing quality improvement work within the networks has seen a significant decrease in the number of unallocated visits at the beginning of the day.

One in-patient fall was reported with major harm at Scunthorpe on the Integrated Acute Assessment Unit (IAAU). The patient sustained a fracture to the neck of femur. No lapses in care were identified at the huddle and the incident has been successfully de-logged.

Complaints are reviewed weekly through the central team Support and Challenge Meetings to ensure all actions are taken, centrally and divisionally, to resolve any delays. The Trust continues to work with its 60 working day timeframe. In March 41 complaints were closed,12 of the closed complaints were over the 60 working day timescale and this was due to the complexity of the complaints. All delays are investigated and narrative shared with divisions. An overall total of 71 % closed complaints were managed with Trust timescale.

192 PALs were closed in March, with 48% in timescale. Themes remained unchanged in both complaints and PALs, with communication being threaded throughout, as an overall theme.

From March 2020 all Trusts received a letter from NHSE/I stipulating that MSA breaches do not need to be returned to NHS Digital from 1 April 2020. Following this period of suspension all Trusts were asked to resume data submission on the number of unjustified mixing from October 2021. In March the Trust declared 14 mix sex breaches and an action plan has been completed.

8 15 steps visits were carried out- 5 outpatient areas and 3 acute ward areas all 3 of which were revisits. 6 Visits were cancelled due to significant pressures within the trust, staffing shortfalls and ward closures, allowing team members to step down and support clinically where needed.

The Gram negative and C.difficile objective for 22/23 will be a significant challenge as the baseline values have been adjusted. As such the deep clean requirements will need further strengthening to continue the progress made over the years.

The national stance is now to learn to ‘Live with COVID’ and this has been reinforced with updated national IPC guidance to deescalate control measures to a pre-pandemic state. A proposed paper was presented to TMB with a roadmap on how the Trust would wind down control measures but ensure mitigations and controls remain in place to safeguard patient and staff safety.

Appendix 1: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	Details	Controls	Assurance (positive and Negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review	RAG Rating
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*	
1. **Staffing Escalation / Surge and Super Surge Plans**								
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance	Winter Planning Meetings and Plan /Surge Plan/ SOP for Staffing Escalation/Staffing plans for critical care areas through surge, which includes training plans	Each Division has a surge plan that sets out how staff and services will be managed in a surge/ Safecare Live used to review and apply clinical judgement if staffing below establishments and to support deployment of staff/ A review of establishment is completed with every ward move, change of demographic, bed numbers and purpose with the Matrons, Associate Chief Nurses and Deputy Chief Nurse with ultimate sign off by the Chief Nurse/ This is fed into the strategic incident command meetings and daily operational meetings. The Nursing Dashboard is reviewed at the Nursing Metrics Panel which has continued throughout the pandemic to ensure safe fundamentals of care/ Daily incidents and Red flags identified on Safecare Live/ training plans in place for deployment to ICU and respiratory areas	N/A	None	None	Staffing level reviews will continue to take place through surge and de escalation processes. 3 times a day daily operational meetings/Safe Staffing meeting daily/use of safe staffing escalation process/red flag and incident reporting. Monthly Assurance Report to QSC.	G
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	As above, included in Winter Planning, surge and Esculation plans. Short Term Staffing SOP updated.	Plans developed in conjunction with divisional teams and signed off by Chief Nurse. These are reviewed following every ward reconfiguration, alongside information from the nursing dashboard/red flags and IPC needs.	N/A	None	None	As above	G
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Information about staffing has been shared through many public meetings and assurances provided on mechanisms/ processes to regulators. They are also available on the Staff hub making them easily accessible.	Information about staffing has been shared through many public meetings and assurances provided on mechanisms/processes to regulators. They are also available on the Staff hub making them easily accessible. Representatives have access to this information	N/A	None	None	As above	G

1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	Quality impact assessments	Quality impact assessment are completed by Chief Nurse and Medical Director for services changes or schemes. This need improving for changes to ward functions and roles. This need embedding into operational policy and surge plans. Evidence of completion by corporate CNO team.	To be added to risk register	Embed within existing structures for completion out of hours and include in Winter/Surge Plans. Review of QIAs to be undertaken within divisions and updated accordingly. Add to risk register	None	Through daily operations meetings	A

2.0 Operational delivery								
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	Daily ops meeting/ daily nurse staffing meeting / Safecare Live review/ Nursing Metrics/ Red Flags and review of daily incidents.	Staffing discussed at the 3 daily operational meetings and safe staffing daily meeting. Proforma used to communicate and escalate rsik that can't be mitigated. No risk assessment or quality impact completed for immediate shortfalls. Safecare live used to escalate staffing shortfalls, to raise red flags and to mitigate based on clinical judgement and acuity. Safety Stop at 2pm each day The daily Safe Staffing Meeting is lead by a Divisional Associate Chief Nurse of Deputy Chief Nurse for oversight and to provide leadership. Overview is then sent to the CNO or verbal escalation if required. Have OPEL type escalation process for staffing in place.	N/A	Review requirement for documented risk assessment/ QIA of immediate risks.	None	SafeCare Live, Red flags, review of daily incidents being reported. We also have 'Stop and Check' which is a safety stop at 2pm eachday, which includes oversight of fundamentals of care and staffing.	G
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained	Daily operational meetings 8:30, 13:00, 16:00. Safe Staffing meetingdaily at 10.00	Daily and weekly forecast position is riskassessed and mitigated where possible via silver / gold discussions. Staffing plans shared with silver and gold on call. Escalation to CN or Gold if additional mitigation required.		Review Matrons staffing plans documentation to ensure this is clear and includes mitigation.	None	Safe Staffing meeting. Impact monitored through Safecare Live.	G
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	Transfer Process/ handover checklist	Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this issuccessful and that safe care is sustained.					
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients	Incident forms.	Concerns raised with line mangers. Staff would complete incident forms. Escalate to matron and site manager depending on time of day.Various ways to raise a concern through escalation process and Professional voice inbox and the Stop and Check process.	N/A	Test staff awareness of and process of red flags	None	Internal review, audit and 15 steps process	G
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	Agency induction checklist	High temporary workforce utilisation can result in staff being redeployed to areas of the Trust where they haven't worked previously, and this requires individual assessment on arrival to an area by NIC. Agency induction checklist available on the HUB for wards/ department to use. Local inductions are provided to agency staff on arrival to the area of work to include a full handover at the beginning of the shift. Induction checklist is completed with individual agency staff members and an orientation to the ward environment is conducted by a substantive staff member.	N/A	Ensure consistent use of agency induction checklist across divisions	None	Audit of agency induction checklist.	A
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	Incident forms Safecare live	Formal routes are available for raising staffing concerns through the incident reporting system. Concerns regarding patients needs can be raised on operational calls. All incidents are reviewed and reported via the workforce report. As per 2.4 and 2.5.	N/A	None	None	As per Staffing review processes, where demographic of ward has changed a staffing review has taken place to review their establishments	G
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on	Workforce report	Incidents and trends are discussed in workforce report . Nursing metrics panel review incidents and triangulate with other quality metrics. As per 2.4,2.5 and 2.6	N/A	Review Safecare live to ensure red flags being actioned/ mitigations documented.	None	Review data in Metrics Panel	G

2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	Vivup Employee Assistance Programme, Remploy Work Based Support HCV Resilience Hub Restorative Clinical Supervision	Comprehensive health and wellbeing offer is in place both at a Trust level and a system level through the HCV Resilience hub. Initiatives implemented to support staff wellbeing continue and staff encouraged to access. Effectiveness of HWB is measured through the staff survey.Trust taking part in the NHDE/I Trailblazer Pilot focusing on 7 areas of staff HWB: Personal H&W, managers & leaders, environment, professional support, relationships, fulfilment at work and data insights. ICU and respiratory wards receiving additional support. Professional Nurse Advocate Programme in place with initial PNAs trained.		Review of recent staff survey and understanding of staff feedback on their HWB and triangulation of findings. Collation of informal feedback	Requirement for additional support to respiratory wards.		A
2.9	The trust has robust mechanisms for	Safecare live and daily OPEL	Safecare live used during daily staffing meeting to support safe deployment of staff.	2421/ 2530	None	None	As above	G
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.	Incident report Safe care	Staffing incidents are reported via Ulysses. Safecare live is also available to raise red flags and add clinical judgments. Both reports are used on the workforce report to monitor staffing incidents and trends. The trust is increasing the number of staff trained as Professional Nurse Advocates in recognition of the burn out, mental health problems and widespread stress experienced by staff. The training provides practitioners with the skills to facilitate restorative supervision to colleagues. Daily Stop and Check safety checks introduced at 2pm.	N/A	Continue to recruit and train PNAs and develop trust strategy to support role. Support debriefing with support from POE and HCV resilience hub. Encourage staff to raise concerns about the impact of the pandemic on their mental and physical health.	None	Monitoring of staffing incidents as above.	A
3.0 Daily Governance via EPRR route (when/if required)								
3.1	Where necessary the trust has convened a multidisciplinary clinical andor workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	This is done through various mechanisms, there is a trust wide HWB Steering group, but this is discussed through daily operations meetings	Health and Wellbeing Steering Group in place. Daily operational meeting with Strategic Meeting in place once per week as per EPRR guidelines					G
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Ops meeting and daily nurse staffing meeting	Staffing is recorded on the SITREP which is shared widely across the trust and with external partners. The Nurse staffing meeting report is sent to senior nurse team.	N/A	None	None	As per previously identified structures	G
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	EPPR meetings Workforce report	Information and pressures shared in local health and care strategic calls - requests for mutual support are through this forum. Additional EPPR meetings are held to review staffing and activity over bank holiday periods. Work closely with HCV Resilience Hub to access H&W resources for staff.					A
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	SafeCare / Roster Perform/E roster/ Short Term Staffing SOP	Safecare live is used by all wards to record patient acuity and reviewing staffing to ensure within agreed safe staffing establishment numbers and to support safe deployment of staff to areas identified as in need. Mitigation documented on Safecare Live. Staffing red flags reviewed daily. There are Safe Staffing & Effective Rostering and Nursing Recruitment & Retention Groups focusing on strengthening workforce information, staffing and workforce issues and the people plan. Includes temporary workforce utilisation.	2421/ 2530	None	None	Daily safe staffing reviews. Triangulation of data in Nursing Metrics Panel.	G

4.0 Board oversight and Assurance (BAU structures)								
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	Nursing Assurance Report monthly	The quality committee, on behalf of the trust board, receive the Nursing Assurance Report. Any concerns about staffing are included as a highlight within the CNO and CMO highlight report to board.	N/A	None	None	Continue to provide report to Q&S Committee	G
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes,patient feedback and clinical harms process.	Nursing Metrics Meeting/ Nursing Dashboard/ 15 Steps/ Ward Assurance Tool Monthly Performance Review Meetings/ Quality Governanace Group monthly	Nursing Dashboard/ Ward reviews as apart of the establishmentprocess.	N/A	None	None	Nursing Metrics Meeting/ Nursing Dashboard/ 15 Steps/ Ward Assurance Tool	G
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reportedfor their impact on the quality of care alongside staff wellbeing and operational challenges.		The IPR does not include specific data in relation to patietns with Covid 19, however the daily sitrep provides this level of detail and data is received by the ICC and reviewed in the Covid 19 Strategic meetings/ The impact of Covid on staffing and quality and safety (nurse sensitive indicators) is triangulated in the Nursing Metrics Meeting and included in the Nurisng Assurance Report monthly for QSC.		Review of IPR and reporting.	None	Daily sitreps/ Nursing Dashboard	A
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.		Nursing Assurance Report	N/A	None	None		G
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care	Will discuss with the committee			Continuous review and triangulation of nurse sensitive indicators.	None		

4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.		*not system wide*					G
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	Committee aware of Nursing workforce, other aspects monitored through and reported to workforce committee BAF and risk register aligned to elements within the BAF						G
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.erisks outside of the desired appetite arenot tolerated without clear discussion and rationale and are challenged if longstanding)		*EM will review with HH*					A
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risksare adequately documented on the Board Assurance Framework		*EM will discuss with HH*					A
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus							G
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing	CQC notification through Executives	There is a clear process of formal notification to the CQC regarding any quality concerns. There are regular engagement meetings with the CQC where concerns are discussed. Any concerns raised directly with the CQC or FTSU guardian are fully investigated.	None	None	None	Quality Report to Board	