Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 6 April 2021, via MS Teams, 10.00 am – 1.00 pm

For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Patients' Story and Reflection** Jo Loughborough, Senior Nurse – Patient Experience	Note	10:00 hrs	Verbal
2.	**Business Items**			
2.1	**Chair's Opening Remarks** Terry Moran, Chair	Note	10:10 hrs	Verbal
2.2	**Apologies for Absence** Terry Moran, Chair	Note		Verbal
2.3	**Declarations of Interest** Terry Moran, Chair	Note		Verbal
2.4	**To approve the minutes of the previous Public meeting held on Tuesday, 2 February 2021** Terry Moran, Chair	Approve		NLG(21)064 Attached
2.5	**Urgent Matters Arising** Terry Moran, Chair	Note		Verbal
2.6	**Trust Board Action Log - Public** Terry Moran, Chair	Note		NLG(21)065 Attached
2.7	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note		NLG(21)083 Attached
2.8	**Integrated Performance Report (IPR)** Helen Harris, Director of Corporate Governance	Note		NLG(21)066 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Executive Report – Medical Director & Chief Nurse** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	10:50 hrs	NLG(21)067 Attached
3.2	**Executive Report – Performance** Shaun Stacey, Chief Operating Officer	Note	11:00 hrs	NLG(21)069 Attached
3.3	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	11:05 hrs	NLG(21)070 Attached
3.4	**Finance & Performance Committee Highlight Report and Board Challenge – February & March 2021 (Performance only)** Neil Gammon, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:10 hrs	NLG(21)071 Attached

4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Executive Report - Workforce** Christine Brereton, Director of People	Note	11:15 hrs	NLG(21)072 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Michael Whitworth, Non-Executive Director & Chair of the Workforce Committee	Note	11:20 hrs	NLG(21)073 Attached
4.3	**Freedom to Speak Up Guardian Update – Quarter 3** Liz Houchin, Freedom to Speak up Guardian	Note	11:30 hrs	NLG(21)075 Attached
4.4	**Gender Pay Gap Report** Christine Brereton, Director of People	Approve	11:35 hrs	NLG(21)076 Attached
4.5	**Modern Slavery Statement** Christine Brereton, Director of People	Approve	11:40 hrs	NLG(21)077 Attached
	BREAK (11:45 hrs)			
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Executive Report – Finance – Month 11** Lee Bond, Chief Financial Officer	Note	11:50 hrs	NLG(21)078 Attached
5.2	**Finance & Performance Committee Highlight Report and Board Challenge – February & March 2021 (Finance only)** Neil Gammon, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:55 hrs	NLG(21)079 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Executive Report - Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	12:00 hrs	NLG(21)080 Attached
6.2	**Clinical Strategy** Ivan McConnell, Director of Strategic Development	Approve	12:05 hrs	NLG(21)081 Attached
6.3	**Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – March 2021** Neil Gammon, Non-Executive Director & Chair of the Health Tree Foundation Trustees' Committee	Note	12:15 hrs	NLG(21)082 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	**Board Assurance Framework – Strategic Objectives Description, Structure, Risks and Risk Appetite** Dr Peter Reading Chief Executive and Helen Harris, Director of Corporate Governance	Approve	12:20 hrs	NLG(21)084 Attached
7.2	**Trust Priorities 2021-22** Dr Peter Reading, Chief Executive	Approve	12:30 hrs	NLG(21)085 Attached
8.	**Approval (Other)**			
8.1	**Trust Management Board (TMB) Terms of Reference** Dr Peter Reading, Chief Executive	Ratify	12:40 hrs	NLG(21)086 Attached
8.2	**Executive Team Terms of Reference** Dr Peter Reading, Chief Executive	Ratify	12:45 hrs	NLG(21)087 Attached

9.	**Items for Information / To Note (please refer to Appendix A)** Terry Moran, Chair	Note		
10.	**Any Other Urgent Business** Terry Moran, Chair	Note	12:50 hrs	Verbal
11.	**Board Performance and Reflection** Terry Moran, Chair	Note		NLG(21)088 Attached
12.	**Governor Questions**	Note	12:55 hrs	Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 4 May, Time TBC **Public & Private Meeting** Tuesday, 1 June 2021, Time 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.

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

APPENDIX A

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

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

9.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
9.1	**Finance & Performance Committee Minutes – October 2020 & January 2021** Neil Gammon, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(21)089 Attached
	Quality & Safety Committee	
9.2	**Nursing Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(21)091 Attached
9.3	**Patient Experience Update – Quarter 3** Ellie Monkhouse, Chief Nurse	NLG(21)092 Attached
	Workforce Committee	
9.4	**Guardian of Safe Working Hours Quarterly Report** Dr Kate Wood, Medical Director	NLG(21)093 Attached
	Health Tree Foundation Trustees' Committee	
9.5	**Health Tree Foundation Trustees' Committee Minutes – November 2020** Neil Gammon, Non-Executive Director & Chair of the Health Tree Foundation Trustees' Committee	NLG(21)094 Attached
	Other	
9.6	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(21)095 Attached

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 2 February 2021 at 9.00 am
Via Video Conference

For the purpose of transacting the business set out below:

Present:

Mr Terry Moran CB	Chair
Dr Peter Reading	Chief Executive
Mr Lee Bond	Chief Financial Officer
Mrs Ellie Monkhouse	Chief Nurse
Mr Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Mrs Linda Jackson	Vice Chair
Mr Neil Gammon	Non-Executive Director
Mr Michael Proctor	Non-Executive Director
Mr Andrew Smith	Non-Executive Director
Mr Michael Whitworth	Non-Executive Director

In Attendance:

Mr Adrian Beddow	Associate Director of Communications
Mrs Christine Brereton	Director of People
Mr David Cuckson	Public Governor
Mrs Elaine Criddle	Deputy Improvement Director
Mr Stuart Hall	Associate Non-Executive Director
Mrs Helen Harris	Trust Secretary
Mrs Jenny Hinchliffe	Deputy Chief Nurse
Mrs Alison Hurley	Membership Manager & Assistant Trust Secretary
Mr Jug Johal	Director of Estates & Facilities
Mrs Jo Loughborough	Lead Nurse – Patient Experience
Mr Ivan McConnell	Director of Strategic Development
Mrs Shauna McMahon	Chief Information Officer
Mr Ian Reekie	Lead Governor
Mrs Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

1. Patients' Story and Reflection

Terry Moran welcomed Jo Loughborough, Lead Nurse – Patient Experience to the meeting. Jo Loughborough shared a video of Jo's Story, Cardiac Rehabilitation. Jo Loughborough highlighted the story showed other quality services the Trust were still running during the COVID-19 pandemic. As there were some technical issues with the video it was agreed this would be shared with the board following the meeting.

Terry Moran thanked Jo Loughborough for sharing the story and sought comments from those in attendance.

Neil Gammon was pleased that kindness and respect had been shown to this patient. No other comments were received.

2. Business Items

2.1 Chair's Opening Remarks

Terry Moran welcomed everyone to the meeting and declared it open at 9.00 am.

Terry Moran thanked everyone for their continued commitment and hard work across the Trust, these were extremely difficult circumstances that staff had worked through in support of patients. Although some of the pressure had eased a little in respect of COVID-19 in-patients there was still an impact on staff. Terry Moran wanted to highlight that the vaccines were being rolled out at pace which was something to be proud of.

A decision had been made to "step up" to normal governance, and would be considered further later in the meeting.

Terry Moran wanted to send best wishes to Captain Sir Tom Moore who had reportedly been admitted to hospital with COVID-19. The efforts had been greatly appreciated in raising so much funds through Captain Sir Tom Moore's charitable efforts for NHS charities.

2.2 Apologies for Absence

No apologies for absence were received for the meeting.

2.3 Declarations of Interest

No declarations of interests were declared.

2.3.1 Updated Register of Directors' Interest – NLG(21)023

Terry Moran referred to the paper and sought comments as to any changes that were required. No comments were received and the paper was noted.

2.3.2 Chairs Annual Declaration – NLG(21)024

Terry Moran referred to the Chairs Annual Declaration and advised an annual review had been undertaken to support the paper. Terry Moran sought comments and questions, none were received.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 5 January 2021 – NLG(21)023

The minutes of the meeting held on the 5 January 2021 were accepted as a true and

accurate record and would be duly signed by the Chair once the following amendments had been made.

- It was noted Shauna McMahon was on the list of attendees but needed to be added to the attendance matrix.
- Dr Kate Wood referred to page 5 and queried whether the Audit, Risk & Governance Committee (AR&GC) had oversight of approving the Ethics Committee Terms of Reference being agreed or if they were to have oversight of the Committee also. It was confirmed the oversight was of the Terms of Reference so the minute reference would be changed. Andrew Smith felt this was slightly more as the AR&GC would also oversee that what was in the Terms of Reference was being applied.
- Neil Gammon referred to page 6 and asked if the reference to the Independent Care Sector could be changed as this referred to the Independent Sector.
- Shaun Stacey referred to page 6, 2.2 in reference to statistics provided. An amendment needed to be made to reference performance for cancer was 70% and the performance for Referral to Treatment (RTT) was 63%. The fourth paragraph should state that it was the wave 3 recovery position that had achieved 90% of its planned activity overall.
- Lee Bond referred to page 9, second paragraph in terms of the sentence referring to a separate amount of funds for Clinical Negligence Scheme Trust (CNST), this should read: separate amount of funds for maternity training.
- Lee Bond referred to page 10, first paragraph as it stated no target date was set for achieving zero vacancies in respect of unregistered nurse vacancies. Jenny Hinchliffe had confirmed this date was the end of March. Ellie Monkhouse confirmed this date was a national date due to the funding through NHS England (NHSE).
- Lee Bond referred to page 12, section 2.4. The minute should read that no adjustment had been made in the Humber area specifically as Yorkshire and North Yorkshire had benefited.

2.5 Urgent Matters Arising

Terry Moran invited Board members to raise any urgent matters that required discussion which were not captured on the agenda.

2.6 Trust Board Action Log – Public by exception NLG(21)026

Terry Moran invited Board members to raise any further updates by exception in relation to the Trust Board Action Log. Shauna McMahon referred to oversight of the Digital Strategy and advised no discussion had taken place as yet with the Executive Team. It was agreed a further update would be provided at the next meeting. Christine Brereton referred to the People item and advised this would be covered within the update provided later in the meeting.

2.7 Chief Executive's Briefing – NLG(21)027

Dr Peter Reading highlighted that there was currently an issue in respect of the length of time between the first and second vaccines being administered. Guidance

from the Joint Committee on Vaccination and Immunisation (JCVI) had confirmed there should be a 12 week gap between the first and second vaccine, however, the British Medical Association (BMA) had not agreed with the guidance which had caused some challenge from Trust medical staff. The Trust would continue as per the JCVI guidance but at the request of the BMA had agreed to raise this concern during the public board meeting. Staff were thanked for the continued effort during the current pandemic. Due to the strains on staff and the impact this had on families, the Executive Team would review the health and well-being offer.

Terry Moran referred to the query raised by the BMA in terms of the length of time between vaccines and agreed with Dr Peter Reading to continue to follow national guidance.

Mike Proctor felt the Trust should continue with the JCVI guidance. Ellie Monkhouse advised that whilst working in the vaccination hub it had been recognised how grateful colleagues from the Health & Social Care Networks had been that they had been offered the vaccine. Terry Moran queried if any board members' wanted to speak against adhering to the JCVI guidance. No comments against were received, the board therefore agreed to follow national guidance issued by JCVI offering the first and second vaccine 12 weeks apart.

Terry Moran referred to the previous agreement made to revert back to normal governance arrangements and sought comments as to whether this should move back to interim arrangements due to current pressures. Ellie Monkhouse advised that although the number of patients with COVID-19 had stabilised, current pressures still remained for certain teams, specifically operational teams. Some teams had also been redeployed to assist with the vaccination programme so were unable to undertake normal roles.

Dr Kate Wood felt going back to the previous interim governance arrangements would not be the right way forward as there were some issues with the appropriate oversight on certain matters. The Quality & Safety Committee (Q&SC) had been held as a shortened meeting and asked if this could be undertaken in respect of other sub-committees to continue appropriate oversight and assurance.

Linda Jackson advised some queries had been raised during the recent Q&SC that should have been considered elsewhere so felt the sub-committees should be reinstated with shortened meetings, agendas and papers. Mike Proctor hoped lessons would be learnt moving forward in terms of the sub-committees being more focussed than they had been previously with greater interaction.

Dr Peter Reading felt there was a need to remember the Trust did have other demands and pressures and there would be a need to ensure the right balance was in place in respect of addressing the urgent waiting lists amongst other priorities. It was the responsibility of the board to guide the organisation to achieve the right balance. Terry Moran felt the importance of oversight and good governance needed to be proportionate and adopt learning from the leaner interim governance arrangements, assurance and governance should be stood up but there would be a need to reflect on what that would be in terms of shortened meetings and papers provided. It was agreed a meeting would take place outside of the board on how this

would look.

2.8 COVID-19 Briefing including NLAG Phase 3 Response (Appendix 1) – NLG(21)028

Shaun Stacey highlighted the significant and ongoing work pressures of staff including those who had not normally worked on the "front door" that had been redeployed from other areas.

Shaun Stacey referred to page 2, final paragraph in respect of an error. The paragraph stated the Trust was "not" taking actions to manage the risks of patients who had cancelled operations, however, this should read are "now". The last sentence of the paragraph, may have been misinterpreted, and was clarified as, the Trust were treating more patients on average than similar sized hospitals in the country. This had meant the Trust had maintained elective care for cancer and elective patients for other similar sized Trusts in the country. This was mainly due to managing the COVID-19 demand and sustained green areas across the site. The Phase 3 was also included as an Appendix within the paper.

Lee Bond referred to page 3 of the report, on the expansion of the diagnostics capacity with an additional eight analysers, and queried how many rapid tests could be carried out within a 24 hour period. Shaun Stacey confirmed each eight analysers could run up to 4 swabs per hour as opposed to 92 every six hours. This allowed decision making as to where patients were placed more quickly which helped the patient flow.

Terry Moran queried what difference the "redirooms" had made. Shaun Stacey advised they had made a fantastic difference, particularly at the Scunthorpe site due to the shortfall of side rooms. The cost had been effective in respect of the "redirooms", it had meant a large number of rooms had not been taken out of operation when there had been outbreaks. One negative was that one "redirooms" took up the same capacity of 1.5 bed spaces. Ellie Monkhouse felt the Trust would not have managed through the winter period without them; and advised although they had helped, they would not be ideal in the longer term due to some patients feeling claustrophobic amongst other issues.

Lee Bond advised the preferred option at the time was a more permanent structure but the Trust had been unable to put this in place due to supplier league times, this had now been revisited and provision had been made to purchase them.

3. Board Assurance

3.1 Board Assurance Framework – Deep Dive Strategic Objective – Handling Emergencies – NLG(21)029

Helen Harris referred the deep dive to be undertaken was in respect of handling emergencies and would be undertaken by Shaun Stacey.

Shaun Stacey advised this referred to strategic risk 3, Adverse Impacts of External Events. The summary detailed how the major incident plan was signed off twice a

year. The Trust continued to monitor the EU exit through the Task and Finish Group. The supply chain routes remained the biggest risk for the Trust but nothing had been experienced at the moment, if anything did arise it would be managed through the original Brexit plan. Some lessons had been identified and were being reviewed following the major incident declared in November. It had highlighted that the oxygen supply had been the issue and not the amount of oxygen the Trust had, this related to the Trust infrastructure so once this had been concluded changes would be implemented. The Trust Board would be updated on any changes required.

Terry Moran sought comments from board members querying whether it was felt there was enough assurance provided to support issues and whether the correct mitigations were in place.

Neil Gammon referred to the exception report on page 4 in relation to diagnostics, under the last heading DMO1 performance. The last bullet point referred to difficulties in providing robust demand and planning data in terms of support. Neil Gammon queried what this related to and what the impact was. Shaun Stacey advised this referred to there not being enough specialist staff within Shauna McMahon and Ivan McConnell's team. Ivan McConnell had worked closely with existing staff so the team now had in place a demand and capacity tool which continued to be refreshed and updated. Neil Gammon thanked Shaun Stacey for the clarification but queried how the Trust would get to the point where it could provide this. Shaun Stacey confirmed that the Trust were in the process of identifying a person with a suitable background in informatics. It was hoped that by quarter one next year this would be in place. Shauna McMahon referred back to the Digital Strategy as this had detailed the data warehouse which would provide some capacity for additional work required. The team were reviewing how this could be improved.

Andrew Smith queried whether the risks presented where residual risks post mitigation. Shaun Stacey advised they were. Ivan McConnell advised there would be a need to consider the wider capacity for planning linked to recovery planning moving forward. There would be a need to not look at this in isolation as there would also be system requirements along with looking at how the Trust collaborates to ensure the right resources were in place.

Terry Moran sought comments from board members in terms of assurance from a deep dive perspective.

Stuart Hall referred to strategic risk 2 in reference to the waiting list outpatients that had not yet being fully risk stratified and queried whether there was a timescale for this being carried out. Shaun Stacey advised this was being worked through at the moment with the support of primary care. This would provide around 3,000 patients being risk stratified per month and this would be in addition to what the Trust were also stratifying. There were around 100,000 patients on the waiting list and this would need to be undertaken in order of priority and in conjunction with the integrated community outpatient programme. Shaun Stacey referred to the query raised by Neil Gammon and reiterated that the Trust did not have the capacity to undertake this work at the moment from a modelling informatics perspective and confirmed this would be available late February.

4. Quality & Safety

4.1 Quality & Safety Committee Highlight Report & Board Challenge including the Patient Impacts Update – NLG(21)031

Mike Proctor highlighted the report shared was also from Ellie Monkhouse, Chief Nurse as this was omitted from the front sheet of the paper. Terry Moran advised the paper had been very helpful in particular the summary that was included. The waiting list position had been particularly encouraging.

Neil Gammon referred to page 15 of the report as it stated the plan was to achieve 90% sepsis screening of patients by the end of March, however, it was noted 50% had not been achieved by December. What would be in place to achieve the 90% by the end of March 2021. Terry Moran queried whether any incidents had been identified due to not screening the required amount of patients. Dr Kate Wood advised sepsis was part of the Trust Priorities for next year. Due to COVID-19 issues this had not been achieved which would mean the 90% target would not be achieved by the end of March due to staff being redeployed, however, a plan was being developed to move this forward. Mike Proctor advised discussion had taken place at the Q&SC and this would again be followed up at the next meeting due to be held in February.

Stuart Hall referred to follow-ups as progress had not been included within the report and requested if the detail could be included within the paper. Mike Proctor advised this had been discussed at the Q&SC, in particular with regard to ophthalmology. The Finance & Performance Committee (F&PC) also had oversight of this issue. Elaine Criddle referred to mortality and asked if this could include what the Trust was learning in respect of the SHMI data. Dr Kate Wood advised discussion had taken place on a number of occasions as it was recognised it was not just about numbers but also the quality of care that was delivered. The Trust had now been within the expected range for 10 months and now needed to reflect back on the first part of the improvement. The first three months of the Grant Thornton work on coding was not in place so the improvement may have been due to the quality or delivery of care so this would need to be identified. Elaine Criddle felt the significant progress should be recognised.

4.2 Annual Safeguarding Report – NLG(21)032

Ellie Monkhouse passed on her thanks for the contribution made during the time Lynn Benefer had been in the interim role as Head of Safeguarding.

Terry Moran welcomed Lynn Benefer to the meeting. Lynn Benefer advised there had been significant progress since the report had been completed. One area of concern was the increased number of children being looked after through social care which had impacted on the team. Additional funding had now been secured through the Clinical Commissioning Group (CCG) which had allowed further recruitment to the team.

The team now had a Named Nurse and two Specialist Nurses to assist with Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DOLS). Lynn Benefer advised the priorities were listed within the report for 2021/22.

Dr Peter Reading explained the very high number of incidents for children in care or receiving care in North East Lincolnshire, was associated with the Council publicising the difficulties with children services over the last couple of years. Dr Peter Reading asked whether this would this mean increased pressure on the team and would the funding through the CCG be adequate. A further query was whether this would bring additional concern due to not being able to monitor the children in the same way and would further investment be required going forward in the longer term. Lynn Benefer advised the funding received would help support pressures in the short term but not the longer term. Lockdown had caused some concern due to children not attending school which was when issues were identified. The query in respect of funding, would see the team through the backlog but if numbers did not drop, more funding would be required in this area. Ellie Monkhouse felt the board would need to receive an update in the future to advise on what the statutory requirements would mean for the Trust.

Board members approved the Safeguarding Annual Report and priorities for 2021/22.

4.3 Ockenden Review – NLG(21)033

Terry Moran welcomed Jane Warner, Head of Midwifery to the meeting.

Jane Warner explained the Trust had provided urgent initial compliance with 12 clinical priorities by the 21 December as required by the Report. A further request was to provide a gap analysis on where the Trust was with further actions. The Executive Summary showed the Trust's compliance and those areas that were being worked through. The report highlighted key points that were in place to address the other actions.

Ellie Monkhouse advised the report had been reviewed prior to it being shared. Neil Gammon referred to page 8 (Appendix 1), as this referred to how Trust boards would be asked to look at how the audit would be undertaken, and queried whether it had been decided if this would be undertaken internally or be included in external audit plans. Jane Warner advised this still needed to be confirmed, however, it had been agreed the Trust Board would be sighted on maternity services including serious incidents (SIs) and risks. Terry Moran asked if further clarification could be provided on this process at the next Trust Board meeting in April 2021.

Action: Ellie Monkhouse

Lee Bond advised that requests for financial support would be reviewed outside of the meeting and would be added to the business planning process. If there were issues that were deemed to be high risk they would be prioritised accordingly.

Dr Peter Reading queried how engaged staff were within Maternity Services on the

Ockenden Review and if further support would need to be in place to raise awareness. Jane Warner advised staff were very loyal and wanted the best for the service so were open to change. A recent event was attended by staff in various roles and future events would be undertaken along with information shared at the Senior Leadership session.

Mike Proctor felt staff were committed and were also well led. Terry Moran sought any further comments for assurance purposes. No further comments were received. Terry Moran thanked Jane Warner for the report and the work involved in supporting this.

4.4 Care Quality Commission (CQC) Progress – NLG(21)034

Lucy Kent advised areas continued to work on actions and progress, however, due to COVID-19 some of this had been slow and steady. Three areas were emerging that would be more resistant to change, these included sickness, mandatory training and other issues including the review of documents that had been impacted on due to COVID-19. The Trust continues to meet with the CQC to review plans.

Terry Moran thanked Lucy Kent for the report and sought comments and questions. Terry Moran felt this was a positive sign the trust wanted to make progress. Linda Jackson wanted to thank Lucy Kent for the progress made during these difficult times and referred to the position papers being shared with the sub-committees as well as internal governance meetings to highlight what was required. Lucy Kent advised they would be shared and will have Executive sign off before they were shared with the CQC. The CQC had anticipated there would be some impact on the level of mandatory training achieved but expected plans to be in place to provide assurance.

Terry Moran referred to the letter received by NHSE/I in terms of easing of capacity as it also mentioned mandatory training. Dr Kate Wood highlighted the letter also mentioned that CQC would continue to maintain its support for those that remained in quality special measures and felt the Trust were benefiting from this. The three key areas that were being focussed on were maternity, emergency care and infection control. Dr Kate Wood highlighted the level of maturity through the divisions for the recognition that there was always more to be done.

Stuart Hall queried what was in place to manage the actions that had been completed to ensure they did not go back to being red again. Lucy Kent advised initial plans were in place and they had been discussed with the CQC. Those areas that were green and blue would be revised to ensure progress was maintained.

Terry Moran sought further comments. None were received. Terry Moran thanked Lucy Kent and Dr Kate Wood for the report shared. Terry Moran felt the contribution Lucy Kent had made to the progress in the Trust had been unquestionable and wanted to record thanks.

5. Finance & Performance

5.1 Finance & Performance Committee (F&PC) Highlight Report & Board Challenge – January 2021 – NLG(21)035

Neil Gammon advised the January meeting had been reinstated at short notice. The committee had therefore not been fully assured as reports were not available in terms of trajectories and risks associated with specific actions had not been provided.

Mike Proctor queried the four hour standard as this had improved from last December to this year and whether the performance may then be better in 2021. It was recognised this was due to improvements being put in place, but whether or not this was due to COVID-19 as it had not been a "normal" winter. Shaun Stacey advised the four hour standards were due to be change. Shaun Stacey advised the bed position was 20% higher than last year. The organisation was also leading the way in same day emergency care, currently running at 35% of patients going into that service that were discharged the same day. Had there not been the COVID-19 impact the Trust would have been in a more sustained position this year.

5.2 Estates Strategy – NLG(21)036

Terry Moran recognised a considerable amount of work had been undertaken for the Estates Strategy. The paper had been approved at the F&PC and the next stage was board approval.

Jug Johal thanked the F&PC for the input and comments that had been shared previously. It was noted the paper had also been shared with the Trust Management Board (TMB). The comments received would further strengthen the strategy especially in terms of the impact of the short to medium term investments. This would not have a significant impact on the back log maintenance and this had been a key point raised at the F&PC. The Clinical Strategy was evolving all the time and the Estates Strategy would need to link with this particularly around November this year.

Andrew Smith felt the paper should be approved but was concerned how the board would capture and manage the risks inherited. The board should be made aware of the subsequent steps post approval and in particular the concern of the estate fitting into Category B; and the capturing of the risks involved. It was felt the organisation would need to be aware of the point the estate may become untenable and whether the Trust had sufficient investment in place.

Terry Moran thanked Andrew Smith for the comments made and agreed the inherent risk was concerning. It was felt a further discussion on this matter should be included within the board development session due to take place that afternoon.

Dr Peter Reading felt the points made by Andrew Smith were important. The board needed to be sighted on what the "pinch points" were in respect of the estate and equipment. Ivan McConnell felt it was important that board members understood the Trust were working with Integrated Care System (ICS) colleagues with the plan to

submit a strategic outline case by March 2022, which should address some of the issues raised. It was important to recognise that there was uncertainty on funding due to different issues. It was felt important to provide assurance to the board that the Trust had engaged with NHSE/I colleagues and with local authority partners.

Lee Bond advised the hospital rebuild programme relied on HM Treasury funding. The role of the Capital Investment Board will undertake a strategic view on what risks could be taken by the organisation.

Terry Moran sought approval of the Estates Strategy, board members' agreed to approve the paper.

5.3 Annual Accounts – Delegation of Authority – NLG(21)038

Lee Bond advised the Trust had to provide a draft set of accounts just after the end of the financial year. The accounts would be submitted to NHSE/I by 15 June 2021 for formal sign off. As the board in June was too early for the final accounts to be shared Lee Bond sought approval for the Audit, Risk & Governance Committee (AR&GC) to have authority to sign them on behalf of the board on the 1 June 2021. Terry Moran sought advice from Andrew Smith as the Chair of AR&GC on this proposal. Andrew Smith confirmed this could be put in place.

Terry Moran sought comments from the board to agree that the AR&GC could have authority to approve the accounts on behalf of the board. Agreement was made to put this in place.

5.4 Finance 2020/21 – Month 09 – NLG(21)039

Lee Bond shared the report and highlighted key points within the paper. Terry Moran queried if there was any risks that should be highlighted to the board. Lee Bond advised there were a number of risks but none were too large that they could not be managed. No risks would be flagged for the 31 March 2021.
Terry Moran thanked Lee Bond for the report and noted it for assurance.

5.5 Integrated Performance Report – NLG(21)040

Helen Harris advised the report was still working progress and wanted to thank executive colleagues for the support provided with the process.

Lee Bond queried whether the board could be assured the numbers were correct due to the paper still being in development. Helen Harris advised there had been some issues in respect of the quality and safety section. The timeline to implement the new report was the 1 April 2021, however, it had been shared at the February board to show where it currently stood. Lee Bond queried if the report could flag the areas that could not yet provide full assurance whilst it was still in the development stage. Helen Harris advised the information was shared by the information team and data quality checks had been undertaken. Helen Harris advised any concerns raised would be reviewed with executive colleagues.

Terry Moran agreed that if the data in summary terms had some outstanding need

for validation then that should be clear in the report.

Neil Gammon referred to page 35 in respect of the unregistered nurse vacancies and queried what lessons could be learned from the vacancy position deteriorating from September 2019. Christine Brereton advised this was one area that required further work around establishment numbers to confirm they were correct. Ellie Monkhouse advised the Trust was working with NHSE/I in respect of the vacancy rates and the date specified by NHSE/I was the 31 March.

Shaun Stacey advised the performance data was provided by the information team and was accurate, however, in terms of cancer the report did not specify whether the data had been validated. Some of the validation work was not up to date and this had been due to the length of time it took to undertake the process and other pressures. The adjustments for this would then be shared in future reports.

Dr Kate Wood asked if the paper could be amended slightly to reflect that it was still in development and not final. It was felt the data did not triangulate across to other data and more understanding was required on why that was. The data would normally be checked through the Q&SC but the opportunity to do that had not happened. It was felt the timescales may also need to be changed if it could not be put right by the April board meeting.

Terry Moran was anxious that the data presented had not been correct. Dr Peter Reading confirmed that going forward the only data presented to the board should be validated data. The intention was to build the report in stages and the gaps would be identified as it was built up.

Terry Moran thanked everyone for the updated provided. It had been clear that not all the data from all areas was fully validate and may therefore be unreliable and this would need to be addressed urgently outside of the meeting. It was noted that full assurance could not be provided for this item but this would be addressed for the next board meeting. The Board would also need to understand whether any previously published data needed correcting retrospectively.

6. Leadership, Organisation Development & Culture

6.1 Self-Assessment Review – Health Education England – NLG(21)042

Christine Brereton shared the paper with the board and advised it had been signed off by the executive team.

Dr Kate Wood advised this was a review of Health Education England into the education of clinical staff, including nurses and Allied Health Professions. It had been acknowledged that there had been issues with medical staffing in particular gastroenterology. The report was now out of date due to COVID-19 as submission should have been September 2020. The concerns in gastroenterology had been raised in respect of the trainee's, which had been resolved due to the work undertaken by operations and recruitment as more consultants had been put in that area. There were still opportunities in respect of training and discussions were taking place with NHS England.

Terry Moran sought comments in relation to the contents of the report and asked for board approval. No comments were received, the paper was approved by the board.

6.2 Workforce Report (including Flu Assessment) – NLG(21)043

Christine Brereton highlighted key issues within the report advising it showed high risks. In terms of outstanding risk assessments, if a member of staff had declined the risk assessment this would be recorded on personal records. In respect of health and wellbeing it was noted staff were tired due to the pandemic and therefore the current support available to staff would be refreshed.

Linda Jackson queried whether the Workforce Committee could review retention as the figure had increased.

Terry Moran advised the paper had requested approval from the board to stand down the flu vaccine programme retrospectively. As this had already exceptionally been stood down in January 2021 the board agreed to the proposal. In respect of the flu checklist requiring approval Terry Moran asked if the board agreed to this retrospectively. This was agreed by the board.

In supporting the decision Mike Proctor nevertheless felt that if approval was required and the decision was needed urgently before a formal board meeting a request should be made to the Chair. Christine Brereton apologised and agreed to put this in place going forward.

6.3 Freedom to Speak Up Guardian Quarterly Report – NLG(21)045

Liz Houchin referred to the quarter two report and advised that the timings of sharing the report at future meetings were being reviewed so that it could be more recent. The data for quarter three showed there had been 55 concerns raised. One consideration that was required was how the National Guardian training was to be delivered, as this was core training for all workers and included the Listen Up Module for line managers. A third module for senior leaders and board members' was due to be released later this year.

Terry Moran thanked Liz Houchin for sharing the report. It was noted there had been a slight increase in quarter three from the previous quarter. Liz Houchin felt this was due to October being the "Speak Up Month" and explained that the CQC would recognise this as positive due to the number of staff feeling confident to speak up. Dr Peter Reading agreed the increase was positive rather than negative. Linda Jackson advised that when meeting with Liz Houchin it was highlighted there were still some underlining bullying and harassment issues, the wellbeing of staff and safety was also within the concerns raised which had been down to wave two of the pandemic. Christine Brereton explained the importance of the information being triangulated with issues around staff complaints of bullying and harassment and other information from datix, themes being identified.

Neil Gammon queried where information was obtained from to confirm the issue had been resolved and whether the member of staff had been satisfied. Liz Houchin

advised every concern was focussed on the outcome the staff member would like and if this was not achieved further discussion would take place. If the staff member was happy with the outcome the concern would be closed. Meetings with Dr Peter Reading take place on a monthly basis and any open concerns were discussed at the meeting. Neil Gammon asked if this information could be included within the report. Liz Houchin agreed to provide this.

Terry Moran was pleased to see the helpful feedback provided on how Liz Houchin supported staff and thanked Liz Houchin for the report and queried if there was anything else that needed to be raised not included within the report. Liz Houchin confirmed there was not. Liz Houchin wanted to note thanks to the board for the support offered.

7. Audit, Risk & Governance

7.1 Audit, Risk & Governance Committee Highlight Report & Board Challenge – January 2021

Andrew Smith drew the boards' attention to three items detailed within the report which were item one, two and four. In respect of item four, a discussion had taken place as to whether the responsibility for strategic objective 3 should be undertaken by an alternative sub-committee. The AR&GC could then adopt a full governance position over this. Terry Moran sought views from the board as to where the ownership should sit. After further discussion it was agreed to discuss this item during the BAF board development session that afternoon. In respect of the update provided for item two, Terry Moran recognised the importance of internal audit matters as this was part of overall governance matters.

In respect of item one, Lee Bond advised the scope to which the auditors could investigate was more wide ranging and this was the first time it had been undertaken in this way.

Mike Proctor referred to the overdue controlled documents item within the paper as it stated the issue would be referred to the Chair of the Q&SC, and queried whether the documents should be reviewed by the executive team, with recommendations shared with the sub-committees to review and approve. Terry Moran advised due to previous audit issues with out of date documents it would not be appropriate to leave this to the executive team alone. The executive team should be invited to make an assessment on what the documents were and whether they were still required, this could then be fed back into the AR&GC. Due diligence would be required to finalise this and it was noted that work of this nature had already been agreed. Dr Kate Wood advised a suggestion had been made to hold a meeting to specifically address document control. This could then be dealt with and a report could then be shared with the executive team and AR&GC. Dr Kate Wood felt the documents should be reviewed by the document control team.

Lee Bond advised the AR&GC would continue to review this issue and would make a proposal for actions going forward. Dr Peter Reading advised it was not the responsibility of the document control team to review the documents. The

document control service was a library facility for managing the controlled documents. It would be the responsibility of the authors or clinicians to adhere to the discipline of updating documents by the review date and to then seek approval from the appropriate forums. Dr Peter Reading and Helen Harris had met to discuss how to support the executive team in undertaking this in a structured way. Terry Moran felt some of the older documents needed to be addressed so improvements could be made.

7.2 Annual Review of Audit, Risk & Governance Committee Terms of Reference – NLG(21)047

Andrew Smith shared the paper and asked for approval of the updated Terms of Reference. The Terms of Reference were approved by the Trust Board.

8. Clinical Ethics Committee

8.1 Clinical Ethics Committee Highlight Report & Board Challenge

Dr Kate Wood advised meetings had not taken place as no issues had been raised.

9. Health Tree Foundation Trustees' Committee

9.1 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – November 2020 – NLG(21)049

Neil Gammon sought comments from Board members. No comments were received.

10. Other Items for Approval

10.1 Annual Review of Non-Executive Director Statutory & Other Lead Roles – NLG(21)050

Terry Moran referred to the paper and sought comments or queries. No comments were received. The paper was approved by the board.

Terry Moran advised a number of Chairs' had raised the issue of the ever increasing list of demands to appoint lead roles for Non-Executive Directors. This was also raised at a Yorkshire & Humber Chairs' meeting, the Acting Chair of NHSE/I, Sir Andrew Morris had been in attendance and had agreed to discuss with colleagues.

11 Items for Information

12. Any Other Urgent Business

There were no items of any other urgent business raised.

13. Board Reflection – NLG(21)051

Terry Moran asked if board members would complete the board feedback when it

was circulated and to particularly feedback on whether the timing of the meeting was adequate.

Linda Jackson wanted to highlight some papers shared at the meeting were still very lengthy which meant more preparation time was required. There had also been some late papers which contributed to there not being enough time to read the paper. Terry Moran acknowledged this and agreed we could do better.

Terry Moran sought comments or questions from board members and members of the public in attendance. Michael Whitworth felt the meeting had gone well in particular the discussion around the risks that would come out of the Estates Strategy, it was felt the outcome of this should be brought back to a future public board meeting.

David Cuckson, Public Governor queried if future agendas could include a "Questions from Governors" section as it was important they were given advance understanding that questions would be invited. It was agreed this would be included on future agendas.

14. Date and Time of the next meeting

Formal Trust Board Meeting
Tuesday, 6 April 2021
Time: TBC
Via video conference

The Private Trust Board meeting was due to follow at 12.30 hours via video conference.

Terry Moran closed the meeting at 12.25 hours.

Cumulative Record of Board Director's Attendance (2020/21)

Name	Possible	Actual	Name	Possible	Actual
Mr Terry Moran	7	7	Mrs Linda Jackson	7	6
Dr Peter Reading	7	6	Mr Jug Johal	7	7
Mrs Jayne Adamson	1	0	Mrs Claire Low	6	5
Mrs Wendy Booth	1	1	Mr Ivan McConnell	7	7
Mr Lee Bond	4	4	Mrs Shauna McMahon	3	3
Mr Anthony Bramley	6	6	Mrs Ellie Monkhouse	7	6
Mrs Christine Brereton	2	2	Mr Michael Proctor	4	4
Mr Neil Gammon	7	7	Mr Jeff Ramseyer	1	0
Mr Stuart Hall	7	6	Mr Andrew Smith	4	4
Mr Marcus Hassall	4	0	Mr Shaun Stacey	7	6
Mrs Helen Harris	6	6	Mr Michael Whitworth	7	7
Mr Jim Hayburn	3	3	Dr Kate Wood	7	7
Mrs Sandra Hills	3	3			

NLG(21)065

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2021/2022

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2021/22

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.1	04.01.2021	Digital Strategy		Executive team to consider where the oversight should sit for the delivery of the Digital Strategy	Shauna McMahon	Apr-21	Update to be provided at the February 2021 Trust Board meeting. Update to be provided at April 2021 Trust Board. Oversight for the Strategy will be monitored through the Finance & Performance Committee.	Completed		
2.3.1	04.01.2021	Risk Assessments for Staff		Clarification to be provided as to whether a generic risk assessment would be sufficient in circumstances where an individual Risk Assessment was unable to be completed	Christine Brereton	Feb-21	Update to be provided at the February 2021 Trust Board meeting. Update to be provided at April 2021 Trust Board. Update provided at the February 2021 meeting.	Completed	February 2021 Public Board Minutes	Shared on sharepoint site
4.3	02.02.2021	Ockenden Review		Clarification of how the audit of challenge and assurance would be undertaken in terms of an internal process or part of the external audit plan.	Ellie Monkhouse	Apr-21	Update to be provided at the April 2021 meeting.	On Track		

Key:

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

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2021/22

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
1.8	01.12.2020	Chief Executive's Breifing - Integrated Care Systems		Discussions took place with the Executive Team and NEDs, in respect of how to move forward with Integrated Care Systems across the NHS in the future. Agreement was reached on the preferred way forward. The Board was asked to consider two options and the preferred option was two.	Dr Peter Reading	Dec-20	Action completed	Completed		

Key:

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

NLG(21)066

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	Tuesday 6th April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Kate Wood Medical Director, Ellie Monkhouse Chief Nurse and Abdi Abolfazi Interim Deputy Chief Operating Officer
CONTACT OFFICER	Helen Harris Director of Corporate Governance
SUBJECT	Integrated Performance Report – Access & Flow and Quality & Safety
BACKGROUND DOCUMENT (if any)	Not applicable
PURPOSE OF REPORT	To provide assurance to the board on delivery against national indicators, trust priorities and quality priorities
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance and Performance and Quality and Safety Committees
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The board has committed to developing the information it receives with particular regard to the presentation and analysis of information and information reporting. Please note revised format for Access and Flow this month.

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

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to? Shade the box this refers to

1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

TRUST PRIORITIES - which Trust Priority does this link to? Shade the box this refers to

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	All
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to progress of the report

Access and Flow
Objective: To give great care
The impact on the current pandemic both in the trust and nationally has affected delivery against the constitutional standards. The Emergency Department are currently seeing levels of patients which is more or less at the pre-covid levels and the department still faces pressure in moving patients through the system as a result of zoning and swabbing as well as challenges with the workforce in terms of number and skill mix across the Trust which has impacted upon delivery of the patient flow and A&E 4 hour target. Performance of the 12 hour trolley wait standard has significantly improved though the breaches are directly attributable to flow within the Emergency Department and the Inpatient exit block compounded by the acuity of patients requiring longer length of stays. This is demonstrated in the Ambulance handover performance over 60 minutes. RTT continues to see an increasing number of patients waiting resulting in performance of 63.65%. There are 1285 patients that have waited in excess of 52 weeks at the end of February. The performance is as a direct result of the reduced elective operating capacity due to the theatre and anaesthetic response to supporting the high acuity of COVID-19 patients and the social distancing and patient choice. Significant progress has been made in creating additional capacity which includes both the use of Goole District Hospital and the Independent sector where the initial focus is on the treatment of urgent and cancer patients. Cancer 2ww standard continues to be achieved at 97.88% though there are some pressures in achieving the 31 day standard which fell short at 94% and the 62 day standard was 55.20%, again this is as a result of capacity, primarily within the diagnostic modalities. Diagnostic services has seen a further decrease in performance which is related to treating patients on urgent and cancer pathways and limited capacity in some modalities, which has been partially addressed through the opening of the new scanning facilities at DPoW in month and the further opening of additional capacity in May 2021. The service continues to explore additional capacity options which include use of the independent sector and community diagnostic hubs.

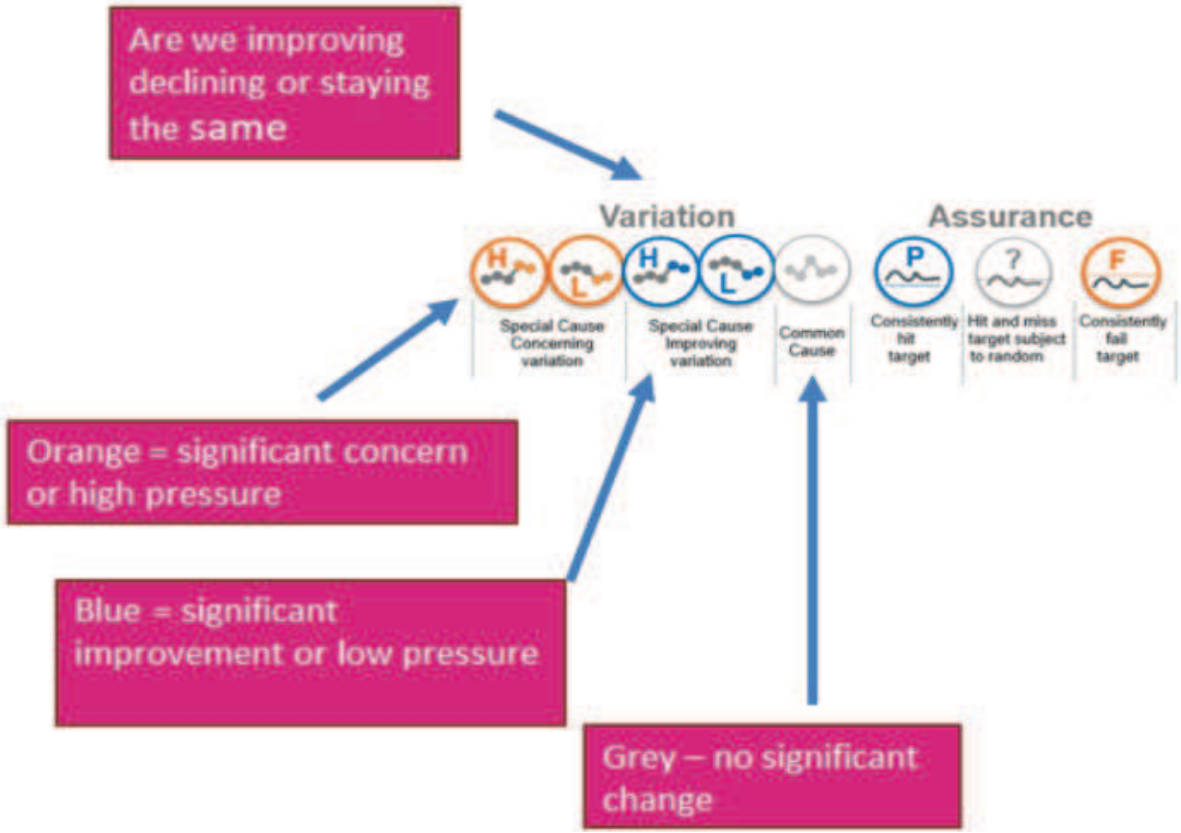
Key to Indicator Status Codes
(these relate to the scorecard)

The purpose of this key is to specify whether each indicator is a nationally agreed indicator.
For national indicators, the key indicates whether the data has been validated and submitted at the point this report is refreshed.
For local indicators, the key indicates whether a specification and agreed methodology is in place or if this is yet to be completed and agreed.

NS	National Indicator - Submitted
NNS	National Indicator - Not Submitted
LSAR	Local Indicator - Specification Agreed and Reviewed
LTBC	Local Indicator - To Be Completed

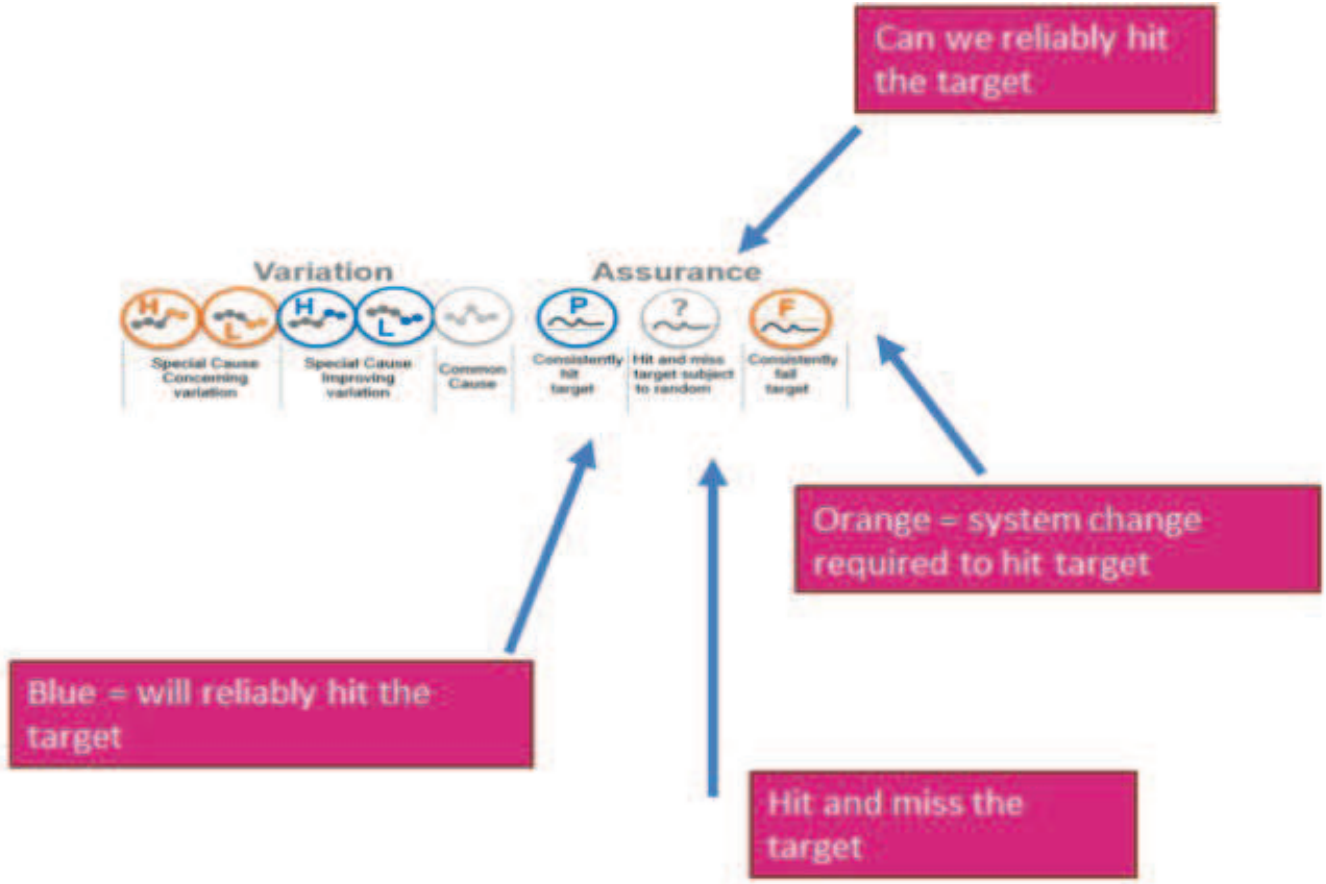
High level key - Variation

Northern Lincolnshire and Goole NHS Foundation Trust



High level key - Assurance

Northern Lincolnshire and Goole NHS Foundation Trust



SPC Images

Name	Image	Reference	Comment
SPCNoChange		SPC No Significant Change	Common cause - no significant change
SPCVariation		SPC Variation Inconsistently Hitting Passing Failing Target	Variation indicates inconsistently hitting passing and falling short of the target
SPCSCCL		SPC Special Cause Concerning Lower	Special cause of concerning nature or higher pressure due to lower values
SPCSCCH		SPC Special Cause Concerning Higher	Special cause of concerning nature or higher pressure due to higher values
SPCSCIM		SPC Special Cause Improving Lower	Special cause of improving nature or lower pressure due to lower values
SPCSCIH		SPC Special Cause Improving Higher	Special cause of improving nature or lower pressure due to higher values
SPCFailing		SPC Variation Failing Target	Variation indicates consistently failing short of the target
SPCPassing		SPC Variation Passing Target	Variation indicates consistently passing the target

Ref	Metrics	Feb 2021	Target	Variance	Assurance	Indicator Status
	RTT waiting times for non-urgent consultant-led treatment					
1	Maximum time of 18 weeks from point of Referral To Treatment (RTT) in aggregate - patients on an incomplete pathway. 18 week %	63.65%	92.00%			NS
2	Total outpatient waiting list	100,368	105,474			LSAR
3	Total inpatient waiting list	10,673	11,536			LSAR
4	Number of incomplete RTT pathways 52 weeks	1,285	0			NS
5	Maximum 6-week wait for diagnostic procedures (Diagnostic Measurement 01)	38.90%	<=1%			NS
	A&E waits					
6	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (4 hour target)	73.27%	92.00%			NS
7	Count of Ambulance Handover delays 15-30mins	888	0			NS
8	Count of Ambulance Handover delays 30-60mins	288	0			NS
9	Count of Ambulance Handover delays 60+ mins	240	0			NS
10	Waits in A+E not longer than 12 hours from Decision To Admit	6	0			NS
	Cancer waits					
11	Cancer Waiting Times - 2 week wait	97.88%	93.00%			NS
12	Cancer 2 week wait (breast symptoms)	94.38%	93.00%			NS
13	Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	65.19%	75.00%			NS
14	Cancer Waiting Times - 31 Day First Treatment	93.94%	96.00%			NS
15	Cancer Waiting Times - 31 Day Surgery	80.00%	94.00%			NS
16	Cancer Waiting Times - 31 Day Drugs	100.00%	98.00%			NS
17	Cancer Waiting Times - 62 day GP referral	55.20%	85.00%			NS
18	Cancer Waiting Times - 62 day Screening	82.84%	90.00%			NS
	Cancelled Operations					
19	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice					
20	No urgent operation should be cancelled for a second time					
	Improve the Trust's waiting list with a focus on 40 week waits, total list size and out patient follow ups					
21	The number of patients overdue their follow up for an outpatient review.	27,803	9,000			LSAR
22	Overall size of the RTT waiting list	28,307	25227			LSAR
23	50% of out-patient summary letters to be with GPs within 7 days	40.00%	50.00%			LTBC
24	Reduce the number of face to face follow up appointments by 10% by 31 March 2021.	11,279	15,903			LTBC
	Improve the effectiveness of cancer pathways focussing on time to diagnosis					
25	Cancer waiting times - 104+ day backlog	36	0			LSAR
26	Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	25.00%	75.00%			LSAR
27	100% Cancer request to test report to be no more than 14 days	84.48%	100.00%			LSAR
	Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon					
28	Average Length of Stay (all)	3.99	4.00			LTBC

Ref	Metrics	Feb 2021	Target	Variance	Assurance	Indicator Status
29	% of patients who were discharged on the same day as admission (non-elective)	29.03%	32.00%			LTBC
30	Non elective Length of Stay	4.18	4.10			LTBC
31	Elective Length of Stay	1.91	2.40			LTBC
32	30 day emergency re-admission rate	7.42%	0.00%			LSAR
33	Number of Medical Outliers	1957	no target			LTBC
34	85% of discharge letters to be completed within 24 hours post discharge	88.60%	85.00%			LTBC
35	Progressive improvement in the number of golden discharges from April 2020	16.24%	35.00%			LTBC
36	Increase in A&E performance to 83.5%	73.27%	83.50%			LSAR
37	Reduction of non emergency patient transfers at night after 10pm by 10%	8.53%	2.80%			LTBC
38	Reduction in average ward moves for non elective patients for non clinical reasons by 7%	12.75%	4.60%			LTBC
39	Number of early supported discharges to increase by 10%					
40	Improvement in the number of patients that have admission prevention services provided by the community services in the North and North East Lincolnshire (target to be agreed)					
41	All patients requiring mental health support in ED will be assessed within 4 hours of referral					
42	Patients on in-patient wards will be assessed and have a plan in place within 24 hours					
43	Daily Discharge Rate					
44	Risk Stratification Inpatients	99.80%	99.00%			LSAR
45	Risk Stratification Outpatients	30.40%	99.00%	Not an SPC	Not an SPC	LSAR
46	40-51 week waiters	1,167	0			LSAR
47	Stranded patients - 21 days	60	no target			LSAR
48	Stranded patients - 7 days	270	no target			LSAR
49	COVID patients in ICU beds	5	no target			LSAR
50	COVID patients in other beds	67	no target			LSAR
51	COVID staff absences	30.58%	no target			LSAR

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: COVID ICU Beds

Local Target

Period	Lower CL
Feb 2021	0.0

Value	Median
5	2.0

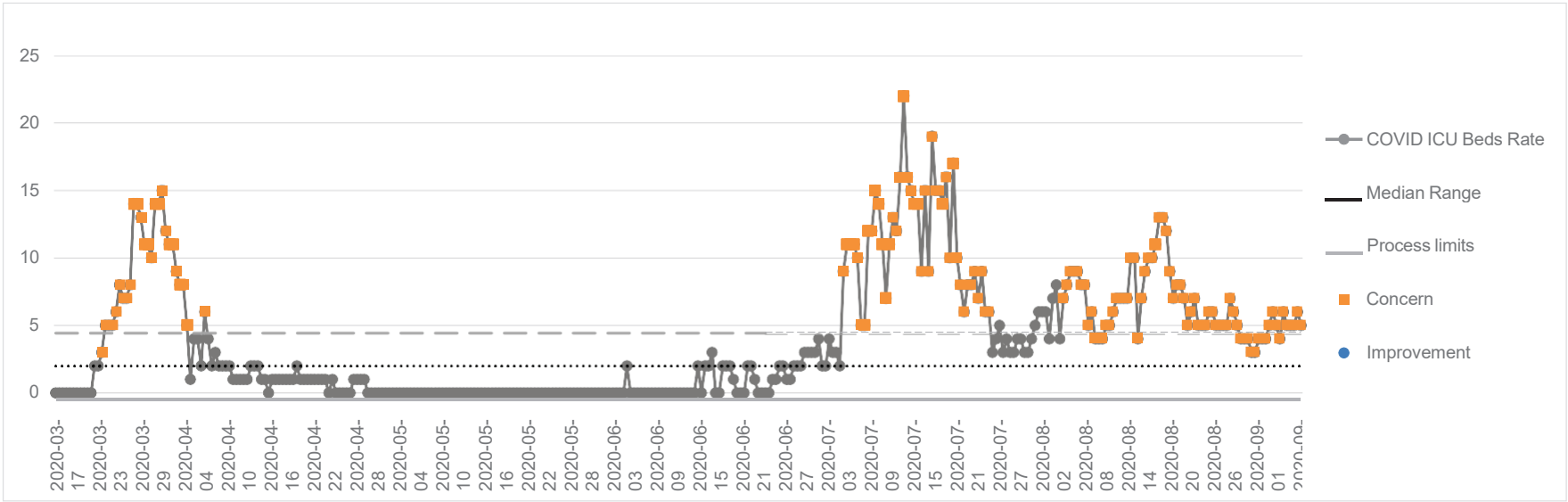
Target	Upper CL
No target	4.4

Variance

Special cause of concerning nature or higher pressure due to higher

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?

The data is provided from WEB V, it indicates number of COVID 19 patients occupying intensive care beds by day.

There was 5 patients within our Intensive Care Units. It is proposed that the limits are recalculated for wave 1 and 2.

Actions

The surge policy states that we will open up the theatre areas for additional ICU beds which does impact on the ability to provide elective care.

Issues And Risks

During times of surge there is the need to create additional ICU capacity to manage the demand.

Mitigations

Indicator: COVID patients in other Beds

Local Target

Period	Lower CL
Feb 2021	26.2

Value	Median
67	40.0

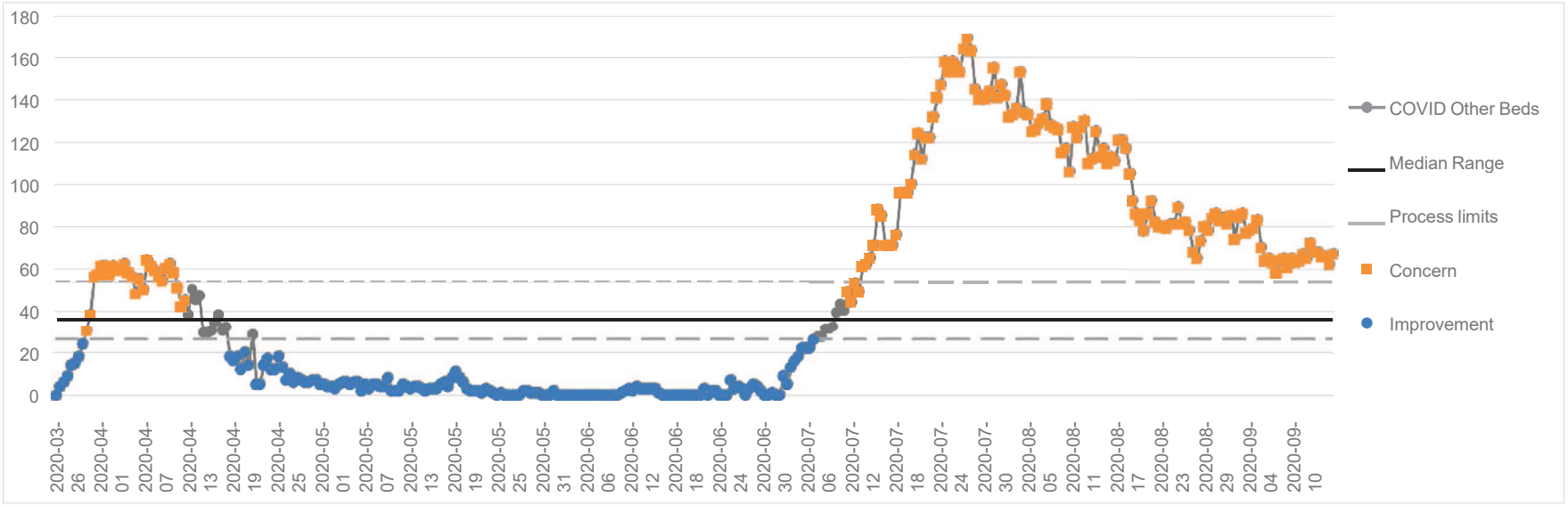
Target	Upper CL
No target	53.7

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
The data is provided from WEB V, it indicates number of COVID 19 patients occupying non-intensive care beds by day. The chart is telling us that there were 40 patients in our hospital beds. The process limits require recalculation for wave 1 and wave 2.	Redi rooms and cubi screens have been implemented to manage infection control and maintain patient safety.

Issues And Risks	Mitigations
The requirement to Zone areas in line with infection control policy impacts on our ability to deliver elective care which has included a reduction in the number of beds on red wards to account for social distancing measures. Reduction in the bed base impacts on the trusts ability to deliver activity.	Ring fenced surgical beds allowing some elective activity to continue.

Indicator: COVID Staff Absences

Period	Lower CL
Feb 2021	27.3%

Value	Median
30.6%	30.6%

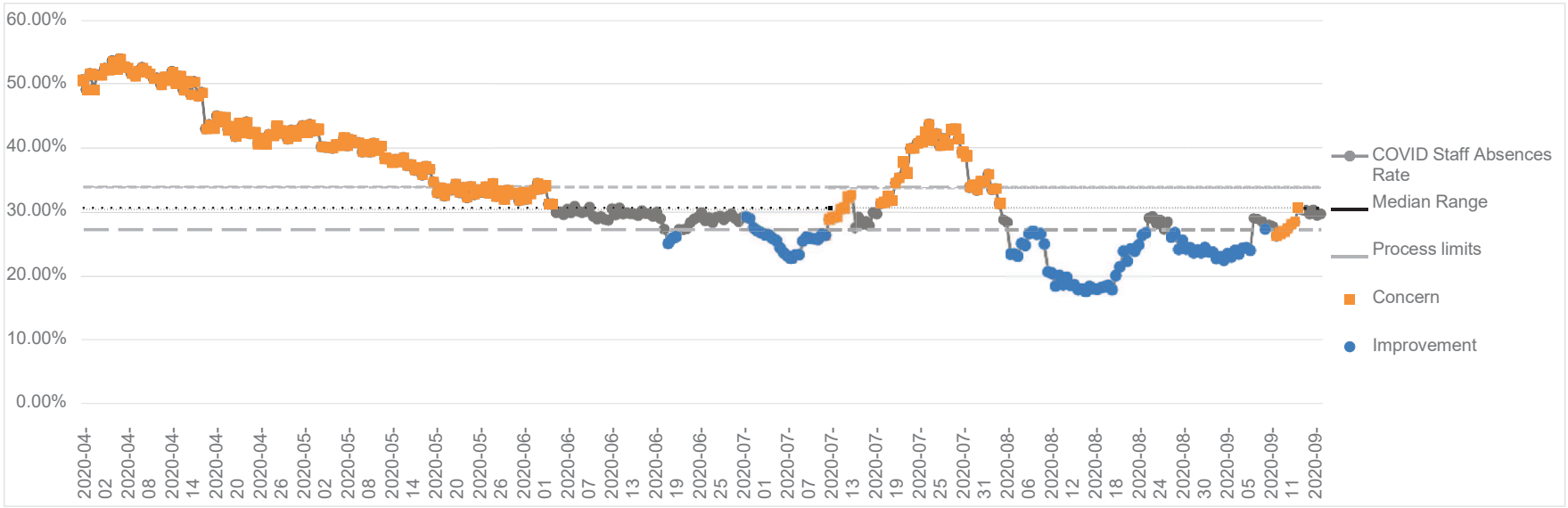
Target	Upper CL
No target	33.9%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?

This chart is showing the number of staff absences relating to the COVID pandemic which is may a direct results of the infection or self isolating.

This is showing the COVID staff absences as a percentage of all staff absence.

Actions

Lateral flows tests have been introduced for staff to assess their fitness to work, these are carried out twice weekly. The first phase of the staff vaccination roll out is almost complete.

Issues And Risks

High risk staff are required to shield which impacts on operational delivery as do the sickness/absence rates due to the impact of COVID-19.

Staff absence having an impact on phase 2 recovery plans.

Increased demand on using agency staff to cover staff absences.

Mitigations

Increase in bank usage to cover staff absences.

Indicator: Cancer Diagnosis Within 28 Days

National Indicator

Period	Lower CL
Feb 2021	46.5%

Value	Median
65.2%	61.5%

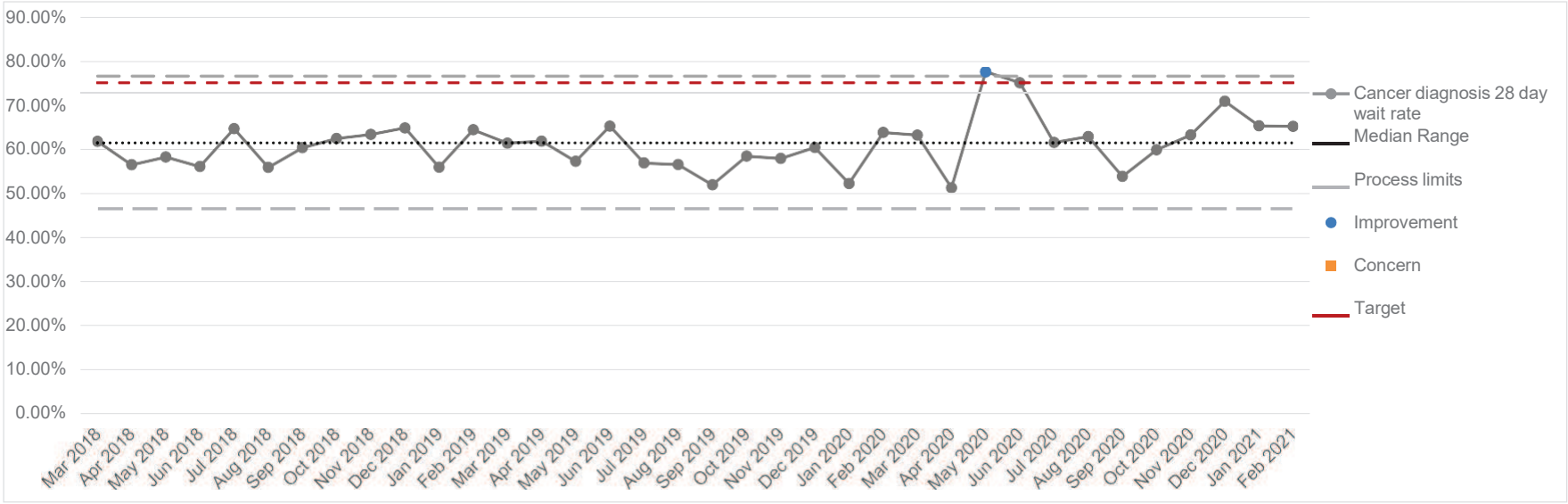
Target	Upper CL
75.0%	76.5%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
Percentage of 2 week wait urgent cancer referrals being informed of cancer diagnosis, or ruling out of cancer within 28 days of referral from GP. This data is unvalidated. Data is produced from the Somerset Cancer Register. The chart indicates that performance is within the process limits but delivery is variable and performance is below the target.	A Cancer Transformation team has been established that is working on developing streamlined pathways to support delivery. Additional capacity within diagnostics is being sourced as part of the diagnostic recovery plan.

Issues And Risks	Mitigations
All tumour sites are facing challenges in delivering against this standard with the exception of breast. Access to diagnostics and streamlined pathways are required.	A process of patient risk stratification has been implemented and the Trust continues to treat urgent and cancer cases as a priority.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Cancer Waiting Times - 31 Days 1st Treatment

National Indicator

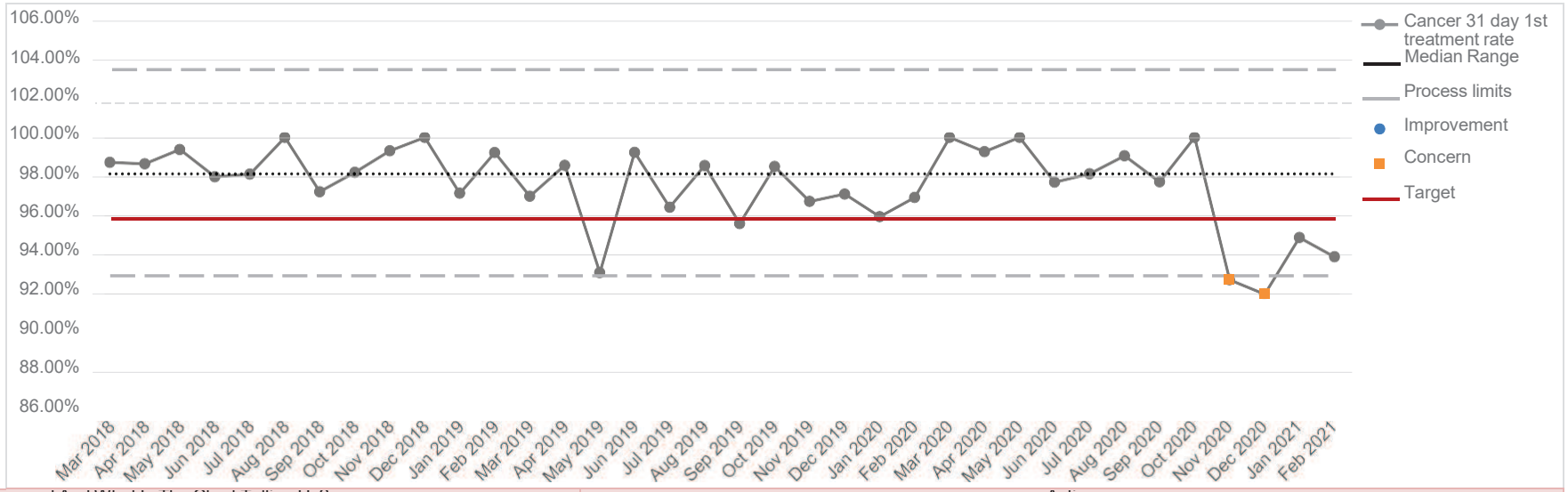
Period	Lower CL
Feb 2021	92.9%
Value	**Median**
93.9%	98.1%
Target	**Upper CL**
96.0%	103.3%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?

Percentage of cancer patients receiving their first definitive treatment for cancer within 31 days of the decision to treat.
Data is produced from the Somerset Cancer Register.

The chart indicates that performance is within the process limits.

Actions

Issues And Risks

Minimal elective beds available

Mitigations

priority.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Cancer 31 Days Surgery

National Indicator

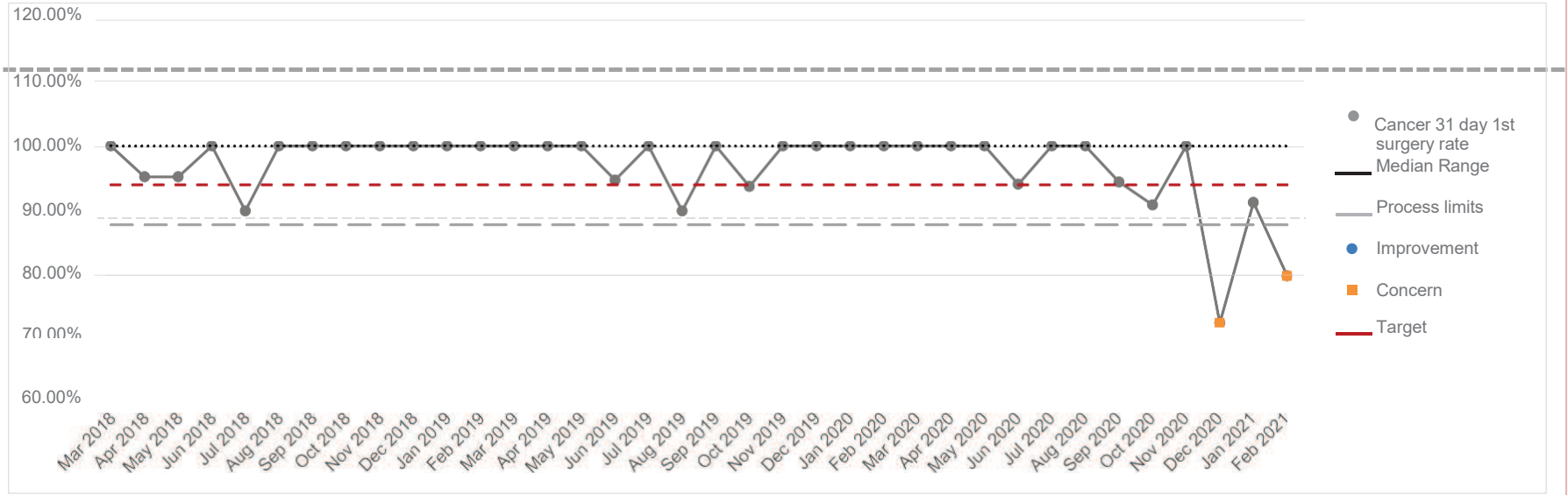
Period	Lower CL
Feb 2021	87.9%
Value	**Median**
80.0%	100.0%
Target	**Upper CL**
94.0%	112.1%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



This indicator is predicated upon a one month (31-day) wait from diagnosis to first definitive surgical treatment.
Due to the national reporting process these figures are unvalidated.
Data is produced from Somerset Cancer Registry.

Indicative performance shows that we are outside our current control limits this month.

Diagnostics sourcing additional capacity.

Reduction in elective beds.

Surgical recovery plans include use of the Independent Sector and maximising capacity at Goole District Hospital to include additional weekend working will support a delivery improvement.

Indicator: Cancer 62 Day GP Referral

National Indicator

Period	Lower CL
Feb 2021	54.2%

Value	Median
55.2%	69.7%

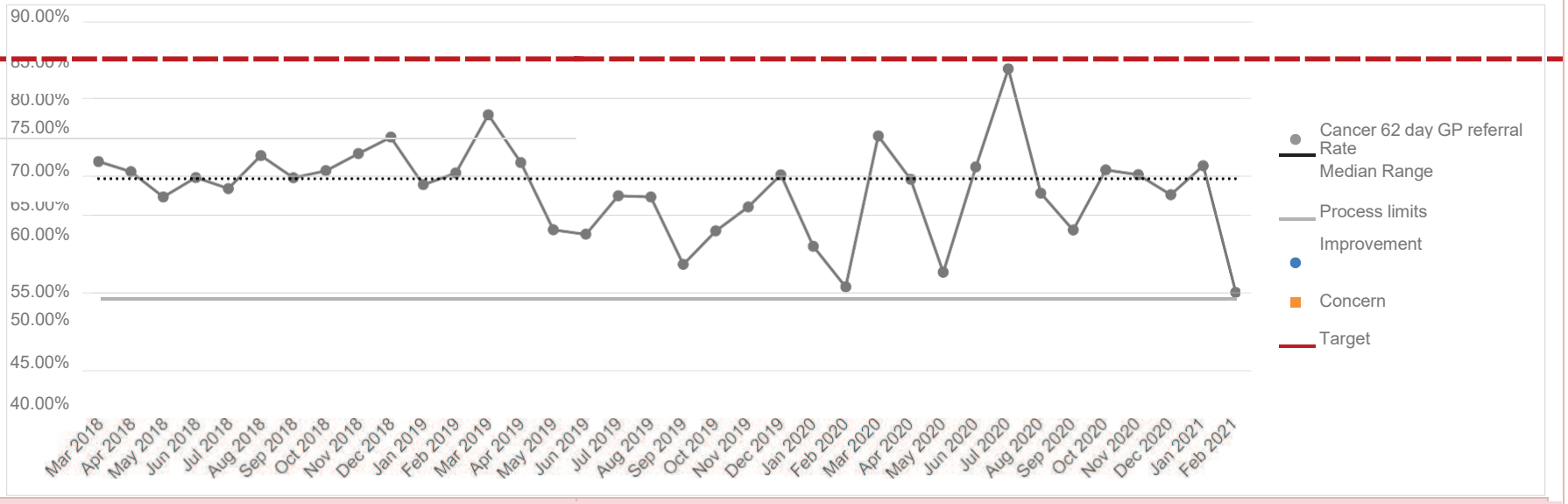
Target	Upper CL
85.0%	85.0%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Due to the national reporting timetable the figures reported are unvalidated.
Percentage of 2 week wait urgent cancer referrals receiving their first definitive treatment within 62 days of referral from their GP.
Data is produced from the Somerset Cancer Register.

This chart indicates that performance is within the control parameters and continues to be variable.
Performance is below the national standard and has remained so for more than 2 years.

A recovery plan is being developed within endoscopy.
The FIT pathway has commenced in Humber Coast and Vale (including N/NE Lincs) and requests for FIT test have been implemented within NLAG (to risk stratify the backlog of patients waiting for diagnosis).

Due to the cancellation of elective surgery in response to the COVID-19 surge in the 1st 2 weeks of November, this resulted in an increased number of breaches. Additional theatre capacity has been sourced in January to support delivery.
The most challenged speciality currently is colorectal.
Oncology outpatient capacity – continues to be a problem due to consultant sickness/vacancy factor and therefore continues to be a risk that will impact on length of pathways and 62 day breaches.
Delays in the Colorectal/Upper GI pathways are occurring due to the restricted capacity within CT Colon modality.

We are continuing to work closely with HUTH (through the Humber Cancer Board) to minimise the impact on patients.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Cancer 62 Day Screening

National Indicator

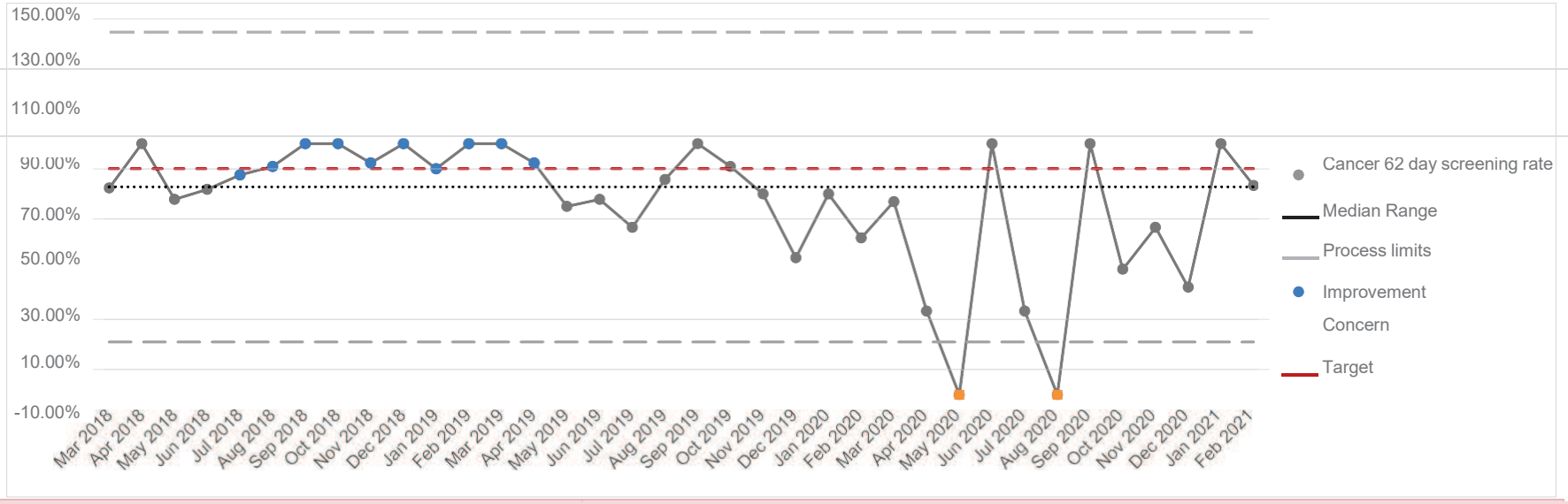
Period	Lower CL
Feb 2021	21.0%
Value	**Median**
83.3%	82.8%
Target	**Upper CL**
90.0%	144.7%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Percentage of screening referrals receiving their first definitive treatment within 62 days of referral from the screening service.
Data is produced from the Somerset Cancer Register.

The chart indicates that current performance is within the process limits. There is significant variation indicated throughout the year though this is due to the small number of patients in this category. Performance suggests that the control limits should be reviewed.

Proposals to create additional capacity within Endoscopy are being submitted to TMB.

Whilst performance appears variable, this is due to the small number of patients involved. The 62 day screening performance is below national standard. Due to the national reporting process these figures are unvalidated.

COVID is playing a large part at present due to limitations in Endoscopy and Radiology for CT Colon as well as theatre capacity, elective capacity as high observation beds are required in many of these major cancer cases and Oncology capacity issues).

Theatre sessions and ring fenced beds now opened at Scunthorpe General Hospital.

Indicator: Cancer 104+ Days

Period	Lower CL
Feb 2021	7.8

Value	Median
36	31.0

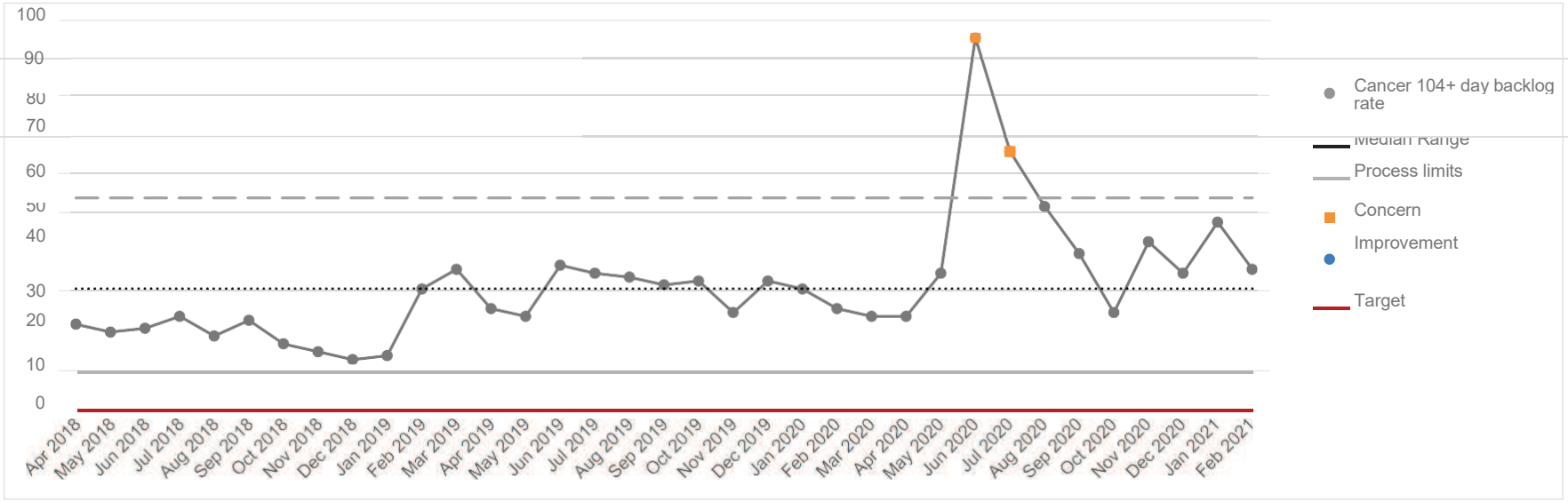
Target	Upper CL
0	54.2

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Number of patients waiting over 104 days since an urgent referral from a GP. Due to the national reporting timetable the figures reported are unvalidated.
Data is produced from Somerset Cancer Register.

The number of patients waiting 104+ days is within the expected range and close to the median.

Extended waiting times for endoscopy and CT Colons is due to the reduction in capacity for scoping procedures following the implementation of infection control measures. System wide monitoring is in place and were possible, additional capacity is being sourced in the independent sector.

Patients, that exceed a wait of 104 days may have cancer confirmed or may still be undiagnosed.

Action plans are in development to address the shortfall in endoscopy capacity.

The FIT pathway has commenced in Humber Coast and Vale (including N/NE Lincolnshire) and requests for FIT test have been implemented within NLaG (to risk stratify the backlog of patients waiting).

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Care Of Patients With Confirmed Diagnosis Transferred By Day 38

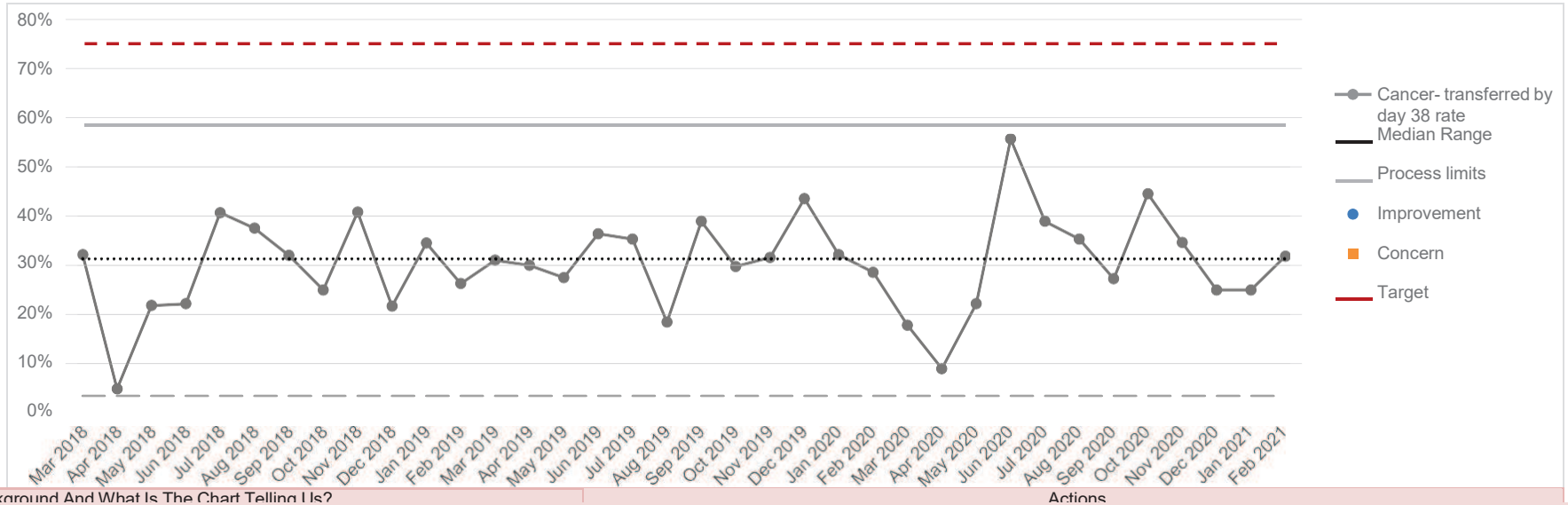
Period	Lower CL
Feb 2021	3.6%
Value	**Median**
31.8%	31.3%
Target	**Upper CL**
75.0%	59.0%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?

Percentage of patients on a 62 day cancer pathway who were transferred to another provider for treatment, that were transferred on or before day 38.
Data is produced from Somerset Cancer Register.
The chart shows that performance is significantly below target and it is unlikely that this standard will be achieved in year.

Actions

consultants delays Inter provider Transfer beyond Day 38 for all urology surgical patients – of which for prostate this is circa 70% of patients. Oncology waiting times for consultant appointment are 21+ days (across all tumour sites).

Issues And Risks

figures reported are unvalidated.

Mitigations

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Cancer Request To Test In 14 Days

Period	Lower CL
Feb 2021	75.7%

Value	Median
83.5%	83.5%

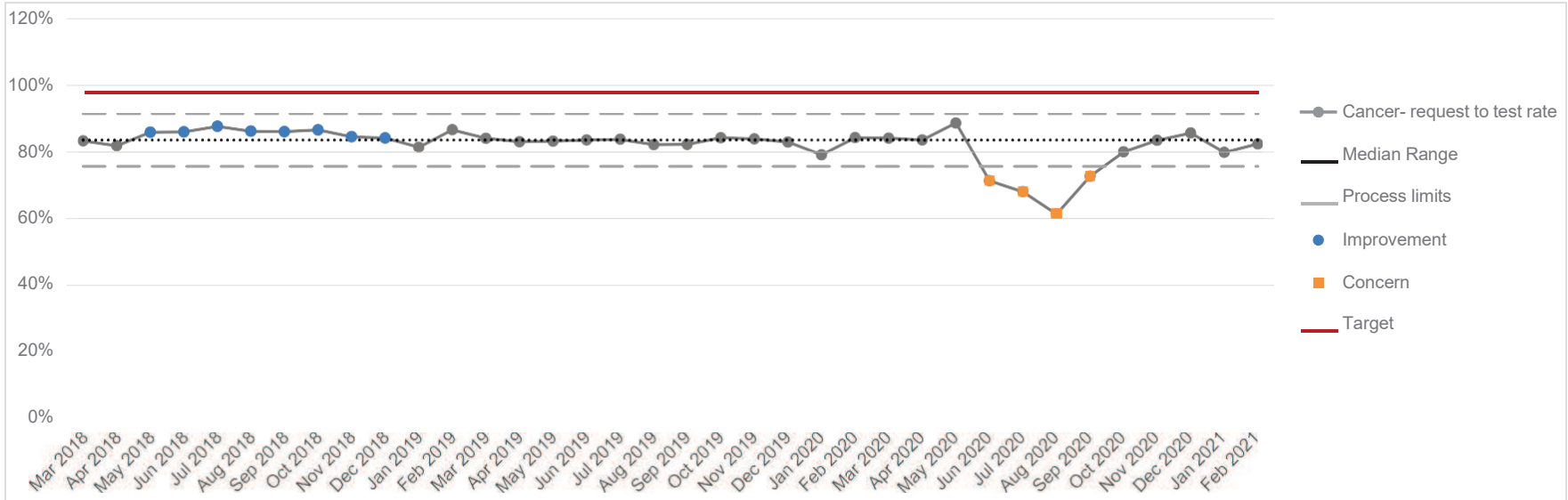
Target	Upper CL
100.0%	91.3%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
This indicator is based upon the percentage of patients on a 31 or 62 day cancer pathway who had a diagnostic test requested, who were seen within 14 days of the test request. Data is produced from the Somerset Cancer Register. The chart is showing that the process is within the control limits however the target has not been met; though performance is on an upward trajectory.	Improvements have been implemented maximise capacity to meet request the test within 7 days. The report turnaround time for 31/62 day pathways is 4 days and will actually achieve request to report in 14 days.

Issues And Risks	Mitigations
	Services have work collaboratively with the cancer team to introduce a process of clear identification of 31/62 day referrals. The was piloted within CT and is a priority for roll out once the impact of the pandemic subsides.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Percentage Of A&E Under Four Hours

National Indicator

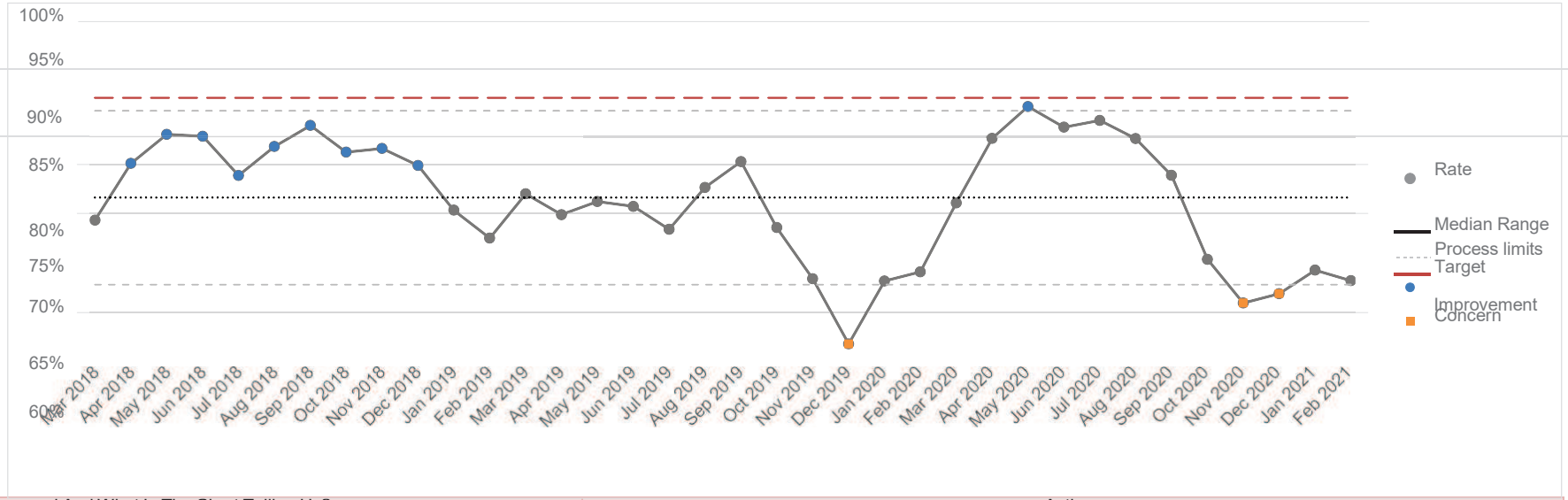
Latest Month	Lower CL
Feb 2021	72.9%
Value	**Median**
73.3%	81.8%
Target	**Upper CL**
92.0%	90.7%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?

Data is produced originally from Symphony, via data warehouse and Patient Care Data Model.

Performance is below target, however the Trust will not meet the national 92% or the local target of 85.3% if performance continues on this trajectory.

Actions

Discharge to assess initiative to enable prompt discharges and create improved bed occupancy levels.
NHS111 First Initiative to reduce avoidable ED attendances.
ED Medical Recruitment Strategy.
NHSE/I ECIST Support.
New ED/AAU build in development.

Issues And Risks

challenges and delays for patient pathway through the ED.
Medical and nurse staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skill mix.
Delays in diagnostic imaging at times.
Delays in specialty in-reach not meeting the less than 30min attendance to review.
Delays in mental health input out of hours resulting in long patient delays within ED for vulnerable patients.
Delays for patients in receiving assessment, treatment and/or admission.
Potential for patient harm if ongoing care not adequately met during prolonged waits in ED.
Negative impact on A&E 4hr performance and ambulance handovers.
Burnout for ED staff resulting in further recruitment and retention challenges.

Mitigations

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 pro-longed ED stays.
Medication and observations as required.
Support offered to staff for health and wellbeing.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: A&E Decision To Admit 12+ Hours

National Indicator

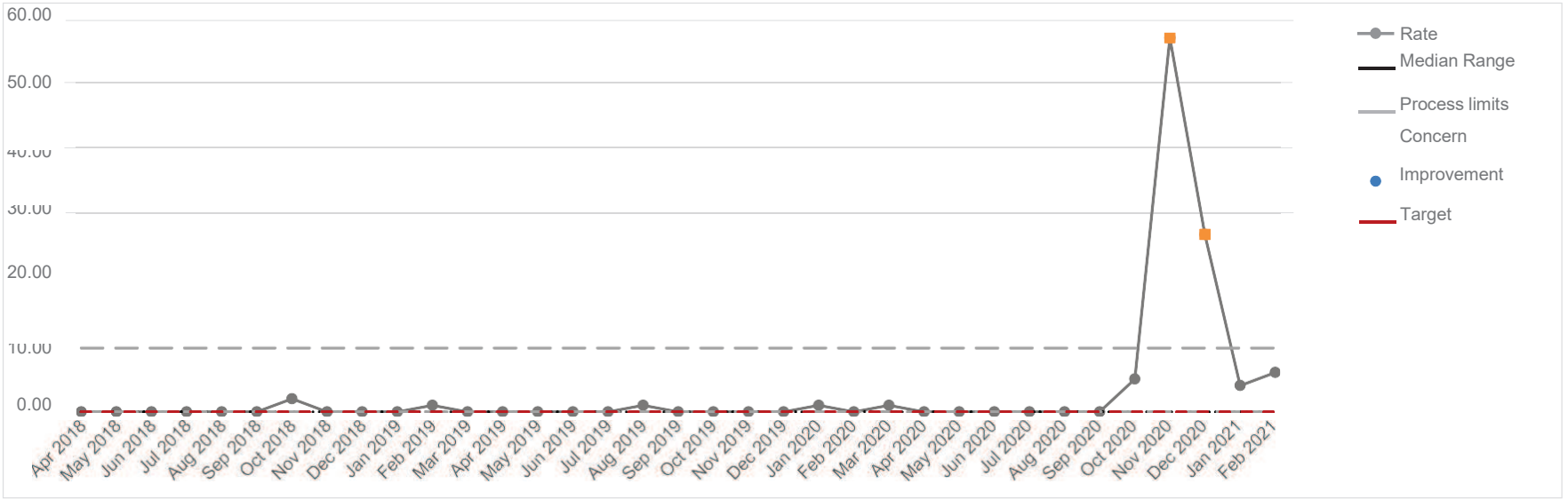
Period	Lower CL
Feb 2021	0.0
Value	**Median**
6.00	0.0
0.00	Upper CL 9.7

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Number of A&E attendances where the decision to admit was made over 12 hours before the patient was admitted.
Data is produced originally from Symphony via a validation by the Ops team with management sign off. Manual entry is then made.

The chart shows there have been 6 breaches against the target of 0 in month.

Discharge to assess initiative to enable prompt discharges and create improved occupancy levels.
IAAU to enable improved access for in-coming admissions.

A lack of patient flow through the hospital results in exit block from ED and long delays for patients awaiting admission
COVID-19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements.

Long waits for patients in ED when waiting for admission have potential to cause patient harm.

Increased staffing in ED.
2 hourly board rounds with EPIC and Clinical Coordinator.
Nursing care needs monitored through care round document – risk assess for pressure ulcers, falls, nutrition, hydration, comfort.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Ambulance Handover Delays 60+ Minutes

National Indicator

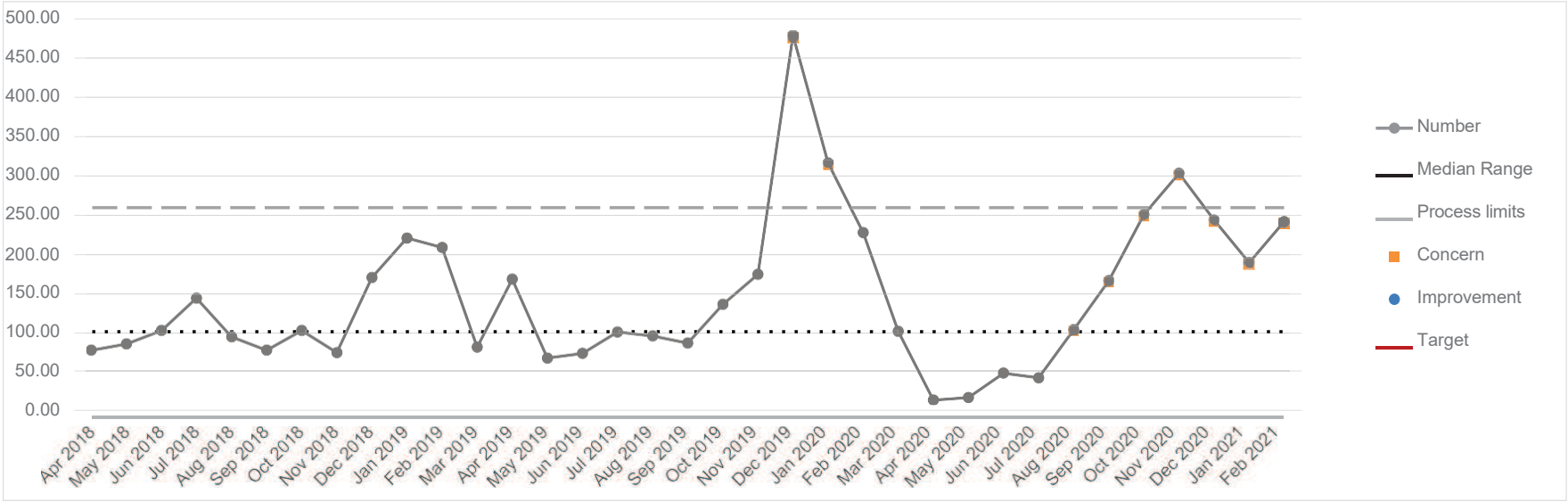
Period	Lower CL
Feb 2021	0.0
Value	**Median**
240	102.0
Target	**Upper CL**
0	259.8

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
The number of Ambulance Handovers that took over 60 mins. Data is produced from email from EMAS and Power BI Report from YAS, uploaded into data warehouse. Uses the time bands provided by EMAS and YAS. Does not include handovers for which one of the key times was not recorded. There is a high level of variation in the number of handover delays. The chart indicates that 188 breaches of 60+ minutes ambulance handovers occurred during January.	Ambulance Handover Task and Finish Group with system partners to drive improvement plan. System-wide Ambulance Handover Improvement Plan which includes 26 actions including reducing inappropriate conveyances by increasing hear and treat/see and treat; making the actual handover process as efficient and clinically safe as possible. New ambulance handover process with digital triage now in place.
Issues And Risks	**Mitigations**
60min+ breaches occur when the handover area is full and there are no clinical cubicles available to accept in-coming patients due to exit block from ED There were 888 breaches of the 15 minute standard and 288 breaches of the 30 minute standard. Infection control arrangements due to COVID-19 have created challenges in balancing the ward configuration to meet the changing demand of patient needs. Patients receiving delayed assessment and treatment whilst waiting in ambulances. Long ambulance waits for handover result in reduction of ambulances to attend emergencies in the community.	Ambulance Handover Improvement Plan. System-wide approach to driving change. Clinical review of patients waiting in ambulances. Prioritisation of patient handovers based on clinical risk/acuity.

Indicator: Inpatient Zero Day Length Of Stays

Local Indicator: Specification To Be Confirmed

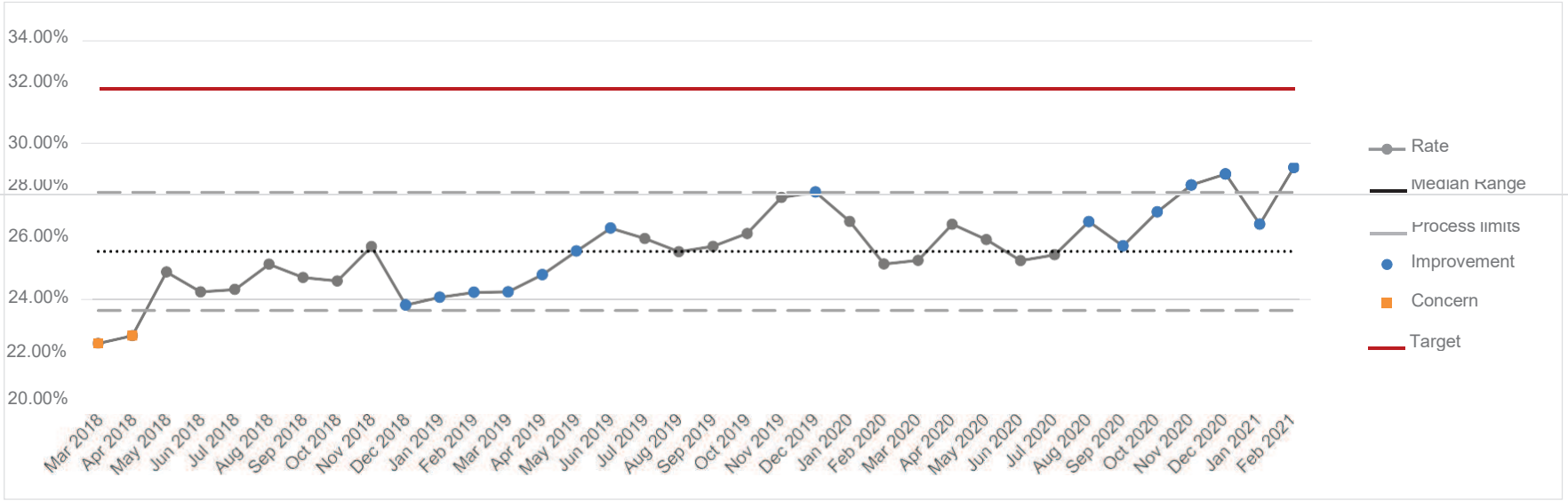
Period	Lower CL
Feb 2021	23.6%
Value	**Median**
29.0%	25.8%
Target	**Upper CL**
32.0%	28.1%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



The chart indicates that the total number of admitted patients staying at the Trust less than 1 day is decreasing in month but has been on an upward. trajectory to date. This is a positive outcome.
The number of patients with zero stay compared to the number of total patients with a hospital stay.

Data is produced from the Trusts CAMIS PAS system.

Target: Increase zero length of stay to 32%.

The Integrated Acute Assessment Units (IAAU) were opened at both hospital sites in October 2020. Their implementation has improved the patient flow to reduce exit block in ED and to increase the number of same day emergency care (SDEC) to avoid unnecessary admissions. SDEC activity has improved to 30%.Further work is required to increase the zero LOS performance in the elective pathways.

Whilst the overall 0 LOS appears to be below trajectory there has been significant work undertaken in the non-elective pathway primarily in the Integrated Acute Assessment Units where the 0 LOS performance is at 42.7%.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Patients Discharged With Right To Reside 7+ Days

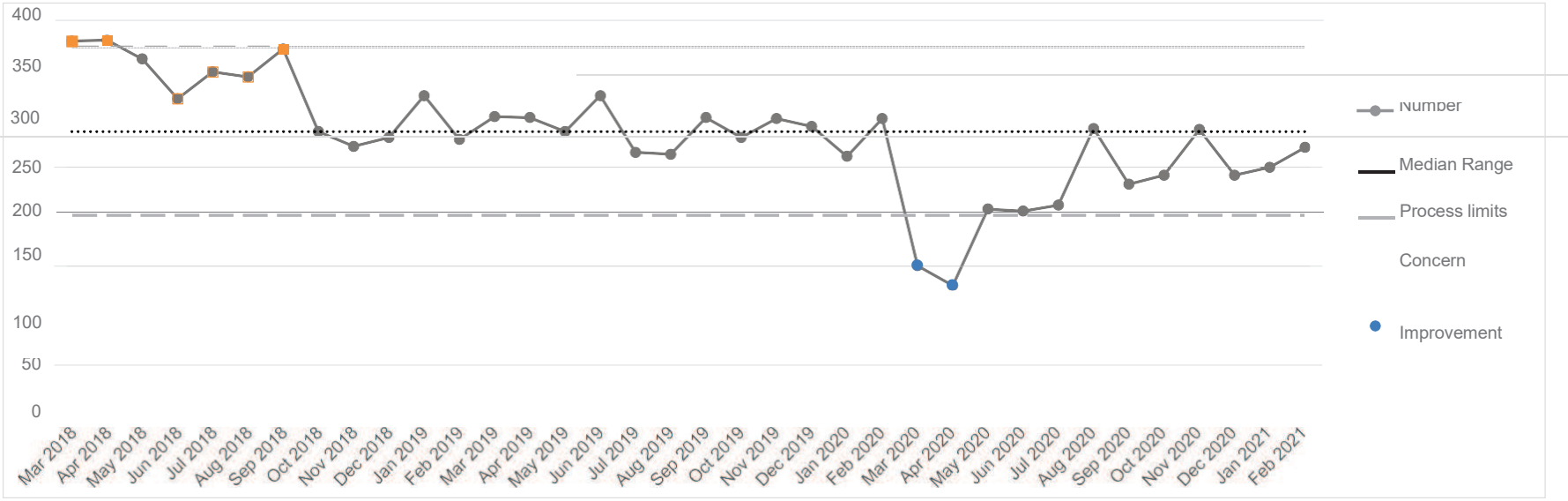
Period	Lower CL
Feb 2021	201
Value	**Median**
270	286
Target	**Upper CL**
No target	371

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



The chart indicates that the number of patients who are residing in the hospital for more than 7 days.

The discharge module on WebV will be able to record right to reside patients and therefore in the future this data will consist only of those patients when it is available.

Issues And Risks	Mitigations

Indicator: Patients Discharged With Right to Reside 21+ Days

Period	Lower CL
Feb 2021	47

Value	Median
60	74

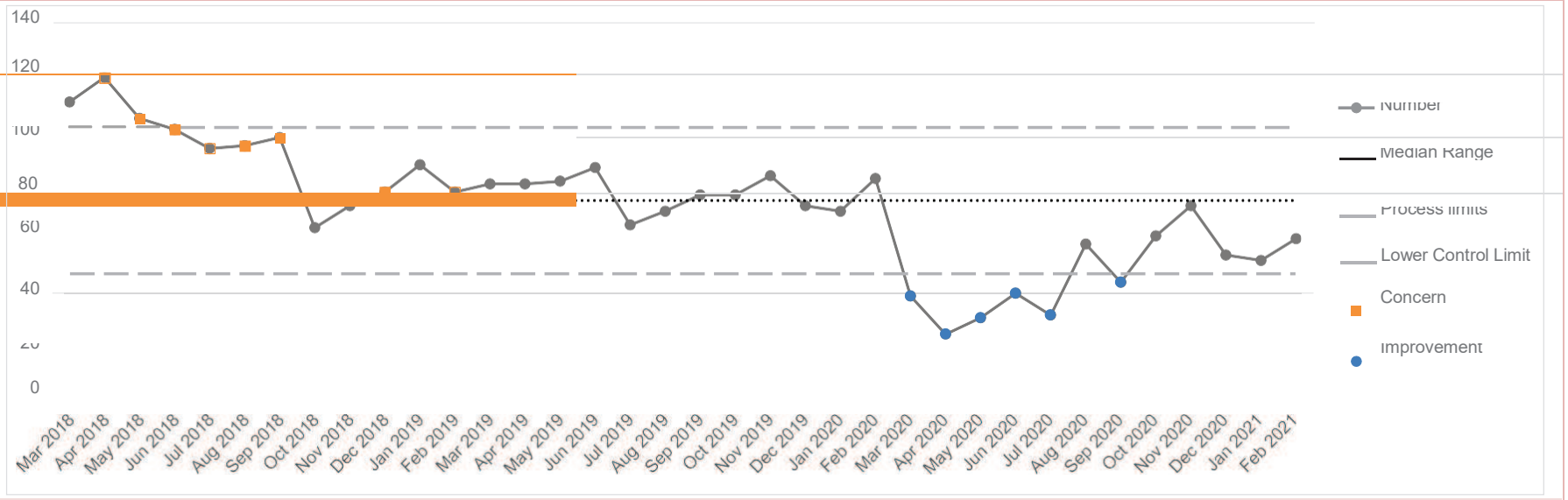
	Upper CL
No target	101

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



The chart is telling us that the process in inside the process limits. Clear consistent improving trend.

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: RTT 18 weeks

National Indicator

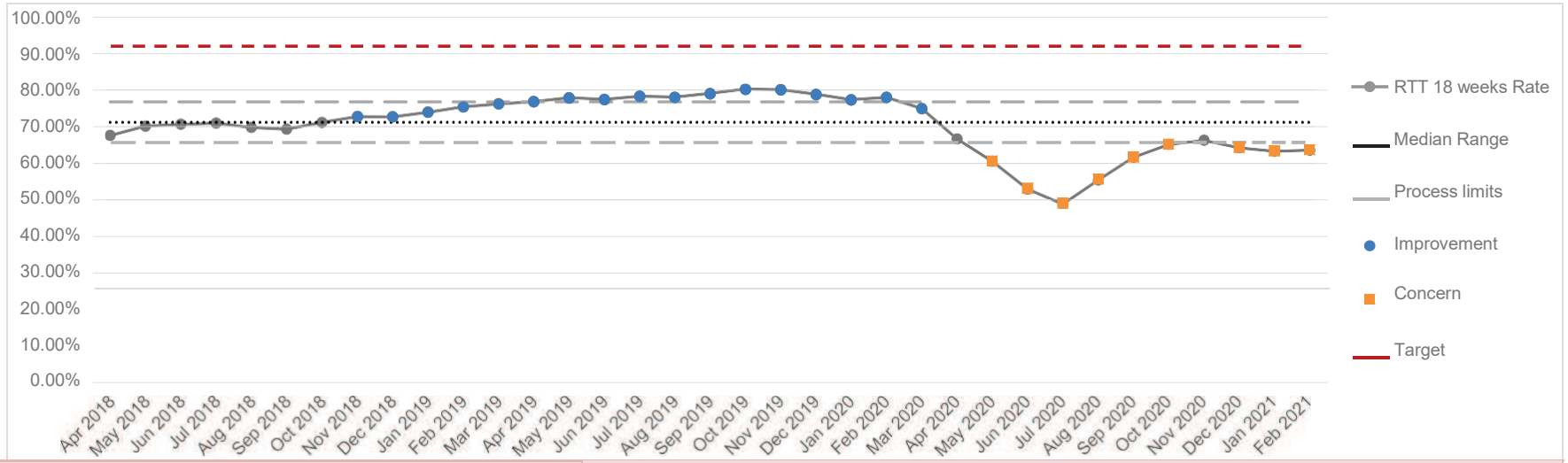
Period	Lower CL
Feb 2021	65.7%
Value	**Median**
63.7%	71.2%
Target	**Upper CL**
[illegible]	76.7%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?

clock has not stopped at the month end which generates this report.
Data is produced from the trusts CAMIS PAS system.

The chart is showing that delivery against RTT is outside of the control limits and below target.

The trust planned to deliver a waiting list size of 25,227 by 31 March 2021 to date the size of the waiting list is 27,959 and is on an upward trajectory.

Actions

addition, the Trust is using Medinet and Nu-medica to support an increase in elective capacity through the contracts being discussed currently. Patients on the inpatient list are being risk stratified. The outpatient clinics are being managed using a virtual modality where possible, but the numbers of discharges from outpatient lists is lower than previously seen. This is being looked at to understand the reasons and address these going forward.

Issues And Risks

Mitigations

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Number of patients on an RTT Incomplete pathway

Local Indicator - Specification Agreed and Reviewed

Period	Lower CL
Feb 2021	25,604

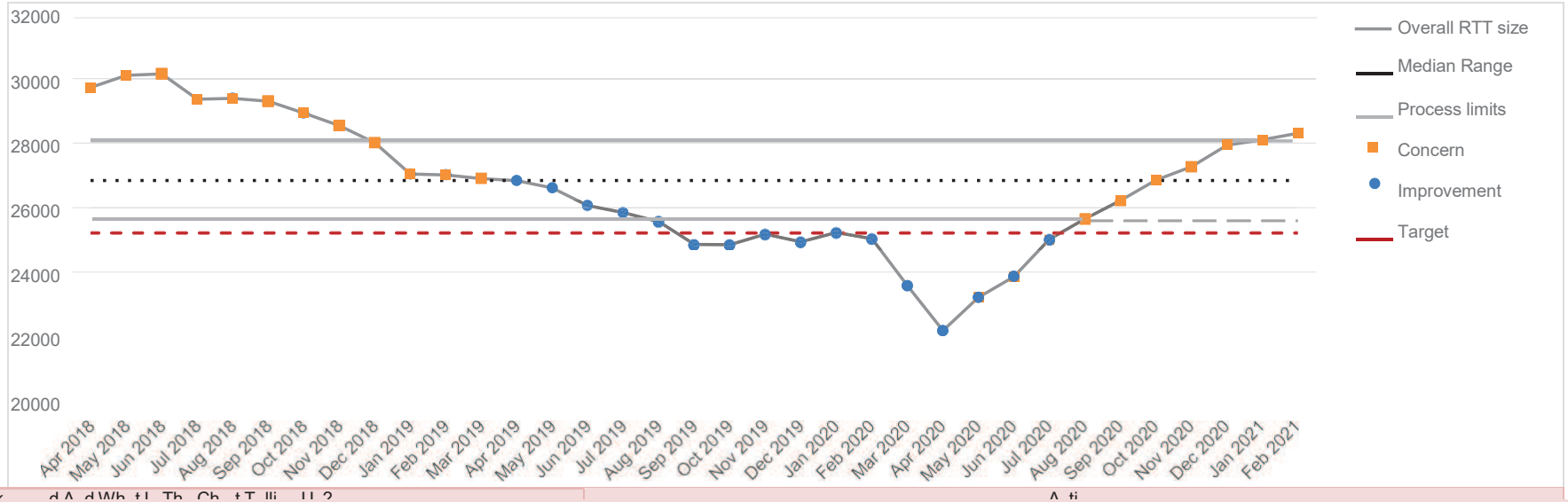
Value	Median
28,307	26,839
	28,074

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



The number of patients on an incomplete RTT pathway awaiting treatment at the end of the month.
The intention of this measure is to maintain the size of the waiting list as at March 2020 in line with national business planning guidance.

The total number of people on a RTT pathway waiting compared to the number on 31 January 2021.
CAMIS PAS.

The chart is showing that there has been a growth in number of patients on the RTT waiting list since April which puts delivery of the target at significant risk.
In April 2020 the waiting list was below target at 22,184 but has steadily increased throughout the year to date and continues on an upward trajectory.

The divisions/specialties are currently reviewing their performance against the Phase 3 plans and developing action plans to mitigate the position, maintaining focus on Cancer Urgent cases and +40 week waiters..

Issues And Risks

this may be deliverable we cannot lose sight of those patients being added to the waiting list following outpatient consultation. Therefore this is extremely challenging in the current circumstances.

Mitigations

Indicator: Number of 52 Week RTT Incomplete Breaches

National Indicator

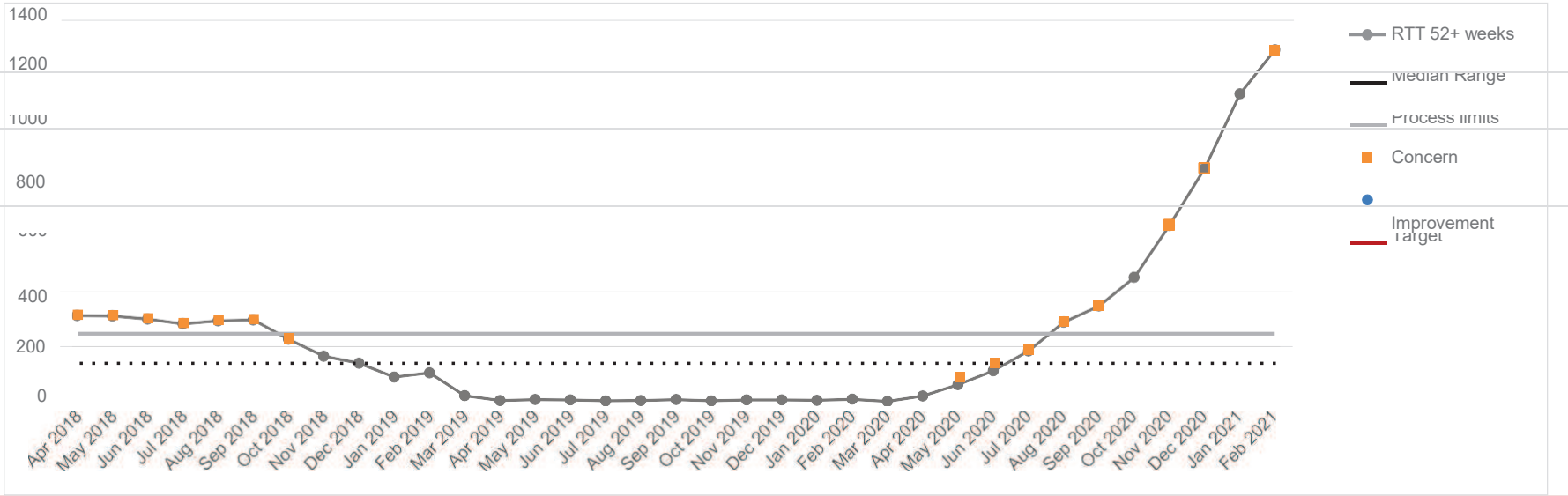
Period	Lower CL
Feb 2021	0
Value	**Median**
1,285	115
Target	**Upper CL**
0	247

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Incomplete RTT pathways waiting over 52 weeks. As per national definitions/guidance. CAMIS PAS. The chart indicates that the number of patients waiting in excess of 52 weeks. Is on an upward trajectory and the position is unlikely to recover in year.	Additional capacity has been created at Goole District Hospital through weekend working and capacity has been sourced in the local independent sector for surgical and diagnostic procedures.
The performance is as a direct result of the reduced elective operating capacity due to the theatre and anaesthetic response to supporting the high acuity of COVID-19 patients and the social distancing and patient choice. Prioritising clinically urgent and cancer patients into reduced theatre capacity	Significant progress has been made in creating additional capacity which includes both the use of Goole District Hospital and the Independent sector where the initial focus is on the treatment of urgent and cancer patients. All patients are being risk stratified and those in the highest clinical priority are being treated first. PTL meetings are held weekly, focussing on managing urgent, cancer and long wait patients according to NHS E/I guidance during Covid-19.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Diagnostic Measurement 01

National Indicator

Period	Lower CL
Feb 2021	2.2%

Value	Median
38.9%	14.3%

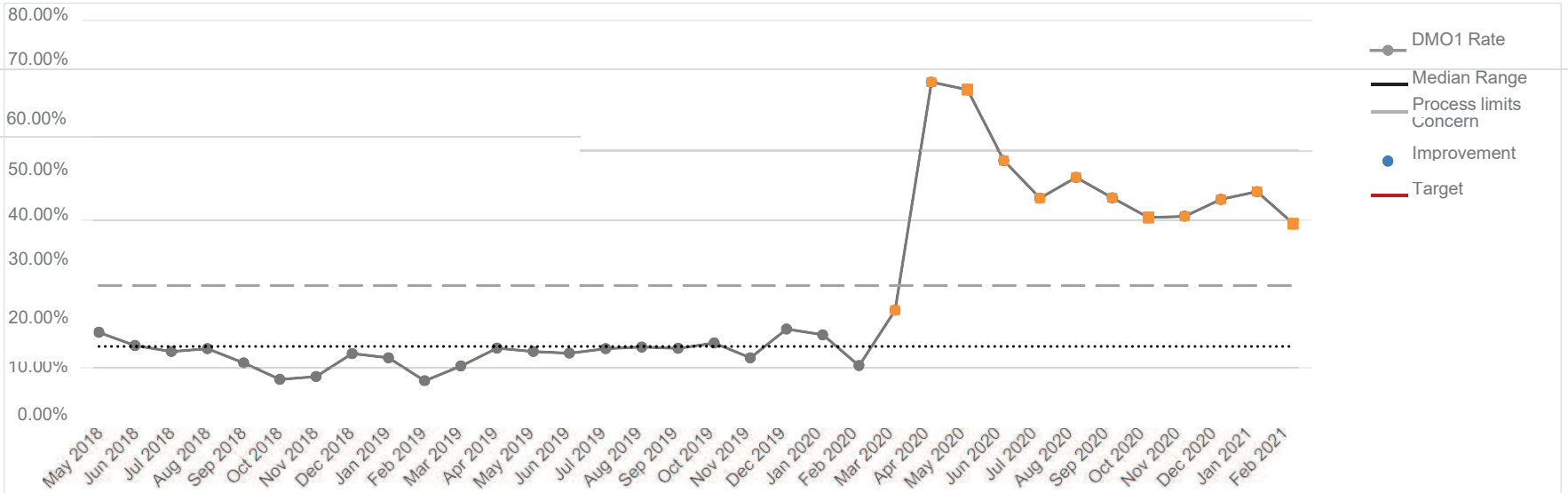
Target	Upper CL
1.0%	26.5%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?

The percentage of DMO1 diagnostics patients who have waited more than 6 weeks for their test to be completed.
The data is produced various systems fed in to our datawarehouse and extracted as per Monthly DM01 SDCS Return.

38.9% of the demand on the 12 diagnostic moalities are breaching against the national 6 week target for referral to diagnostic report completed. The chart indicates that there is a special cause which in this instance is the impact of the pandemic.

Actions

Audiology will now receive referrals ahead of the ENT appointment.
A private sector provider for NOUS has been identified to provide additional capacity, negotiations are in progress.
CT colonoscopy capacity continues to be of concern and the division is exploring the feasibility of undertaking Capsule Endoscopy.
Recruited 1 Consultant Radiologist.
Good recruitment into General Radiology with a view to rotation into specialties.

Issues

Lost capacity due to poor patient compliance because of fear of catching COVID in the hospital setting.

CT Colon capacity remains a concern – 2ww position improving, looking at capsule endoscopy to support waiting list position.

Mitigations

Medinet referrals for lung function tests and endoscopy should be streamlined to aid capacity management.
Request to extend MRI mobile contracts to maintain current capacity levels beyond April.
Potential delay with DPOW MRI scheme – notified 12/2/21.
Dialogue with Surgery and Medicine to support capsule endoscopy pilot.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Number of outpatients overdue their follow up appointment

Local Indicator - Specification Agreed and Reviewed

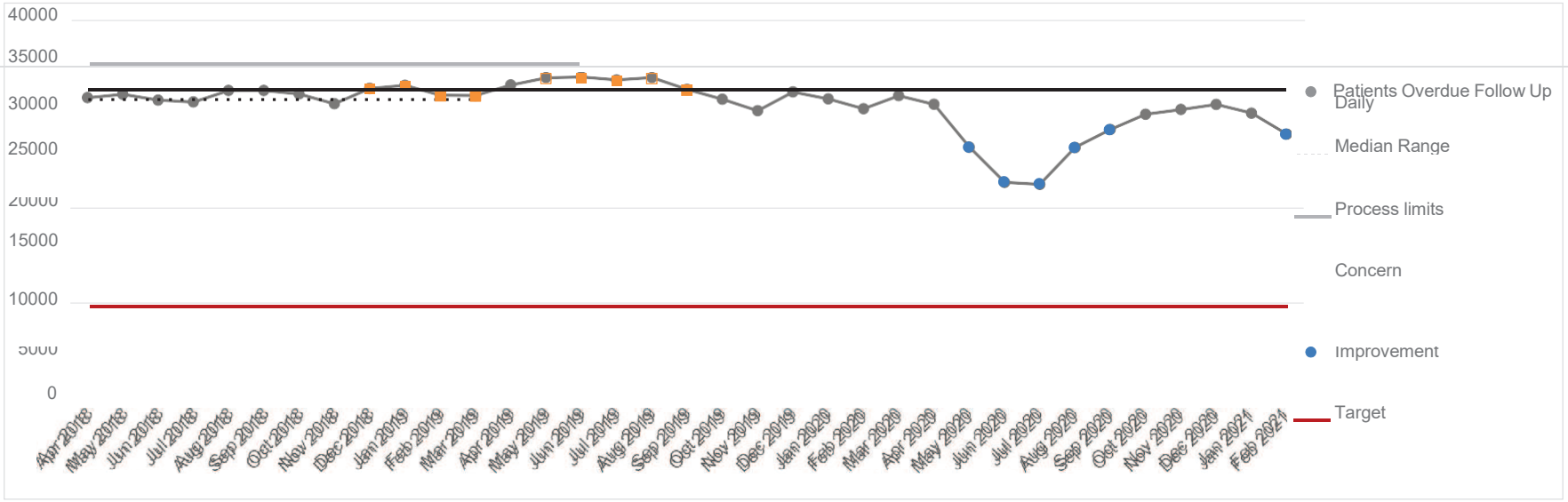
Period	Lower CL	Median	Target	Upper CL
Feb 2021	28,474	31,469	9,000	34,464
27,803				

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



The total number of overdue follow up outpatient waiters not on an active RTT pathway, combined across the Trust. This is a local indicator agreed with the CQC to avoid the application of a Section31.
Data is produced from CAMIS PAS.

The chart shows that our performance of our outpatient overdue follow up is not delivering the agreed target of set with the CQC and local commissioners which we aimed to achieve by March 2021.
The chart shows that whilst performance is within the process limits, the trust is unlikely to achieve the target.

Non-face to face telephone appointments and video consultations have been introduced.

All specialities have implemented patient initiated follow ups, though to date the numbers are small.

ENT, General Surgery, Breast, Paediatrics, Gynaecology, Respiratory, Haematology and General Medicine are all achieving targets/trajectories that have been set.

All other specialties working with PCN's

Following the significant drop over the summer, due to the introduction of virtual appointments, the numbers are beginning to increase. This has further been exacerbated by the 2nd wave of COVID. Outpatient work has been impacted on by the amount of ward work that our medical teams are having to support.

All specialties have implemented Patient Initiated Follow Up (PIFU) though to date numbers are small. Specialties continue to work with clinical teams to roll out. Virtual appointments and PIFU.

On going work with the primary care network.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Average Length Of Stay (Elective and Non Elective)

This is a Local Indicator: Specification To Be Confirmed

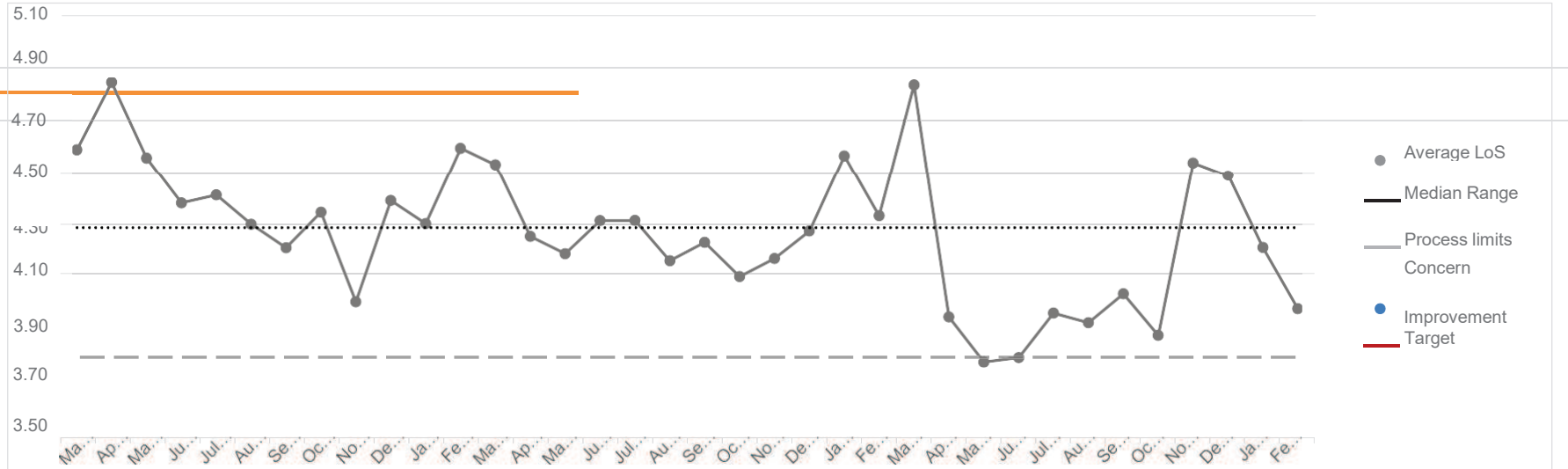
Period	Lower CL
Feb 2021	3.8
Value	**Median**
3.99	4.3
Target	**Upper CL**
4.0	4.8

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?

The average length of stay (elective/non elective) compared to the target of less than 4 days.

This excludes daycase patients.

Data is produced from the CAMIS PAS.

The chart is telling us that we are inside the control limits and this month nearly acheiving the target.

Actions

The Northern Lincolnshire system have agreed three main actions going forward which will enable the trust to fully embed the hospital discharge policy set out by the government in August 2020.
Knowledge and education at ward level to enable the hospital to enact a safe and timely discharge.
Quality of Discharge to Assess Referrals to enable the community Hubs to enact a safe and timely discharge.
Implementation of senior multi-disciplinary board rounds to identify those patients who no longer have a criteria to reside in an acute hospital bed.

Issues And Risks

place through board rounds to maintain this.

Mitigations

support.
Education to all consultants around effective board rounds.
Continuous support and monitoring for board rounds ensuring everyone understands roles & responsibilities.
Education and sup-port to all wards around roles & responsibilities with a clear escalation plan in place for ward support.
Web V Discharge module in final stages of development which will support the DQ for discharge to Assess.

Indicator: Outpatient Letters

Local Indicator: Specification To Be Confirmed

Period	Lower CL
Feb 2021	27.5%

Value	Median
40.0%	35.7%

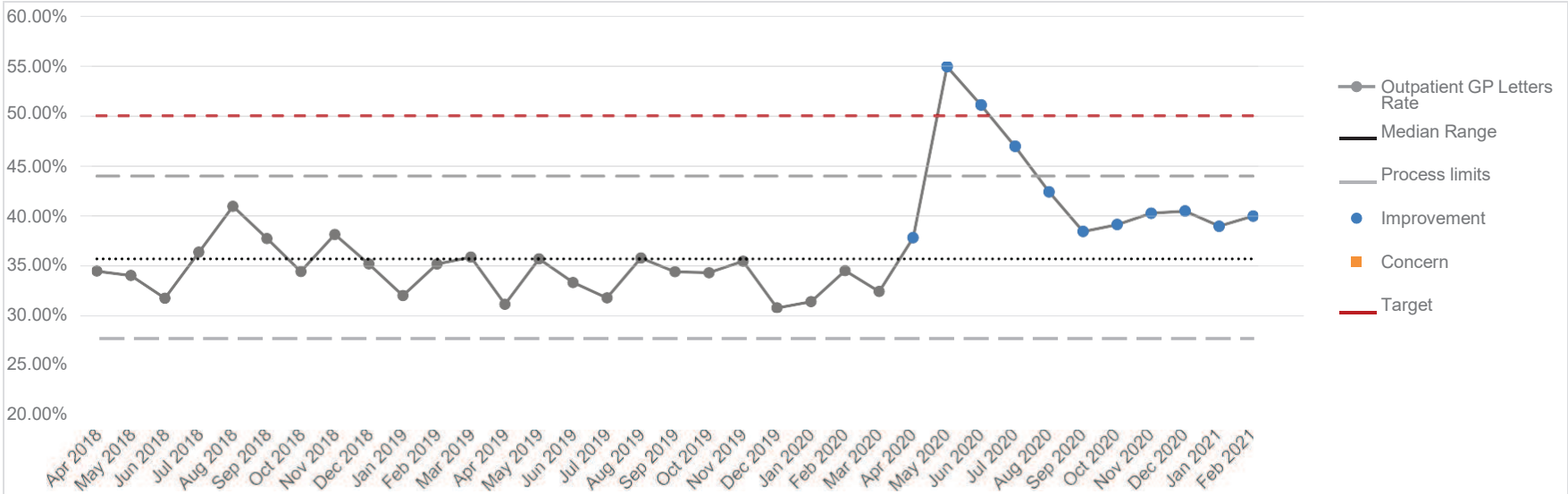
Target	Upper CL
50.0%	44.0%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Percentage compliance of letters sent to GPs within 7 days of appointment compared to the 50% target.
Data is produced from Dictate IT.

The chart indicates that performance is improving and is on an upward trajectory.

Some doctor's job plans only have 1 admin session per week scheduled.
The development to utilise back end speech recognition for all typing in Dictate IT.
Out-patient functionality is being developed on WebV as a potential alternative solution to DictateIT.
Letters with the longest delays are raised fortnightly at the Patient Access Working Group and shared weekly at the PTL meeting.
All Clinicians have identified a deputy / deputies who can sign on their behalf.
A proposal has been submitted to the DCD/Operational Management to review the option of sending as "dictated but not signed by" if letters are sat in the e-approve stage for more than 7 days.

The lowest five performing specialities are Looked After Children, Endocrine/Diabetes, ENT, Dermatology and Urology (all under 20% of their out-patient summaries reach the recipient within 7 days).

The overall process of dictate, transcribe, admin review, e-approve, distribute, does not lend itself to a 7 day turnaround. A business case principle was agreed, but must remain cost neutral which led to back end speech recognition to be piloted and project plans commenced to roll this approach out, but since stopped.

Web V are developing an out-patient module which could further support a more effective turnaround time of out-patient summaries and the connected health network admin model may also produce a more effective turnaround time of out-patient summaries.

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Progressive Improvement In The Rate Of Golden Discharges

Local Indicator: Specification To Be Confirmed

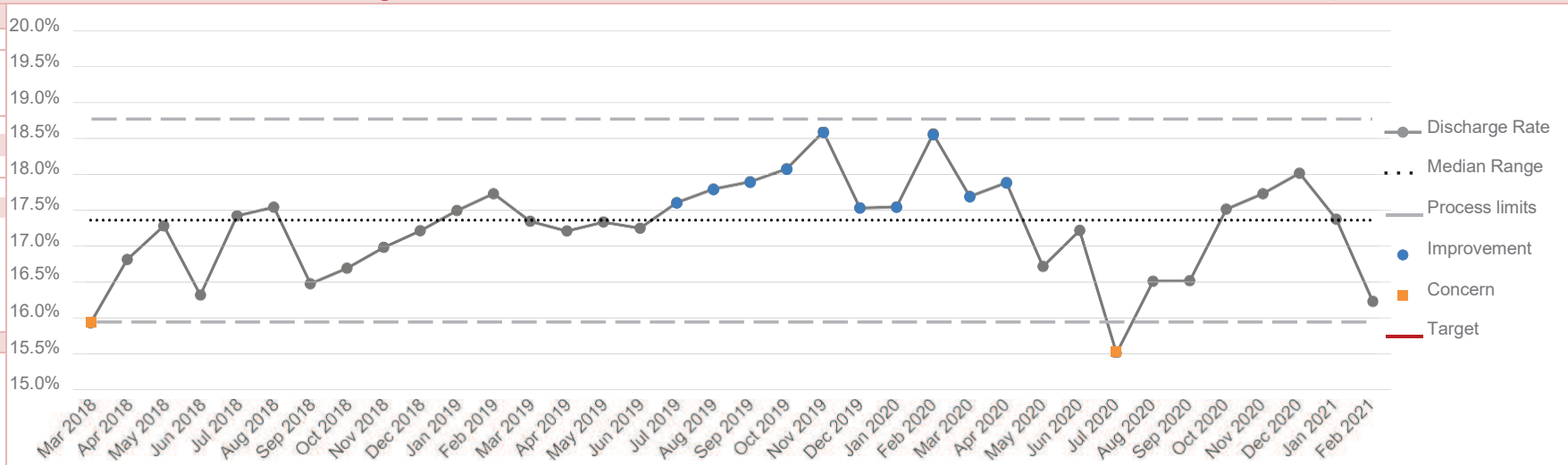
Period	Lower CL
Feb 2021	15.9%
Value	**Median**
16.2%	17.4%
Target	**Upper CL**
35.0%	18.8%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?

The aim of this indicator is to ensure all steps are in place to enable fully optimised patients to be discharged in a timely manner; before 12 noon.

The data is from the CAMIS PAS system..

The chart is telling us that performance is variable but is inside the current control limits.

Actions

Each day the wards identify these patients on the basis that: patients who are medically optimised and can return to their usual place of residence with no ongoing care (Pathway 0) these patients are then taken to the discharge lounge within 1 hour of identification and TTO's Discharge letters are then sought to enable return home. Patients who are medically optimised who may require a level of ongoing care (Pathway 1-4) for these patients the ward complete a discharge to assess form with patient detail via web V, the discharge to assess team then action this ensuring a plan for discharge is made within 24 hours, the aim is to assess the patient once they return home rather than in an acute setting.

Issues And Risks

Mitigations

Engagement with clinical teams has improved and board rounds are being rolled out across all wards..

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Risk Stratification - Outpatients

Local Indicator - Specification Agreed and Reviewed

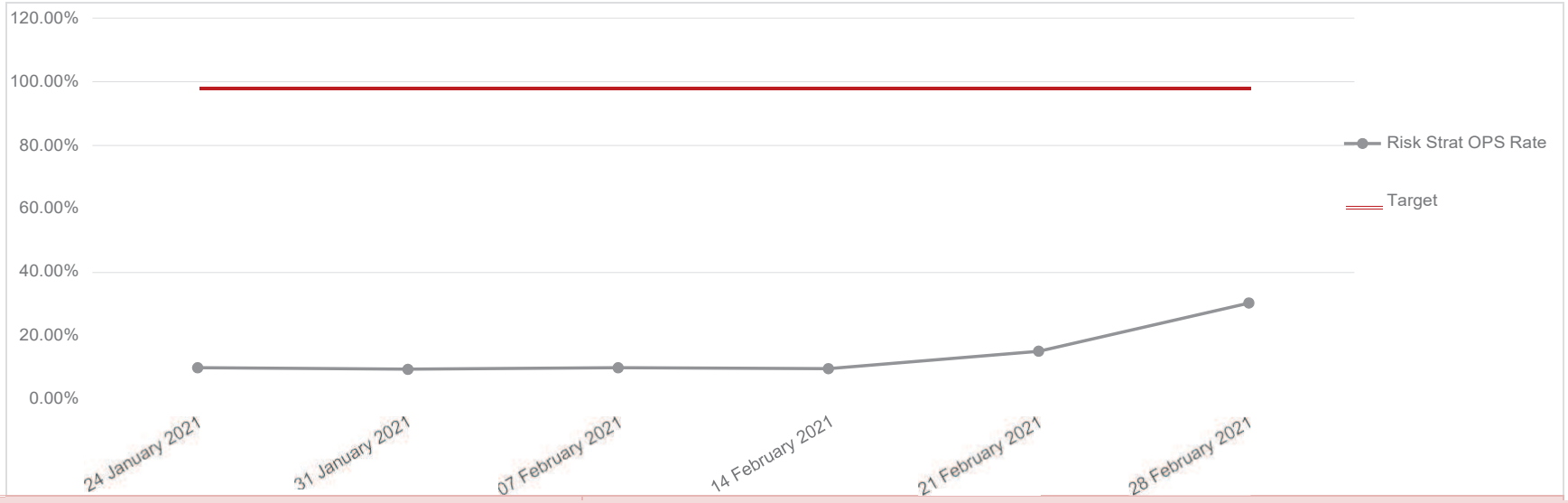
Period	Lower CL
Feb 2021	No Lower CL
Value	**Median**
30.4%	No Median
Target	**Upper CL**
99.0%	No Upper CL

Variance

There are currently insufficient data points for an SPC chart

Assurance Inconsistency

There are currently insufficient data points for an SPC chart



Percentage of patients who have been risk stratified on outpatient pathway.
Data is produced from CAMIS PAS system.

Insufficient data point to create an SPC.

Risk stratification for outpatients is significantly below target.

Work is underway with the PCNs to risk stratify some of the medical specialty outpatients, circa 9000 to be completed by 31/3/21.

Plan in place for all 52 week waiters and all new patients to be risk stratified by the end of March 2021.

All specialities working towards there agreed targets with trajectories applied to risk stratify the follow ups.

Clinical availability is a pressure as there are a significant number of conflicting priorities at this time.

Glossary of Terms		
A-	A&E	Accident and Emergency
	AAU	Acute Assessment Unit
	AGM	Assistant General Manager
B-	BAF	Board Assurance Framework
	BE	Barium Enema
C-	CT	Computerised Tomography
D-	DEXA	Dual Energy X-ray Absorptiometry
	DTA	Decision to Admit
E-	ED	Emergency Department
F-	FFT	Friend and Family Test
	FIT	Faecal Immunochemical Test
	F2F	Face to Face
G-		
H-	HCSA	Healthcare Support Assistant
	HCSW	Healthcare Support Worker
	HCV	Humber, Coast and Vale
	HSMR	Hospital Standardised Mortality Ratio
	HUTH	Hull University Teaching Hospitals
	HWB	Health and Well Being Board
I-	IAAU	Integrated Acute Assessment Unit
	ICC	Incident Command Centre
	ICS	Integrated Care System
	IPR	Integrated Performance Report
	IT	Information Technology
	IV	Intravenous
J-		
K-		
L-	LoS	Length of Stay
	LTR	Labour Turnover
M-	MRI	Magnetic Resonance Imaging
	MRSA	Methicillin-resistant Staphylococcus Aureus
	MSSA	Methicillin-susceptible Staphylococcus Aureus
N-	NEL	North East Lincolnshire
	NEWS	National Early Warning Score
	NL	North Lincolnshire
	NHS	National Health Service
	NHSE/i	National Health Service England/Improvement
	NLAG	Northern Lincolnshire and Goole
	NOUS	Non-Obstetric Ultrasound
O-	OEWS	Obstetric Early Warning Score
P-	PEWS	Paediatric Early Warning Score
	PIFU	Patient Initiated Follow Ups
	POE	People and Organisational Effectiveness
	PTL	Patient Treatment List
Q-		
R-	RAG	Red-amber-green
	RTT	Referral to Treatment
	SDEC	Same Day Emergency Care

Glossary of Terms		
S-	SHMI	Summary Hospital-Level Mortality Indicator
	SJR	Structured Judgement Review
	SPC	Statistical Process Control
T-		
U-		
V-	VTE	Venous Thromboembolism
W-		
X-		
Y-		
Z-		

Ref	Source	Metrics	Jan 2021 unless otherwise stated	Target / Trajectory	Variation	Assurance
		National Requirements				
1	Nat	Mixed-sex accommodation breaches *(Not being measured nationally during the NHS Pandemic Response)*	N/A	0		
2	Nat	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0		
3	Nat	Methicillin - susceptible Staphylococcus aureus (MSSA) bacteraemias	2	no target		
4	Nat	Escherichia coli (E.coli) bacteraemia bloodstream infection (BSI)	2	no target		
5	Nat	Trust attributed C-Diff	1	<3 per month		
6	Nat	Number of gram-negative bloodstream infections	3	no target		
7	Nat	Venous Thromboembolism (VTE) risk assessment	74.51%	95%		
8	Nat	Duty of candour (Relating to Serious Incidents)	100.00%	no target		
9	Nat	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites. *(Not applicable to Trust - HUTH prescribe chemotherapy)*	N/A	N/A		
10	Nat	Emergency C-section rate	14.10%	<=15.2%		
11	Nat	National Patient Safety Alerts to be actioned by specified deadlines	100.00%	100%		
12	Nat	Occurrence of any Never Event	1	0		
13	Nat	Dementia assessment and referral: the number of patients aged 75 and over admitted as an emergency for more than 72 hours: **a)** who have a diagnosis of dementia or delirium or to whom case finding is applied *(Data not currently available)*	N/A	90%		
14	Nat	Dementia assessment and referral: the number of patients aged 75 and over admitted as an emergency for more than 72 hours: **b)** who, if identified as potentially having dementia or delirium, are appropriately assessed *(Data not currently available)*	N/A	90%		
15	Nat	Dementia assessment and referral: the number of patients aged 75 and over admitted as an emergency for more than 72 hours: **c)** where the outcome of b0 was positive or inconclusive, are referred on to specialist services *(Data not currently available)*	N/A	90%		
		Trust Quality Priorities				
		Quality Priority 1: Improve the Trust Waiting List:				
16	QP	Reduce delayed transfers of care to 60 (move flow and access) *(Data not currently available)*	N/A	N/A		
17	Nat	The number of patients overdue their follow up for an outpatient review.	29661	9000		
18	Nat	Number of incomplete RTT pathways 52 weeks	1127	0		
19	QP	The overall RTT waiting list to be less than it was on 31 January 2020	28106.00			
20	QP	50% of out-patient summary letters to be with GPs within 7 days	40.30%	50%		
21	QP	Reduce the number of face to face follow up appointments by 10% by the 31 March 2021	10702	15903		
		***NB:** For more detailed information on performance against these quality priorities, including SPC charts, please refer to the Access and Flow section of the Integrated Performance Report.*				
		Quality Priority 2: Reduce mortality rates and strengthen end of life care				
22	Nat	Hospital Standardised Mortality Ratio (HSMR) - **Data is for December 2020**	104	100		
23	Nat	Summary Hospital level Mortality Indicator (SHMI) - **Data is for September 2020**	106	100		
24	QP	Mortality Screen of 50% of deaths	84.0%	50%		
25	QP	Structured judgment review (SJR) in 100% of those requiring a review	21.0%	100%		
26	QP	Adults: Timeliness of observations within 30 minutes of due time	89.35%	>85%		
27	QP	Children: Timeliness of observations within 30 minutes of due time	88.24%	>85%		
28	QP	Improve frequency of sepsis screening and robustness of reporting	7.46%	Improvement		

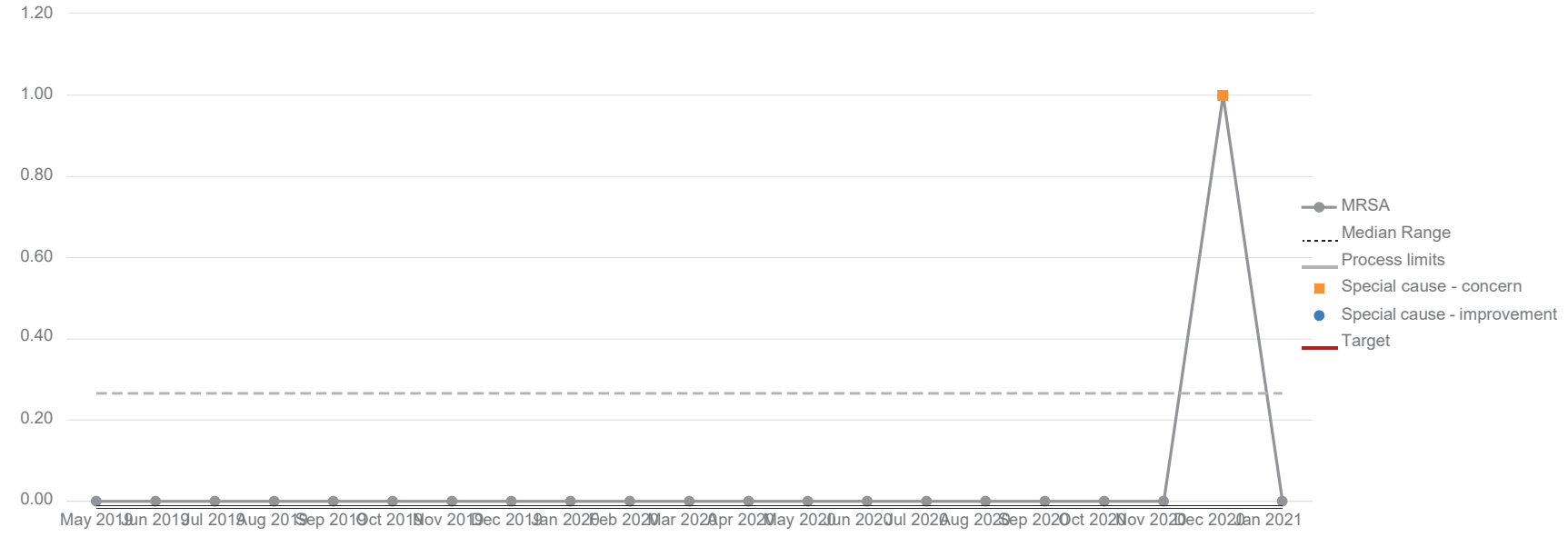
29	Nat	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis *(Data currently not available)*	N/A	90%		
		Quality Priority 3: Improve the management of diabetes				
30	QP	Improvement in monitoring of blood sugar in patients with diabetes - DPoW - **Data is for December 2020**	78.9%	no target		
31	QP	Improvement in monitoring of blood sugar in patients with diabetes - SGH *(Data currently not available)*	N/A	no target		
32	QP	5% reduction in insulin errors causing significant harm in 20/21	0	0		
33	QP	Diabetes role specific training compliance	84.1%	>85%		
34	QP	Blood glucose taken in ECC if NEWS over 1 for adults	95.0%	100%		
35	QP	Blood glucose taken in ECC if PEWS over 1 for children	80.00%	100%		
		Quality Priority 4: Cancer Pathways				
36	QP	Percentage of service users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or ruling out of cancer	64.6%	75%		
37	QP	Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	21.7%	75%		
38	QP	100% cancer request to test report to be no more than 14 days	80.8%	100%		
39	QP	Develop a clear service model and a Trust target to ensure that cancer services are maintained *(Data currently not available)*	N/A	N/A		
40	QP	Number of combined site MDTs to be 100%	100.0%	100%		
		***NB:** For more detailed information on performance against these quality priorities, including SPC charts, please refer to the Access and Flow section of the Integrated Performance Report.*				
		Quality Priority 5: Safe flow and discharge				
41		Reduction in the average length of stay to less than 4 days	4.20	4.0		
42		% of patients who were discharged on the same day as admission (non-elective)	26.9%	32%		
43		Sustained improvement in the 0 – 1 day length of stay *(Data currently not available)*	N/A	N/A		
44		5d) Reduction in non-elective length of stay to less than 4.1 days	4.40	4.1		
45		5e) Reduction in elective length of stay to less than 2.4 days	2.30	2.4		
46		5f) Reduction in the number of medical outliers	2045.00	N/A		
47		5g) 85% of discharge letters to be completed within 24 hours post discharge	88.5%	85%		
48		5h) Progressive improvement in the number of golden discharges from April 2020 (target: 35%)	17.5%	35%		
49		5i) b) Increase in A&E performance to 92% (national target)	74.4%	92%		
50		5j) Reduction of non-emergency patient transfers at night after 10pm by 10% (Target: 48)	187.00	48		
51		5k) Reduction in average ward moves for non-elective patients for non-clinical reasons by 7% (Target: 128)	451.00	128		
52		5l) Number of early supported discharges to increase by 10% *(Data currently not available)*	N/A	N/A		
53		5m) Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire *(Data currently not available)*	N/A	N/A		
54		5n) All patients requiring mental health support in ED will be assessed within 4 hours of referral *(Data currently not available)*	N/A	N/A		
55		5o) Patient in in-patient wards will be assessed and have a plan in place within 8 hours of referral *(Data currently not available)*	N/A	N/A		
		***NB:** For more detailed information on performance against these quality priorities, including SPC charts, please refer to the Access and Flow section of the Integrated Performance Report.*				
		Quality Priority 6: Complaints & Patient Feedback				
56	Nat	Inpatient scores from Friends and Family test - % positive *(Data currently not available)*	N/A	N/A		
57	Nat	A&E scores from Friends and Family test - % positive *(Data currently not available)*	N/A	N/A		
58	Nat	Maternity Scores from Friends and Family Test - % positive *(Data currently not available)*	N/A	N/A		
59	Nat	Community Services Score from Friends and Family Test - % positive *(Data currently not available)*	N/A	N/A		
60	Nat	Staff Friends and Family Test % *(Data currently not available)*	N/A	N/A		

61	Nat	Written Complaints Rate	6.6	no target		
62	QP	85% Pals responded to in 5 working days by the 31 January 2020 [Amended]	46.0%	85%		
63	QP	**NEW Indicator** 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 2021	6.00	100%		
64	QP	**NEW Indicator** 100% of all complaints on 'old' process pathway to be closed by 28 Feb 2021	10.00	100%		
65	QP	85% of all complaints resolved within timescale by the 31 July 2021	25.0%	85%		
66	QP	85% of reopened complaints resolved within 20 working days by the 30 November 2020 (Quarterly)	25.0%	85%		
67	QP	100% Complaints acknowledged within 3 days by the 31 July 2021	100.0%	100%		
68	QP	100% complainants offered a face to face meeting during initial resolution planning by the 31 Dec 2020 [Amended]	100.0%	100%		
69	QP	100% of all upheld complaints to have evidence of learning by the 31 October 2020	83.0%	100%		
70	QP	100% formal complaint responses reviewed by Chief Nurses Office by the 31 July 2020 [Amended]	100.0%	100%		
71	QP	50% reduction in reopened complaints by the 31 January 2021	3.00	50%		

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Methicillin-resistant Staphylococcus Aureus (MRSA)

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	0	0			



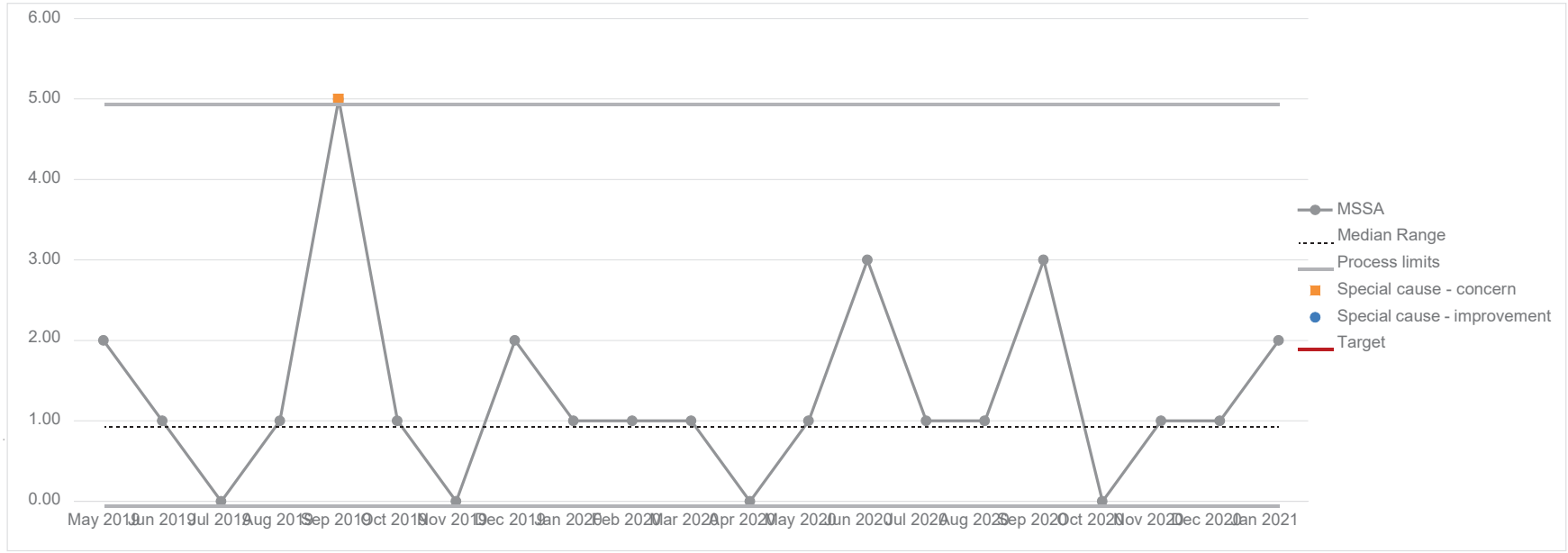
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us we have had no reported cases this month.	Patients experiencing a MRSA Bacteraemia. MRSA bacteraemia cases which Public Health England have apportioned to the Trust upon consideration of the evidence submitted. The data is produced by taking a rolling 12-month count of trust assigned MRSA infections out of a rolling 12 month average occupied beds days multiplied by 100,000. The organism data comes through into the IPC module (in WebV) from PathLinks as the results are available. The Infection Control Team submits the all the organisms and not just the trust assigned cases PHE England via the HCAI DCS Mandatory Surveillance website. The cases are trust assigned based on compled rules determined by PHE which vary by organism. This is a monthly submission and is a national requirement.		In December, after a year and half the Trust experienced the first MRSA bacteraemia. Full investigation undertaken, however there is no evidence of cross infection.

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Methicillin - susceptible Staphylococcus Aureus (MSSA)

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	2	No target			



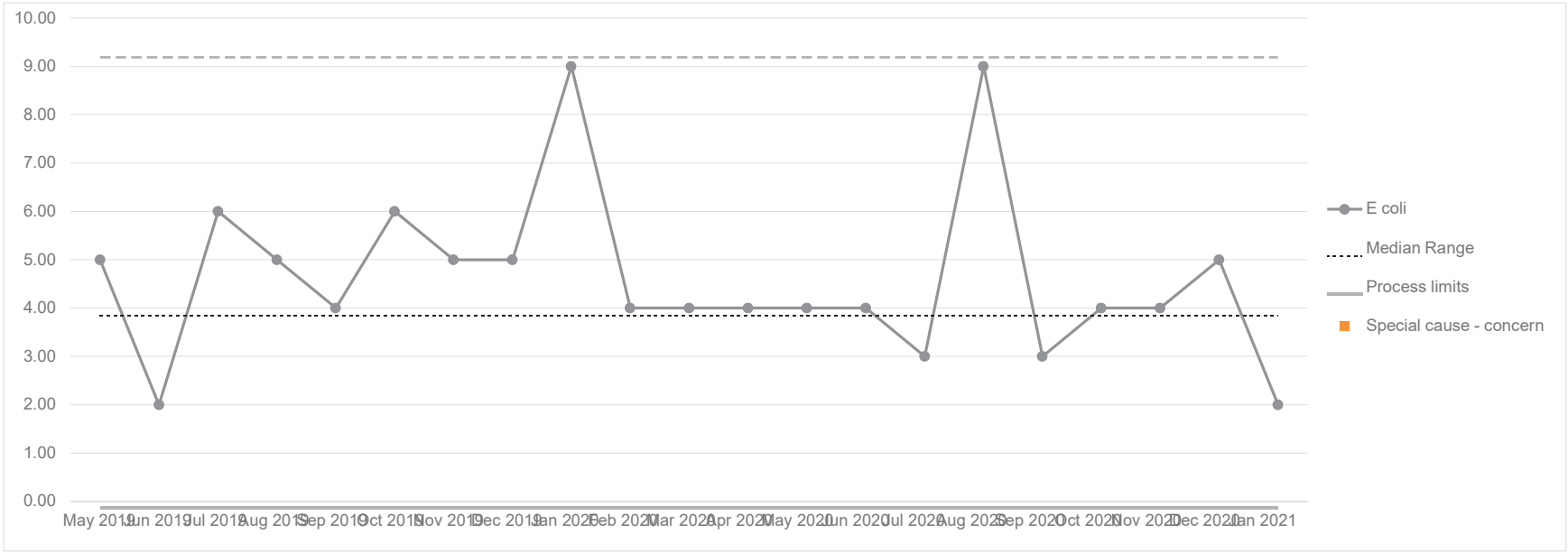
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us we have had 2 cases reported this month	Cases where the patient has been within the hospital for 3 or more days are deemed to be Trust apportioned. The data is produced by taking a rolling 12-month count of trust assigned MSSA infections out of a rolling 12 month average occupied beds days multiplied by 100,000. The organism data comes through into the IPC module (in WebV) from PathLinks as the results are available. The Infection Control Team submits the all the organisms and not just the trust assigned cases PHE England via the HCAI DCS Mandatory Surveillance website. The cases are trust assigned based on compled rules determined by PHE which vary by organism. This is a monthly submission and is a national requirement.	There is no current target set by Public Health England for this indicator.	All Trust apportioned cases are investigated and SBAR is completed and distributed. Trust performance is reported against peer on a monthly basis within the 'Mandatory Healthcare Associated Infection Monthly Surveillance Report Yorkshire and Humber PHE Centre'.

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Escherichia coli (E.coli) bacteraemia bloodstream infection**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	2	No target			



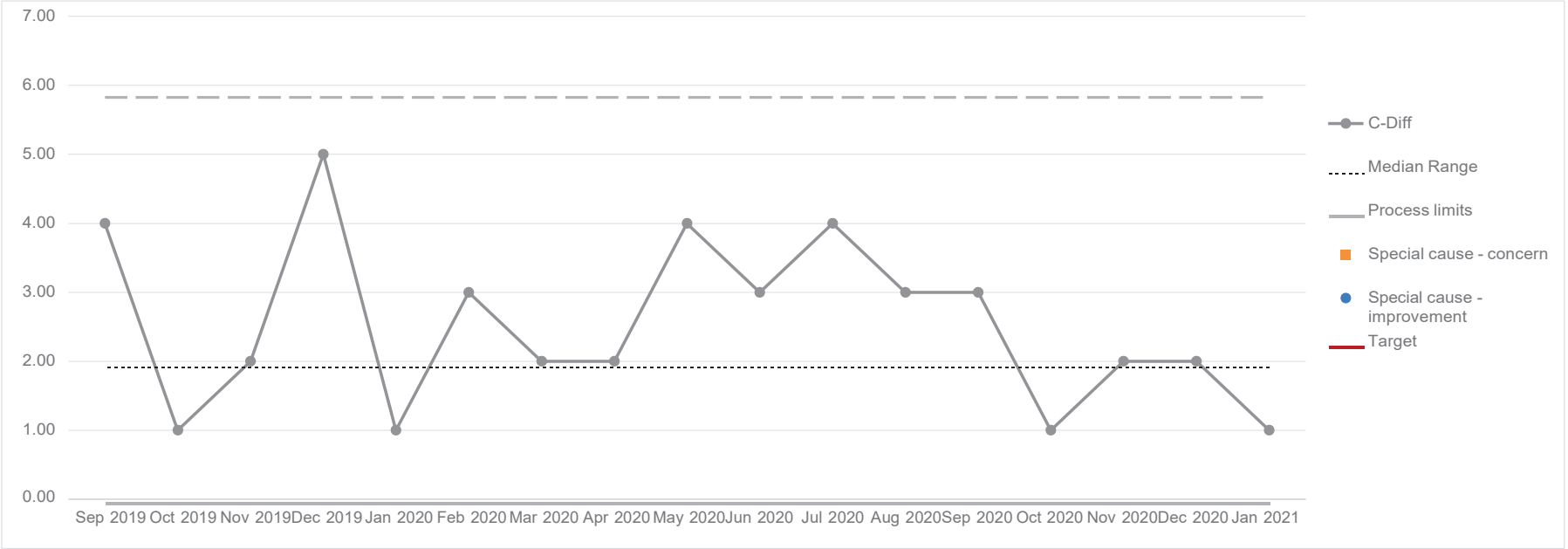
What Is The Chart Telling Us?	Background	Issues	Actions
Do we understand peaks and troughs? Mean average of 4 each month	Cases where the patient has been within the hospital for 2 or more days are deemed to be Trust apportioned. The data is produced by taking a rolling 12-month count of trust assigned MSSA infections out of a rolling 12 month average occupied beds days multiplied by 100,000. The organism data comes through into the IPC module (in WebV) from PathLinks as the results are available. The Infection Control Team submits the all the organisms and not just the trust assigned cases PHE England via the HCAI DCS Mandatory Surveillance website. The cases are trust assigned based on compled rules determined by PHE which vary by organism. This is a monthly submission and is a national requirement.	There is no current target set by Public Health England for this indicator.	All Trust apportioned cases are investigated and a post investigation review (PIR) is undertaken to identify any lapses in care or practice and any lessons to be learnt. Trust performance is reported against peer on a monthly basis within the 'Mandatory Healthcare Associated Infection Monthly Surveillance Report Yorkshire and Humber PHE Centre'.

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Trust attributed C-Diff

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	1	<3 per month			



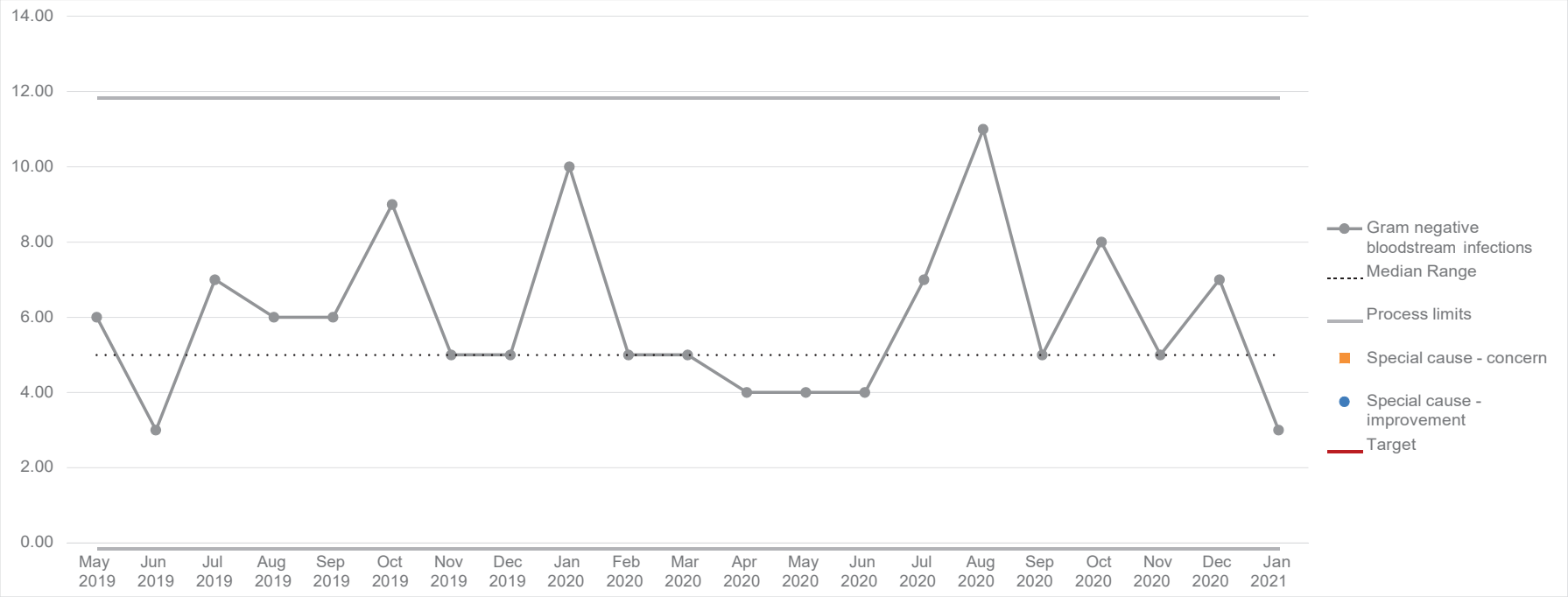
What Is The Chart Telling Us?	Background	Issues	Actions
Reducing over time	The data is produced by taking a rolling 12-month count of trust-apportioned C.Difficile in patients aged 2 years and over out of a rolling 12-month average occupied bed days per 100,000 beds. The organism data comes through into the IPC module (in WebV) from PathLinks as the results are available. The Infection Control Team submits the all the organisms and not just the trust assigned cases PHE England via the HCAI DCS Mandatory Surveillance website. The cases are trust assigned based on compled rules determined by PHE which vary by organism. This is a monthly submission and is a national requirement.	No target set by PHE this year. Trust ambition of 36 cases - 3 per month.	Trust performance is reported against peer on a monthly basis within the 'Mandatory Healthcare Associated Infection Monthly Surveillance Report Yorkshire and Humber PHE Centre'.

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **Gram negative bloodstream infections**

Period	Total Value	Target	Trajectory	Variance	Assurance
Jan 2021	3	No target			



Breakdown of gram negative infections

E Coli	Kleb	Pseudom
2	0	1

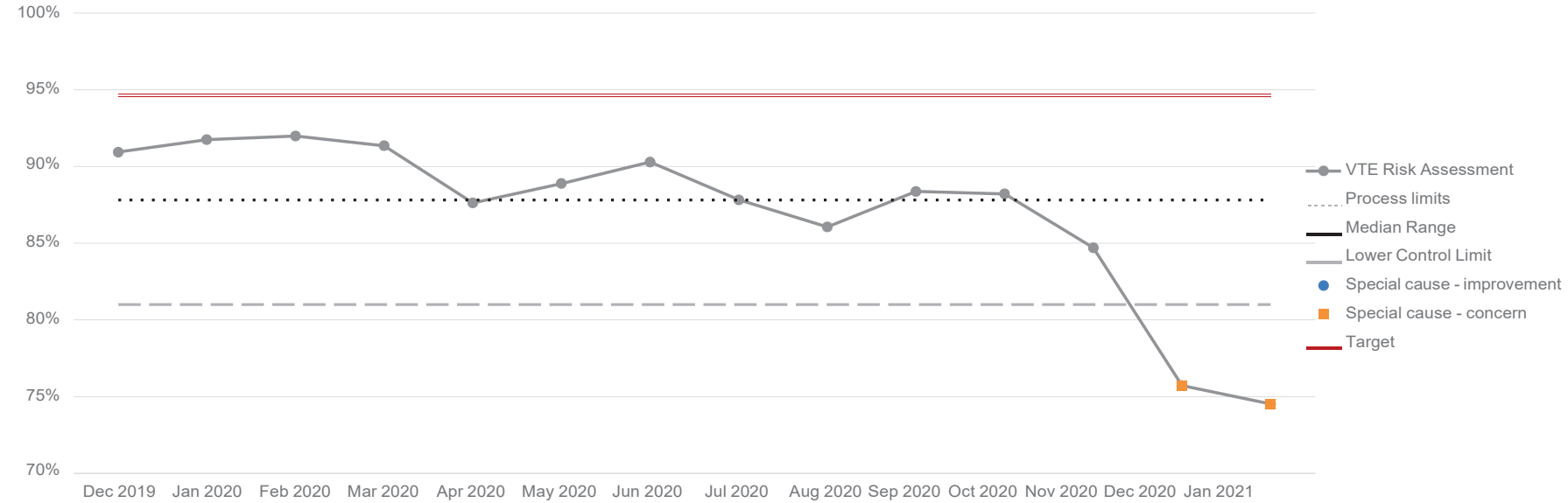
What Is The Chart Telling Us?	Background	Actions	Risks and Mitigation
	The data is produced by taking a rolling 12-month count of trust-apportioned gram-negative bloodstream infections in patients aged 2 years and over out of a rolling 12-month average occupied bed days per 100,000 beds. The organism data comes through into the IPC module (in WebV) from PathLinks as the results are available. The Infection Control Team submits the all the organisms and not just the trust assigned cases PHE England via the HCAI DCS Mandatory Surveillance website. The cases are trust assigned based on compled rules determined by PHE which vary by organism. This is a monthly submission and is a national requirement.	No target or ambition set by PHE	

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Venous Thromboembolism (VTE) risk assessment

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	74.5%	95.0%			



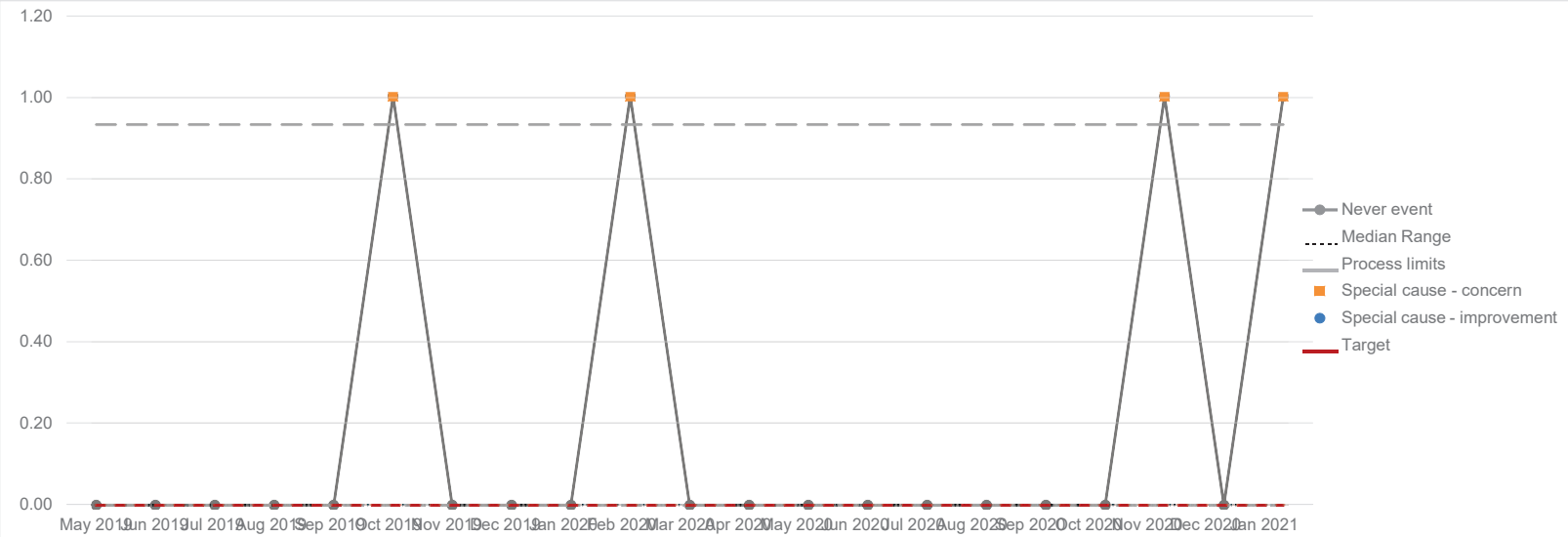
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that we are outside the control limit causing a special cause concern.	1. The number of adults – aged 18 or over – admitted as inpatients in the month who have been risk assessed for VTE on admission 2. Total number of adult inpatients admitted in the month 3. Calculated from (1) and (2), the percentage of adult hospital admissions, admitted within the month assessed for risk of VTE on admission VTE risk assessment compliance data is produced from a combination of WebV records and Clinical Coding team review to ensure risk assessments completed are caputred and this data is then submitted by Information Services. This a national Requirement.	VTE risk assessment performance has reduced during the Trust's response to the 2nd wave of Covid-19 during November and December and the ongoing management of patients with or at risk of Covid-19. Changes in operational procedures such as re-zoning wards rapidly on both the DPOW and SGH sites required to create Red / Yellow A / Yellow B CoViD areas to cope with the increasing demand of CoViD-related (or CoViD-suspected) acute admissions have likely impacted on performance.	Medicine have appointed 2 Clincial Leads to support compliance and an operational focus on VTE. An electronic VTE screening tool has been launched on WebV. Clinical Leads / DCD / Deputy Medical Directors / Senior Nursing Staff to continue to attend medical & nursing handovers on ward areas in both DPOW and SGH to reinforce the importance of timely recording of VTE risk assessments.

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **The Occurrence of a Never Event**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	1	0			



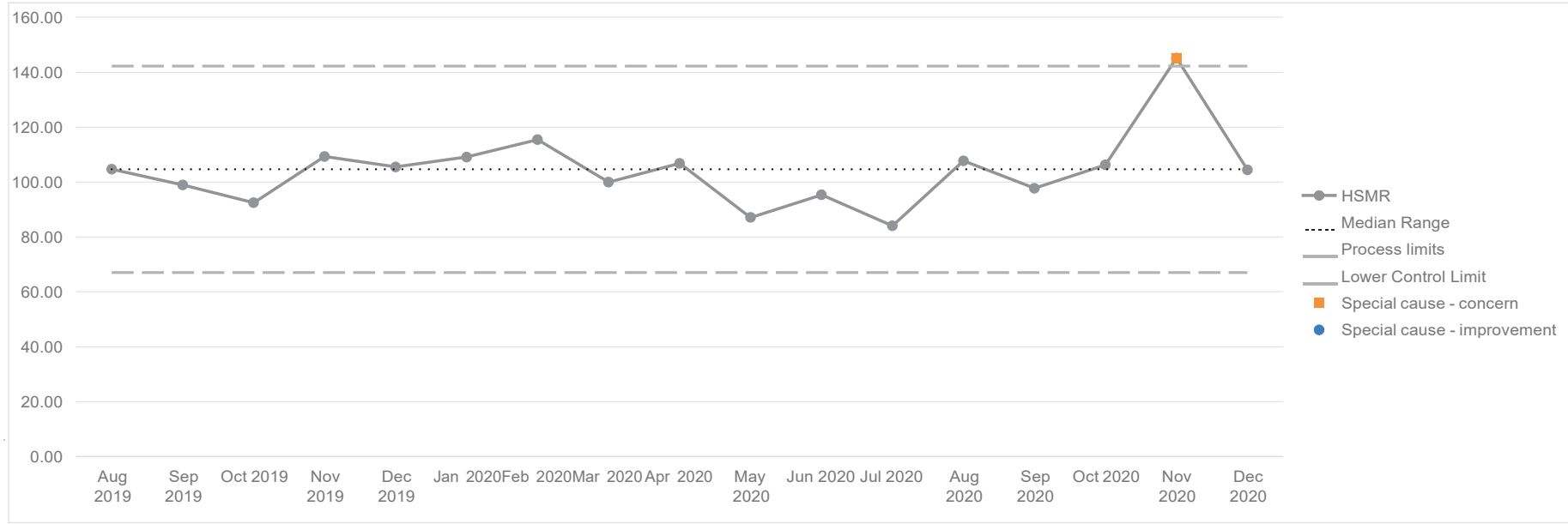
What Is The Chart Telling Us?	Background	Issues	Actions
There has 1 never event reported in January.	'Never events' are defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. This looks at a Count of Never Events in a rolling twelve-month period, presented per month. The data comes from the Datix system and this is both a national and local requirement. National: Reported on national Strategic Executive Information System (STEIS). Submitted by Risk Management Central Team. Local: This measure is monitored on a monthly basis by risk management central team and reported to QGG. Monitored by CCGs at the joint monthly Serious Incident Collaborative meeting. Indicator from the Single Oversight Framework (SOF)	There have been two never events in the space of 3 months relating to Ophthalmology relating to wrong lens implant for the same patient. One occured at St Hughes in November 2020 and the second event happend in January 2021 at DPoW main hospital. The first case was due to the checking process, the second was due to a minus lens being selected instead of a plus sized lens. The investigation work is still underway.	Key actions agreed to date are as follows: Trust wide Lens Implant verification process has been revised. the whiteboard within Theatres is no longer used as part of the checking process; Revised process to be shared and agreed with St Hughs including removal of whiteboards to ensure clincians have the same process for both working environments Minus Lens now special order only due to the infrequency they are used to reduce the potential for wrong selection.

Risks	Mitigations
There is a risk that further Never Events could occur	Revised checking SOP, WHO checklist and WHO checklist audit

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Hospital Standardised Mortality Ratio (HSMR)

Period	Value	Target	Trajectory	Variance	Assurance
Dec 2020	104.4	100			



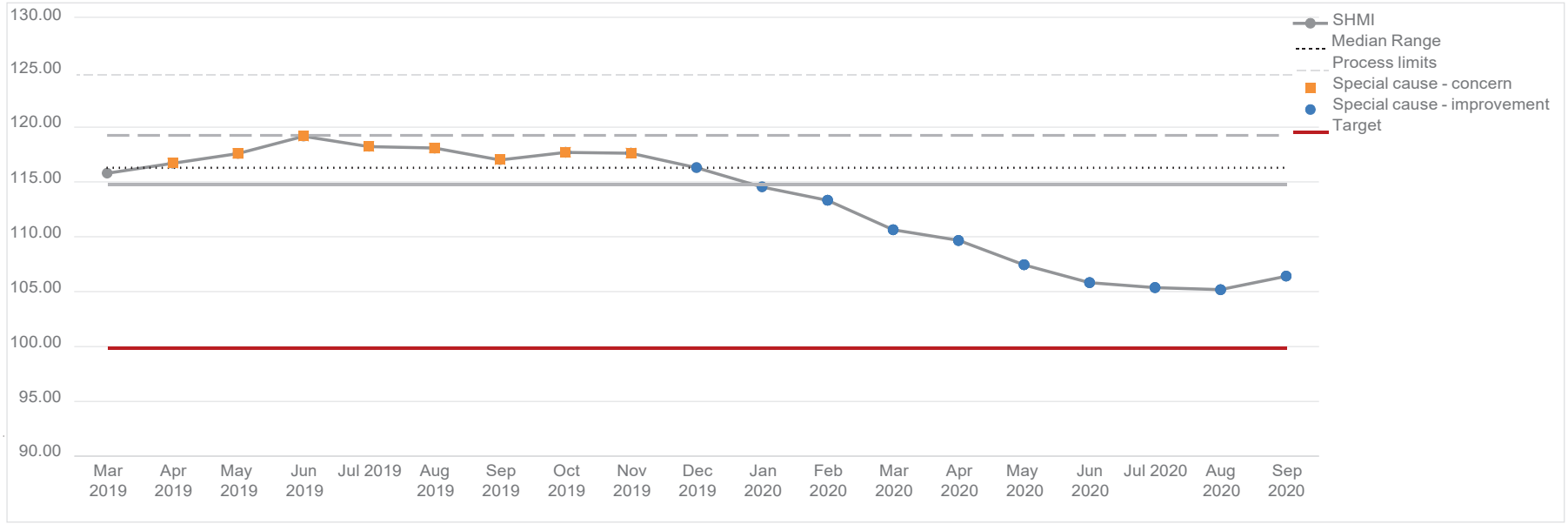
What Is The Chart Telling Us?	Background	Issues	Actions
The chart indicates HSMR is within the 'as expected' range. During November 2020 there has been a statistically significant increase above the Upper Control Limit (UCL). This corresponds to the peak of Covid-19 wave 2 pressures on the Trust and correlates to the Crude mortality trend seen during the same time.	HSMR (Hospital Standardised Mortality Ratio) 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. This is reported on a rolling 12 month basis and is a national indicator. Originally the data on deaths comes from the Trust PAS system, and the scores themselves are calculated and then provided back by NHS Digital and HED so ensure these balanced across the country using data from all hospitals. NHS Digital Provide the Official SHMI, and the HED system provide a slight variation on that SHMI and the HSMR information.	The Trust's HSMR has shown statistically significant reduction during 2020. The HSMR shows a significant increase (special cause variation) in mortality during the month of November, this correlates with the same picture seen when reviewing the Trust's crude mortality trend. When viewed as a rolling trend, the Trust's trend is one of improvement and remains just above the national average of 100.	Coding validation work led by clinicians continues alongside the focus on increasing the number of deaths reviewed from a quality perspective. Mortality Improvement Group (MIG) oversees this area and reports into Quality Governance Group.

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Summary Hospital-level Mortality Indicator (SHMI)

Period	Value	Target	Trajectory	Variance	Assurance
Sep-20	106.4	100			



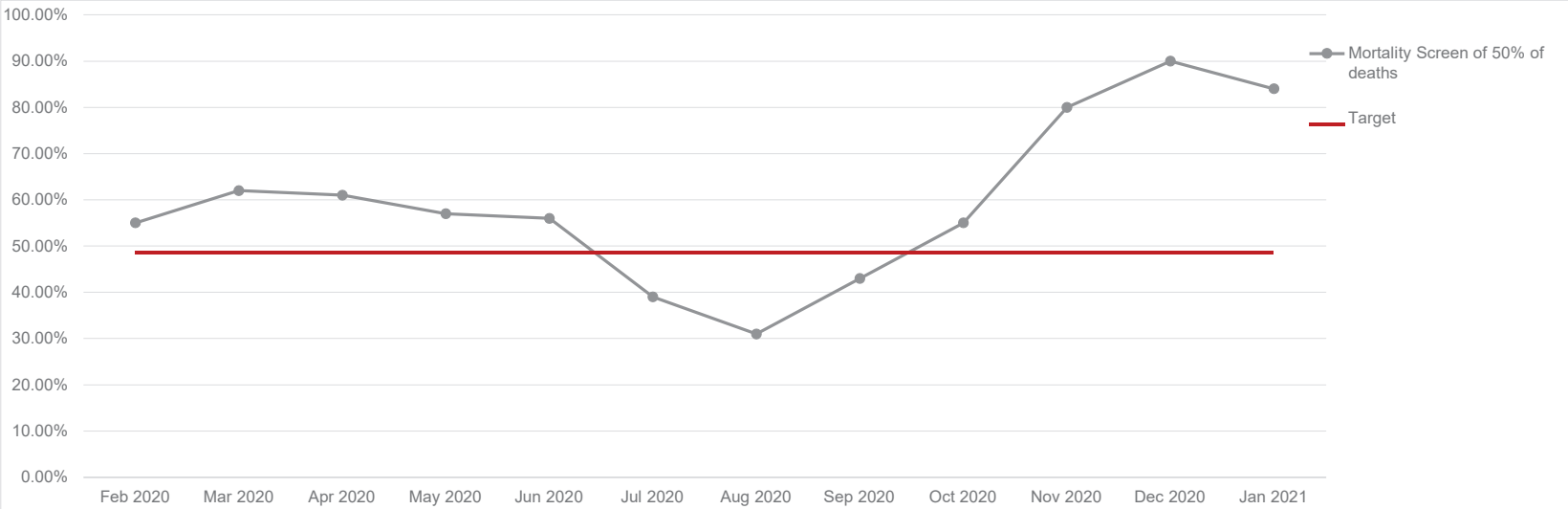
What Is The Chart Telling Us?	Background	Issues	Actions
The graph is showing a special cause improvement. The trust is now comparable to other local peer organisations. The trust remains within the 'as expected' banding.	SHMI is a ratio between the number of actual deaths (in hospital and within 30 days of discharge from hospital) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. This is reported on a rolling 12 month basis and is a national indicator. Originally the data on deaths comes from the Trust PAS system, and the scores themselves are calculated and then provided back by NHS Digital and HED so ensure these balanced across the country usingn data from all hospitals. NHS Digital Provide the Official SHMI, and the HED system provide a slight variation on that SHMI and the HSMR information.	The latest SHMI data is published covering the October 2019 - September 2020 period. The trend has been one of statistically significant improvement. The SHMI is likely to increase, as HSMR has, linked to the Covid-19 pandemic pressures seen during Wave 2 during November and December 2020. The SHMI includes deaths out of hospital within 30 days of discharge. Reviewing the data shows that the Trust's out of hospital SHMI - i.e. those patients having died within 30 days - remains higher than would be expected. The Trust is undertaking ongoing review work with local CCGS to look into this in more depth. The local system are also receiving support from NHSE/I to undertake a focuss audit of EOL care provision across the Trust and Community. This will commence in April 2021.	Continued oversight at Mortality Improvement Group of performance with SHMI improvement measures including clinician led validation of coding, quality of care focus and specific projects looking at out-of-hospital factors. NHSE/I commisioned external audit of EOL services is being planned to commenc in April 2021.

Risks	Mitigations
There is a risk the SHMI will rise again if deaths are not reviewed in a timely way or if deaths are not appropriately coded	Continued oversight at Mortality Improvement Group, ongoing reviewing work on out of hospital deaths, increased screening to identify deaths which would benefit from a Structured Judgement Review. Mortality & Morbidity meetings.

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: **Mortality Screen, 50% of deaths**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**84.0%**	**50.0%**			



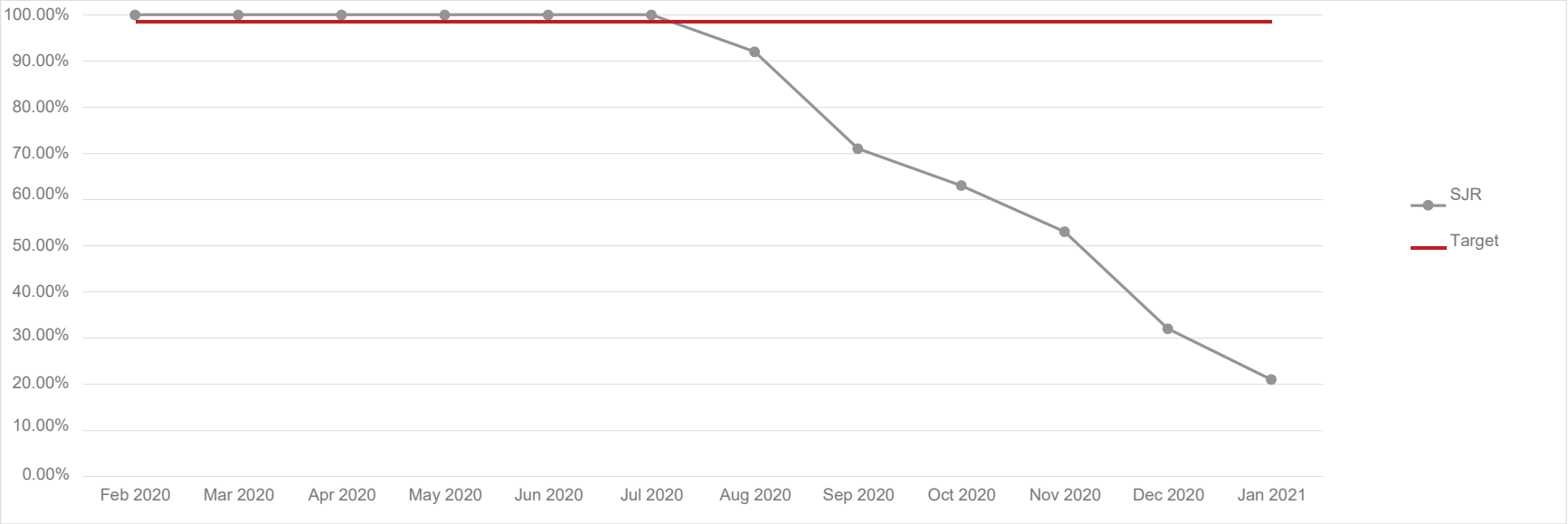
What Is The Chart Telling Us?	Background	Issues	Actions
The chart demonstrates improvements in process that support the Trust exceeding the 50% target set from October 2020 onwards.	The Screening Tool Review process commenced across NLAG from January 2020 with the aim of reviewing a higher proportion of deaths which as a result identifies more cases with potential learning opportunities. The process was further enhanced from November 2020 with the addition of Screening Reviews merging with Coding validation sessions across NLAG enabling higher proportion of cases to be reviewed. The agreed target for completion of Mortality Screening Reviews is 50% or more of all deaths each month. This looks at th number of Screening Tool Reviews Completed out of the Number of Deaths (Per Month) and the data comes from the Central Mortality Database /CAMIS. This is a local requirement and the measure is monitored on a monthly basis by the Mortality Improvement Group [MIG], reporting to the Quality Governance Group.	The linking during November 2020 of the Clinician led validation work and the quality of care screening tool has resulted in above target rates of mortality screening which provide greater targetting of specific cases for review in more detail with the SJR review tool.	Ongoing oversight by MIG.

Risks	Mitigations
There is a risk screening will not capture some deaths which would warrant a Structured Judgement Review	Clinician led validation linked to the Quality of Care Screening tool. Links to SI Panel where a death with potential error can be referred back to the SJR process directly.

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: Structured Judgement Review, 100% of those required

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**21.0%**	**100.0%**			



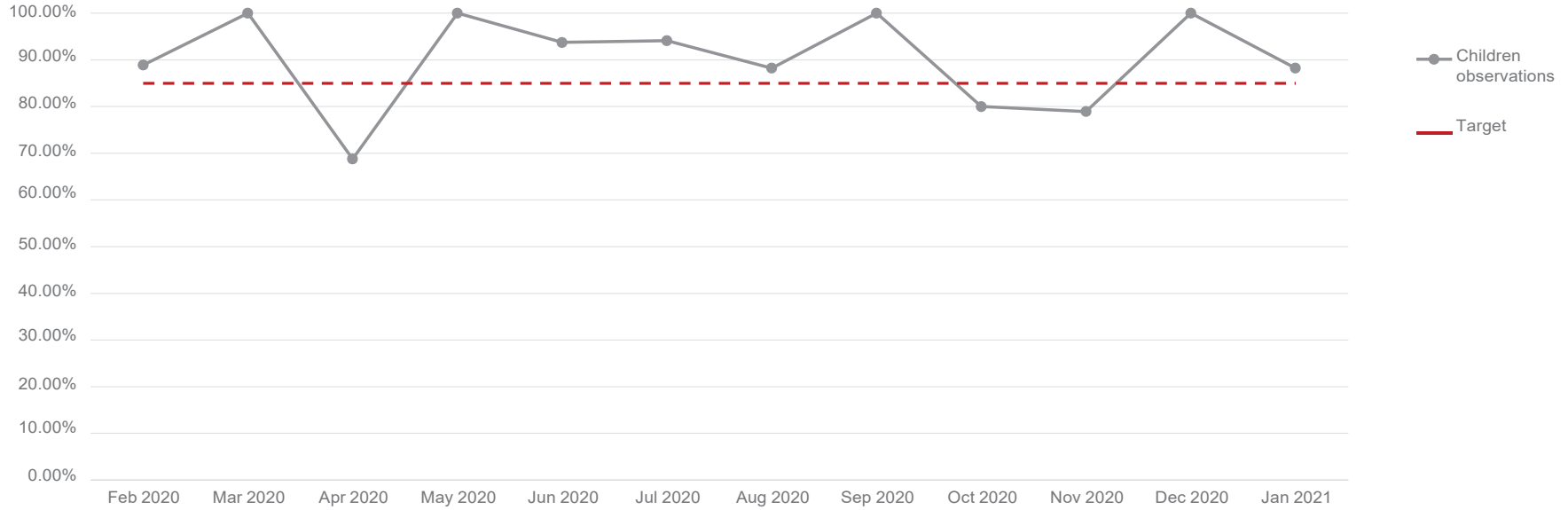
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that since June there has been a deterioration in compliance.	Structured Judgment Review (SJR) in 100% of cases for those meeting full SJR Criteria (Per Month). Methodology is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is consistently reproducible. SJR relies upon trained reviewers looking at the medical record in a critical manner and commenting on specific phases of clinical care. The data looks at the number of SJR Reviews Completed out of the Number of SJR priority cases raised (Per Month) and the data comes from the central mortality database. This is a local indicator which is monitored on a monthly basis by the Mortality Improvement Group [MIG], reporting to the Quality Governance Group.	The operational pressures faced during the pandemic has impacted on the availability of clinician time to undertake SJR reviews. This has resulted in a backlog of cases. The Trust is still achieving 100% but it takes longer to complete all cases, as shown in the chart that demonstrates a current focus on August 2020 deaths requiring SJR review.	The use during wave #2 of shielding reviewers has supported to mitigate this risk but has not fully closed the gap. This is on the Trust's risk register.

Risks	Mitigations
Increase in operational pressures relating to COVID-19 has adversely impacted on clinician time to undertake SJR reviews. This has been added to the Trust's Risk Register.	Prioritisation of cases requring review by shielding clinicians has been used to mitigate, but this is not fully mitigating the backlog and risk resulting.

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: Children, timliness of observations

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**88.2%**	**85.0%**			



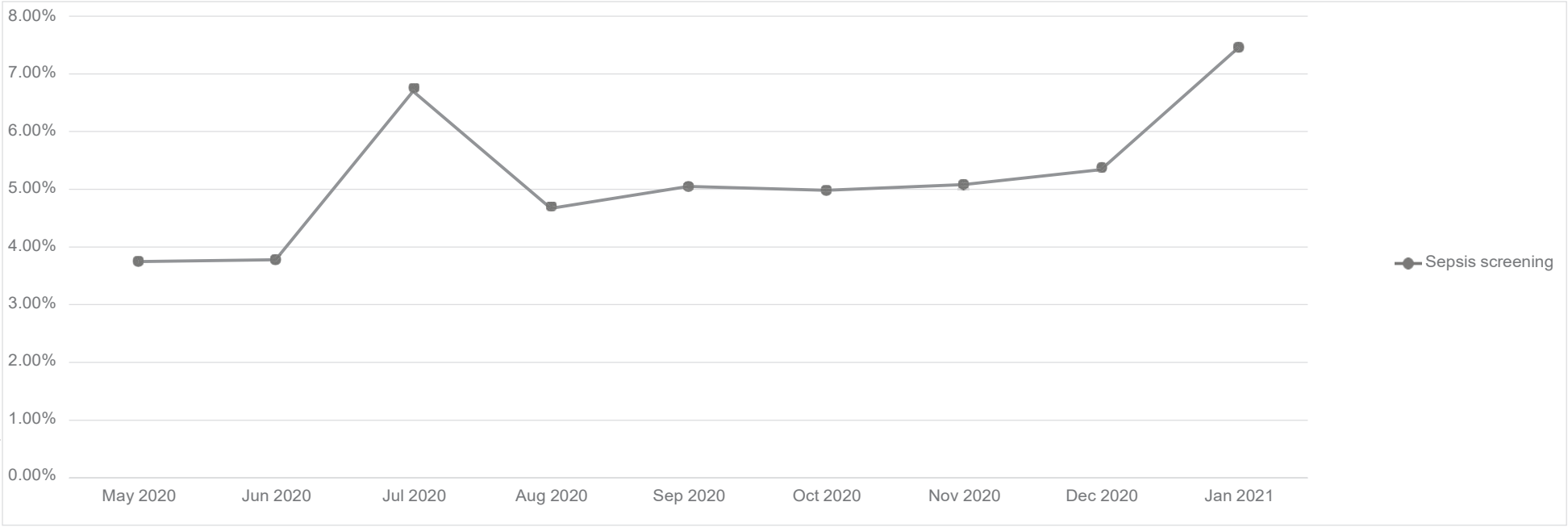
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that we are achieving the target during the last two months. In a few months time we will be able to see trends as currently we have insufficient data to comment.	The spot checks are undertaken on the paediatric wards at each site (Disney at SGH and Rainforest at DPOW) by the ward managers. 10 children per site are identified randomly based on those on each ward at the time of data collection on a monthly basis (if fewer than 10 on the ward, all patients will be audited). The source of the information is the Trust's WebV system.	None.	Ongoing monitoring. Working with the National Team on electronic reporting and potentially being a pilot site.

Risks	Mitigations

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: Sepsis screening

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**7.5%**	Improvement			



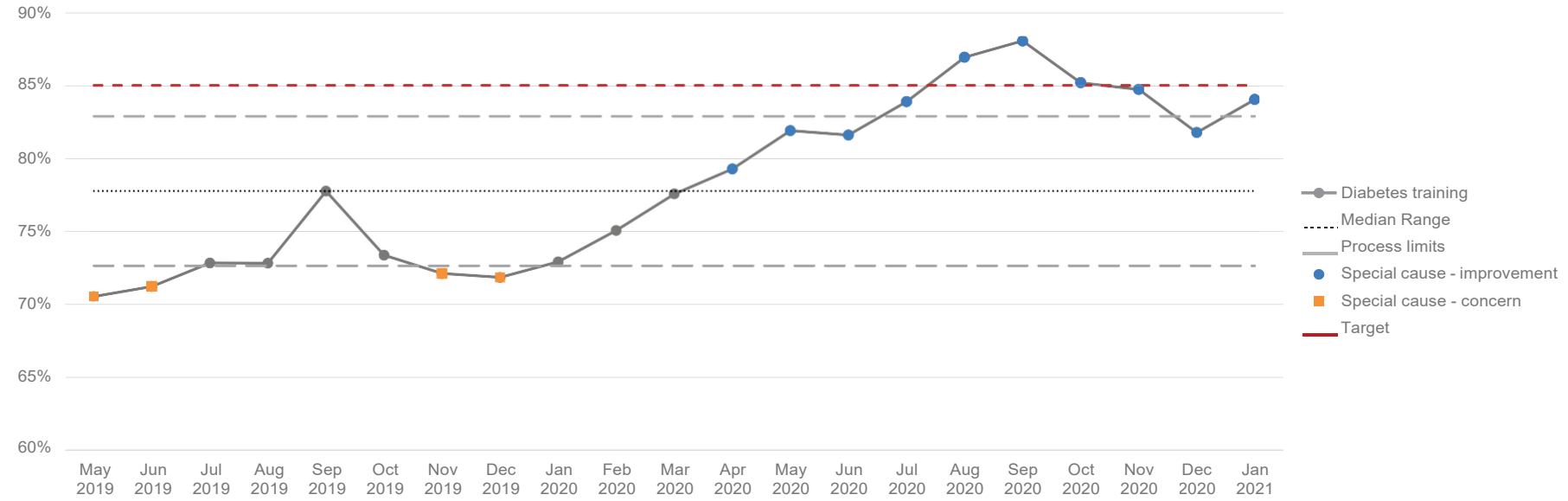
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that this is extremely under target.	This indicator measures compliance with E-Sepsis screening on WebV. Improvement plans were impacted upon by Covid which has delayed some ward areas being further supported to use WebV for sepsis risk assessment. It is likely that paper based screening processes are still being used which means that the E-Sepsis screening data is not an accurate reflection of current performance.	Sepsis screening using WebV is not being fully utilised. Plans were in place during 2020 to work with wards to improve their use of the WebV E-Sepsis screening tool, but operational pressures linked to Covid-19 impacted on these plans. There is currently a gap in assurance around sepsis risk assessment and appropriate actions being taken.	Actual performance is likely higher as manual paper based documentation is still in use. In December a revised Sepsis Screening Tool in WebV went live. The tool will now be split into two sections, with the second section coming as a link to the Sepsis Six Pathway if appropriate. An 'S' icon will also feature on the boards with a colouring system to indicate if patients have had the screening, if the screening is in progress or if screening is required - escalated to MIG for assistance as currenlty a delay. An audit assessing complinance with NEWS escalation and Sepsis action is currently underway to close the gap in assurance.

Risks	Mitigations
There is a gap in assurance around the appropriate action taken in response to sepsis being suspected.	Currenty undertaking manual audits to ensure sepsis screening is being completed on patients who require it.

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: Diabetes Training

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**84.1%**	**85.0%**			



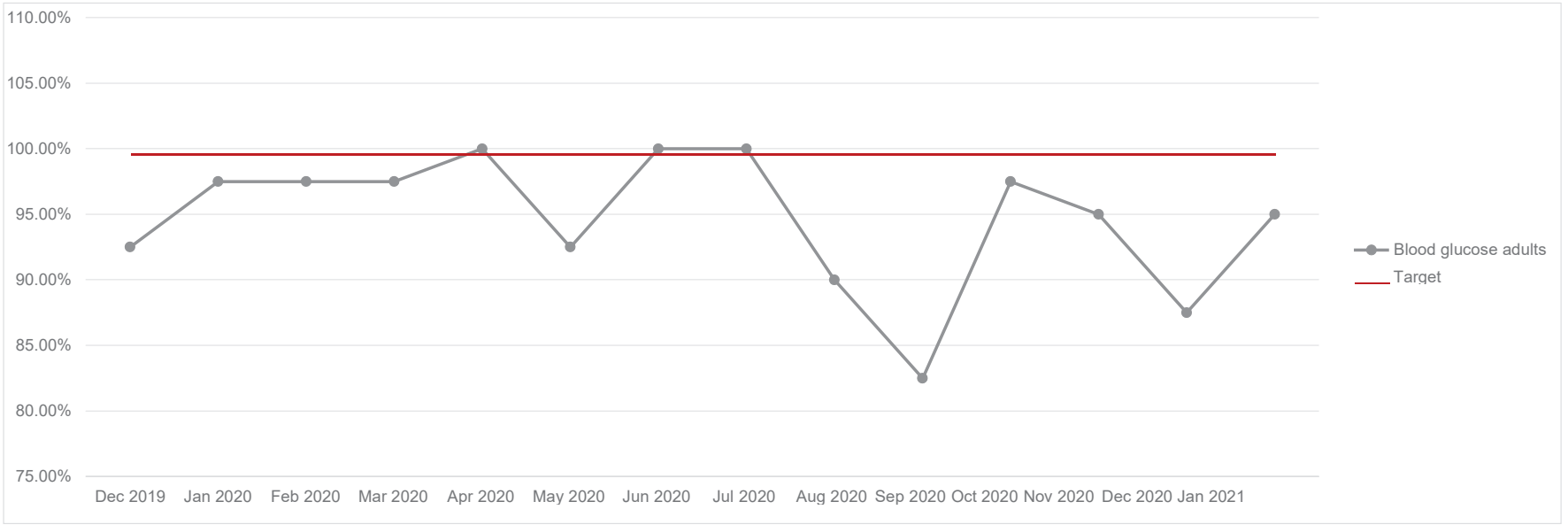
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling that there has been a special cause improvement. However we not achieving the trust target this month.	Data for this indicator is made available from the Trust's Training and Development team linked to this mandatory training having been undertaken. This is further broken down by staff group.	One particular staff group, medical staff, stands out as not being compliant with this mandatory training.	Discussed at the safer medication group on a monthly basis. This is also reviewed by the Diabetes Task and Finish Group. Escalation to Diabetes Clinical Lead regarding the staff group currently underepresented in the mandatory training compliance data.

Risks	Mitigations
Wave 2 of COVID has had a direct impact on mandatory training.	

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: **Blood Glucose Adults**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**95.0%**	**100.0%**			



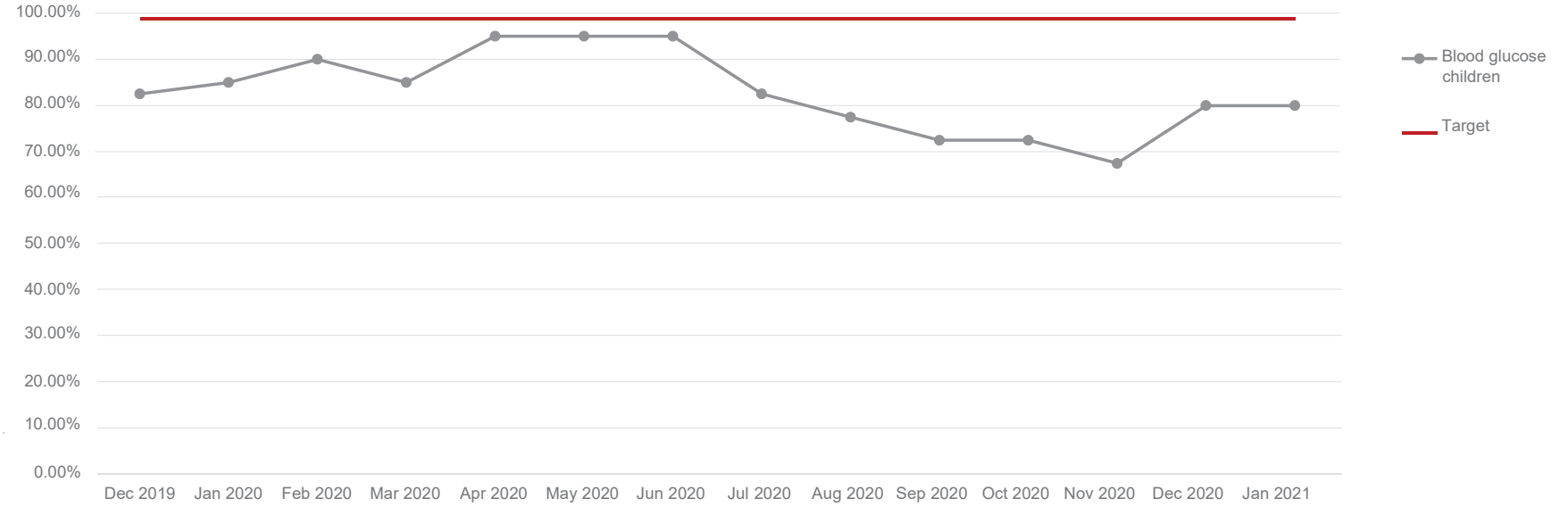
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that we are below target. Next month we will have enough data points to look at any trends.	A random sample of patients (Adult and Paediatric) presenting to the ED were extracted from Symphony (A&E Record) in each time period with abnormal vital signs with the parameters listed below. Symphony, Web V and ECC documentation reviewed to test compliance.	Following a Serious Incident Investigation, the Trust implemented BM testing to be carried out within the Emergency Department for patients who present to triage with abnormal vital signs. This is a snap-shot audit to review the implementation of this testing.	Nursing metrics meeting/Ward managers meetings take a focus on Hypoglycaemia and Insulin related incidents. Insulin incidents and learning from these is shared within Governance meetings to ensure Nursing and Medical awareness. The Pharmacy and Diabetes team are reviewing stock of insulins to ensure no common gaps leading to failure to administer/provide. There is a rolling monthly audit in place in the ED's to show compliance with the completion of a capillary blood glucose (CBG) on all patients with a NEWS of >1 (adults) and PEWS >1 for children. This is reviewed through Medicine Governance and ED Quality and Safety meetings.

Risks	Mitigations

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: Blood glucose taken in ECC if PEWS over 1 for children

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**80.0%**	**100.0%**			



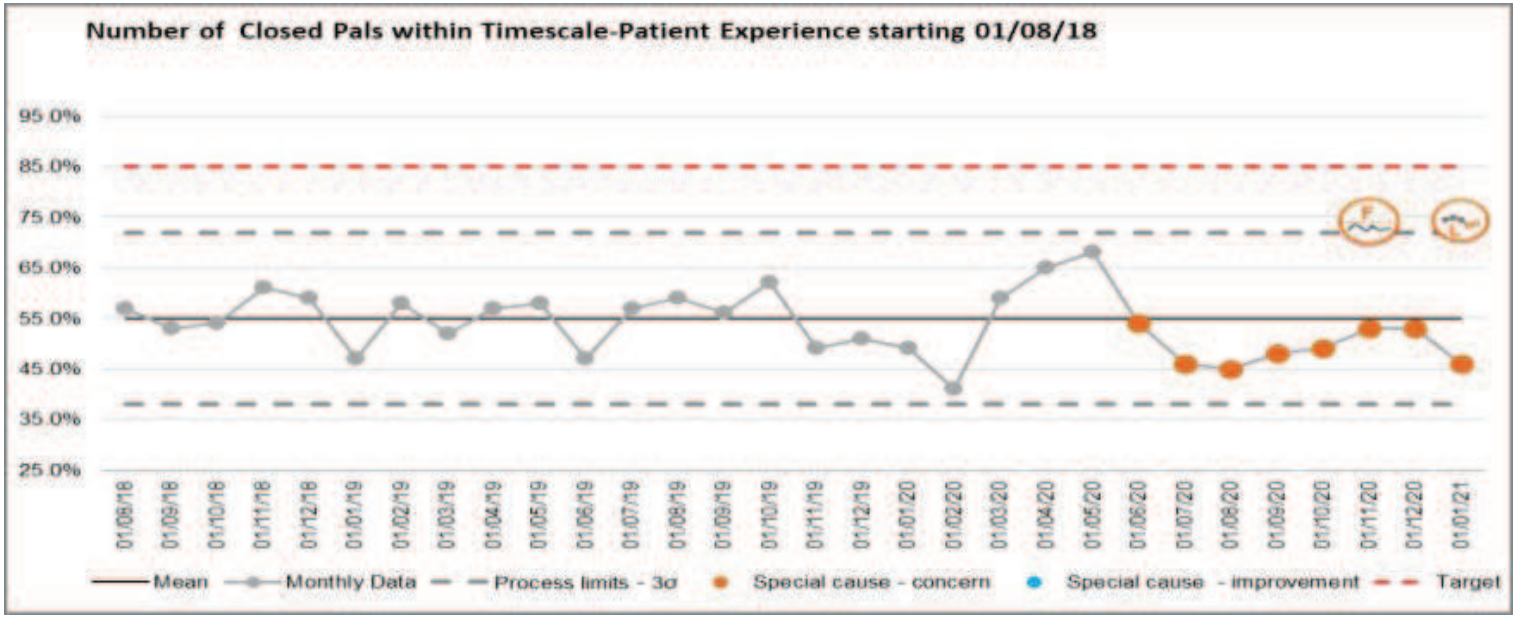
What Is The Chart Telling Us?	Background	Issues	Actions
The chart is telling us that we are below target. Next month we will have enough data points to look at any trends.	A random sample of patients (Adult and Paediatric) presenting to the ED were extracted from Symphony (A&E Record) in each time period with abnormal vital signs with the parameters listed below. Symphony, Web V and ECC documentation reviewed to test compliance.	Following a Serious Incident Investigation, the Trust implemented BM testing to be carried out within the Emergency Department for patients who present to triage with abnormal vital signs. This is a snap-shot audit to review the implementation of this testing.	Nursing metrics meeting/Ward managers meetings take a focus on Hypoglycaemia and Insulin related incidents. Insulin incidents and learning from these is shared within Governance meetings to ensure Nursing and Medical awareness. The Pharmacy and Diabetes team are reviewing stock of insulins to ensure no common gaps leading to failure to administer/provide. Registered Childrens nursing now based in ED in core hours to support the care of a sick child. The Paediatrics team are going to review those cases that do meet this standard to understand in greater detail reasons for this

Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **85% PALS responded to in 5 working days by the 31 January 2021**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**46.00%**	**85.00%**			

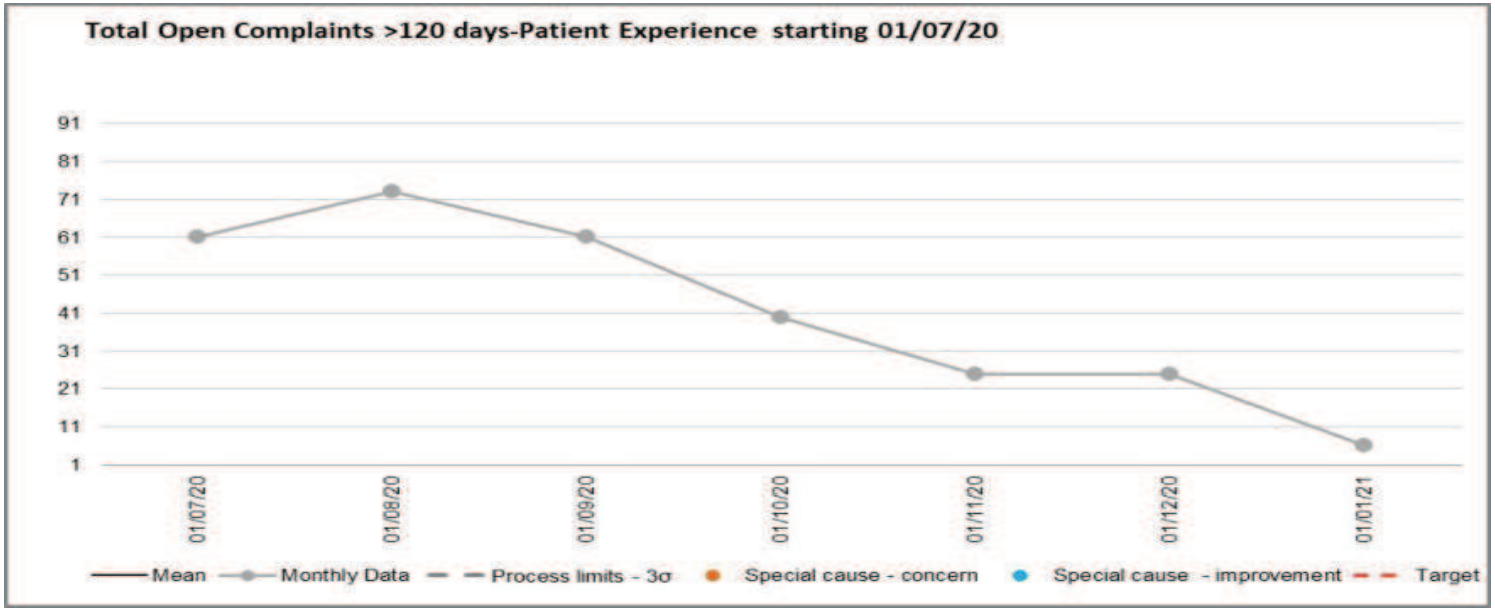


What Is The Chart Telling Us?	Background	Issues	Actions
The data correlates to the lack of sustained process change. There are periods where collaboratively the out of timescale Pals are addressed but then without a trust wide process change then the pattern repeats itself	The timescale for this priority has been amended from October 2020 to the end of January 2021. Improvements seen. Project manager working now with team and divisions to streamline processes/reduce duplication and set Standard Operating Procedures for team. Work continues to embed across multiple services.	Understanding central and divisional issues : Centrally - constant flux within divisions makes identifying right person first time challenging Divisionally - capacity of workforce to allow central oversight of Pals in larger divisions Process in central team is repetitive due to incident reporting system Lack of oversight of Pals team - focus has primarily been on complaints team	Project Lead liaising with divisions and central team to understand issues/views/solutions Reviewing data of FS , who use single point of contact for Pals - Pals team no located in central building with Pals and Complaints Manager Weekly meeting with Pals team commenced

Risks	Mitigations
Agreeing on Trust wide model to reduce timescales due to capacity in divisions	Pals team are running weekly dashboard to " chase" out of timescale concerns

Indicator: 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 2021

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**6.0**	**100.00%**			



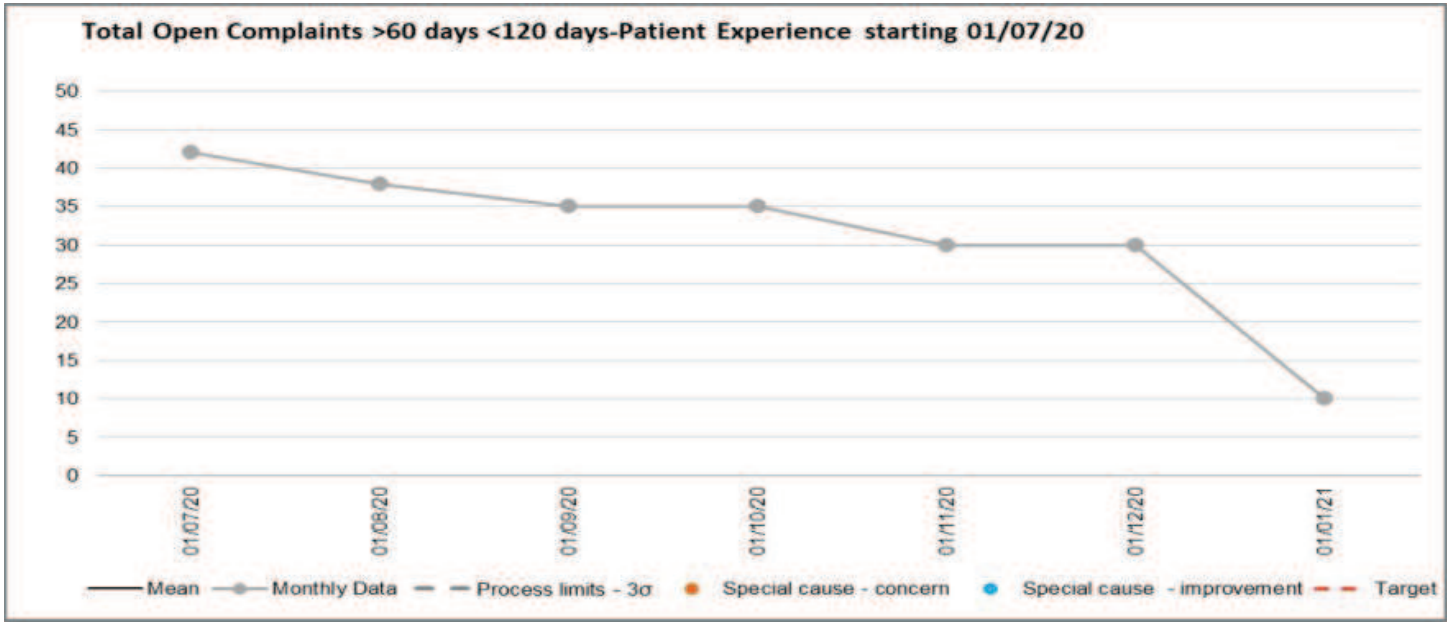
What Is The Chart Telling Us?	Background	Issues	Actions
The KPI is on track for completion . Continued improvement has been seen since introduction of this and the associated action plan - giving clear oversight	The new complaints process went live on 2nd November 2020. This will support more timely closure for complainants. As a result of this these indicators are new which aim to track progress with the closure of all existing complaints within the old process (by the end of February 2021. Total complaints >120 days: The number open in December was 25; this has reduced to only 6 remaining open during January 2021. All 6 that remain open are in the final stages of being signed off and will be closed by the 19 February 2021.	Possible access to clinical staff during pandemic wave Capacity of existing team	NHSI band 5 post appointed until March 31st 2021 - focussing on older complaint closures weekly Complaints Support and Challenge Meetings to monitor progress and assign escalations /actions

Risks	Mitigations
None	N/A

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **NEW Indicator** 100% of all complaints on 'old' process pathway to be closed by 28 Feb 2021

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**10.0**	**100.00%**			



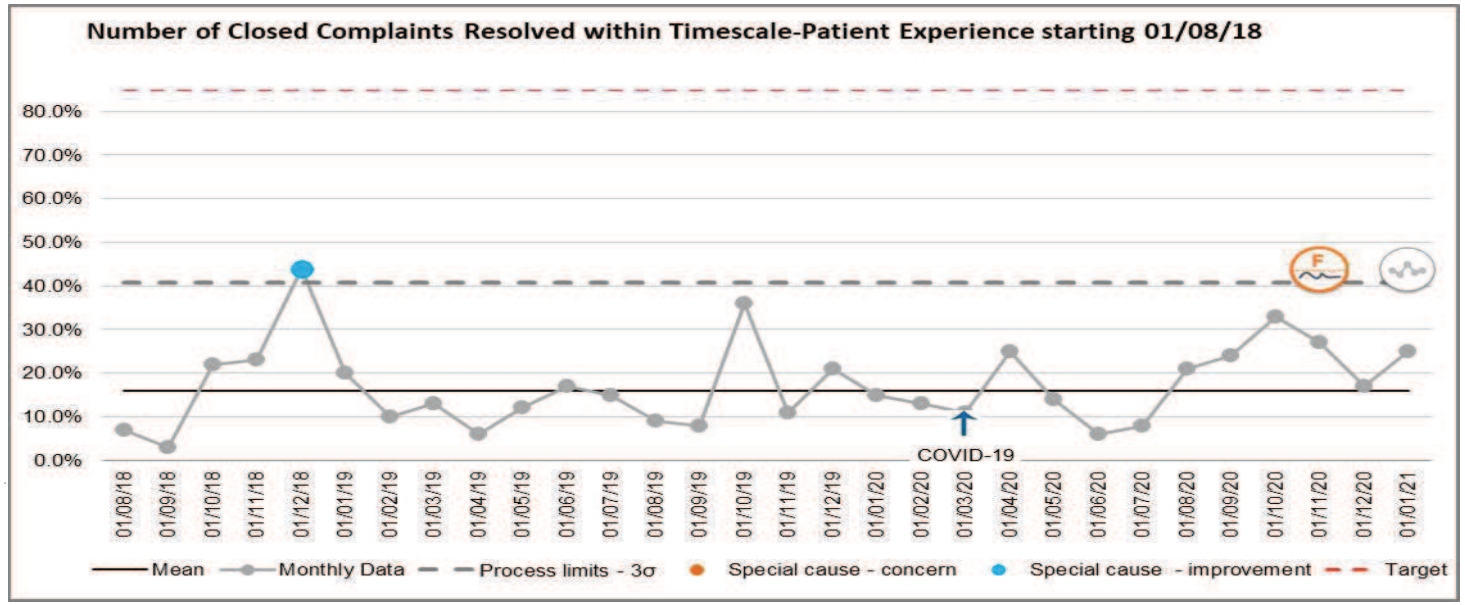
What Is The Chart Telling Us?	Background	Issues	Actions
The KPI is on track for completion . Continued improvement has been seen since introduction of this and the associated action plan - giving clear oversight	The new complaints process went live on 2nd November 2020. This will support more timely closure for complainants. As a result of this these indicators are new which aim to track progress with the closure of all existing complaints within the old process (by the end of February 2021. Total complaints on old process: The total number open in December was 30, this has reduced to only 10 remaining open, all of which are going through the final checking and sign off process.	Possible access to clinical staff during pandemic wave Capacity of existing team	NHSI band 5 post appointed until March 31st 2021 - focussing on older complaint closures weekly Complaints Support and Challenge Meetings to monitor progress and assign escalations /actions Twice weekly update to Patient Experience Lead from Pals and Complaints Manager

Risks	Mitigations
Delays in final stages of sign off process due to further issues raised by checking process meaning deadline will be missed	Twice weekly updates of progress and any issues for immediate escalation to DCN

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **85% of all complaints resolved within timescale by the 31 July 2021**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**25.00%**	**1**			



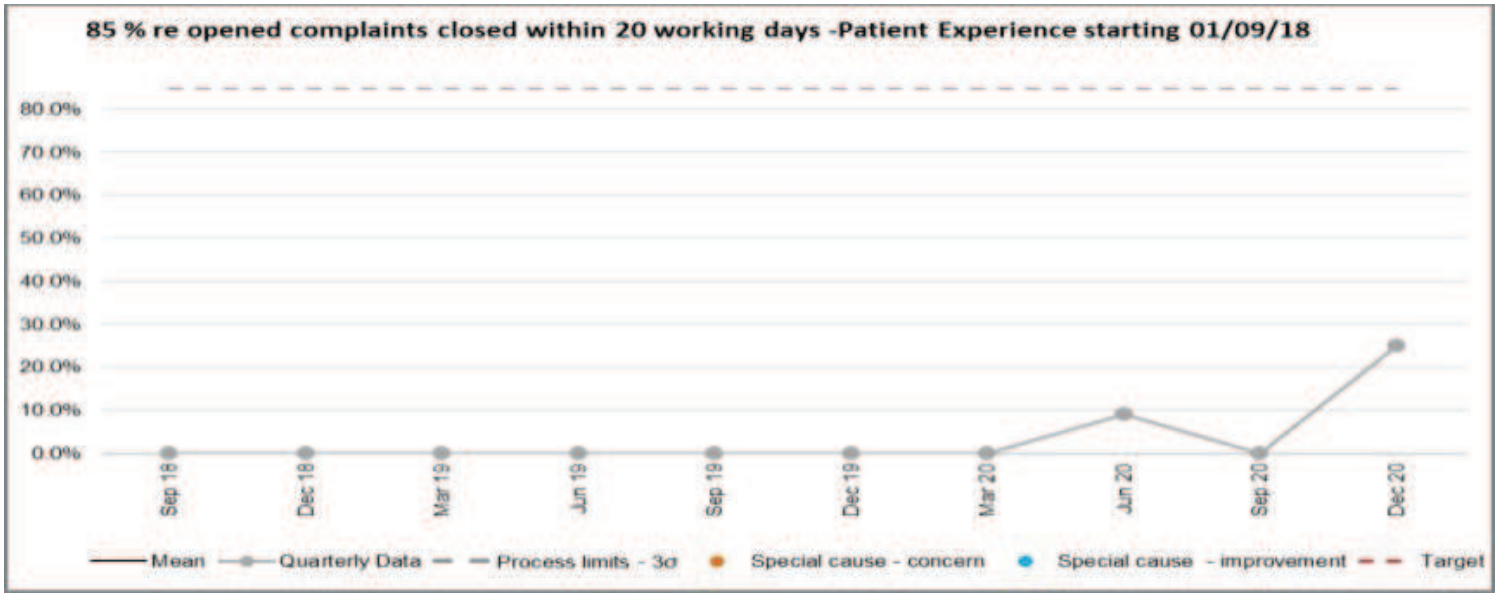
What Is The Chart Telling Us?	Background	Issues	Actions
As there still number of older complaints within this cohort the data will not show improvement until the old process is closed	December data demonstrated that 17% were resolved within timescales, this increases during January to 25%. This is mitigated by the focus on closing all complaints which are longstanding in the 'old' process (see 6b and 6c). 90% of all complaints in the 'new' process are within the 60 working day timescales.	Running two complaint processes Historical old complaints Implementing Trust wide new complaint process Engagement and Training central complaints staff in new complaint process Training divisional staff in new complaint process Impact of Covid on access to clinical staff to support process	Transition plan in place to close all old process complaints project Lead appointed until March 31st 2021 to add pace to implementation and training Dedicated engagement and training of central complaint team Training plan and ongoing programme developed to support divisional training - induction/face to face/online/paper Engagement with divisions throughout changeover Re write of Complaints Policy Clarity of escalation and associated timescales

Risks	Mitigations
Capacity of divisions to be trained in new process, Lead Investigator capacity during Covid Competing priorities may lead to complaints not being seen as important	Pals and Complaint Manager and Project Lead to be available to support at any point and provide training

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **85% of reopened complaints resolved within 20 working days by the 30 November 2020**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**25.00%**	**85.00%**			



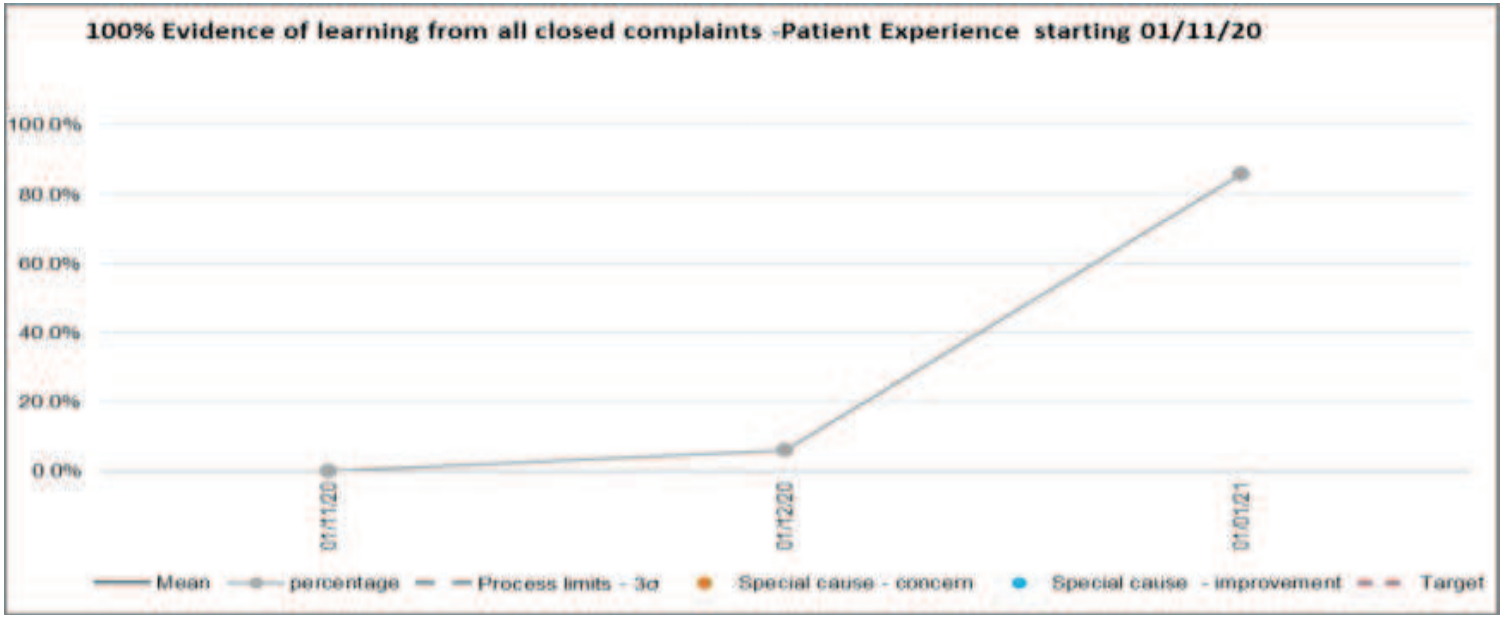
What Is The Chart Telling Us?	Background	Issues	Actions
Anecdotal evidence tells us that the process for re opened complaints is not effectively managed within a timeframe - therefore new timescale set in Sept 2020. Data is measured quarterly and improvement seen data	The latest quarterly data shows an improvement to 25%. There are now two clear management pathways in place. Further work is needed to ensure oversight of data and weekly monitoring.	Lack of set timescale to manage re opened complaints unclear pathways for reopened complaints regarding new questions no central oversight of reopened process	Centrally agreed timescale for reopened to ensure a good patient experience Review of current reopened complaints two pathway approach being developed : clarifying - reopened new questions not detailed in original complaint - new complaint Pals and Complaint manager to have full oversight of all these Performance slide introduced to Weekly Complaint support and Challenge Meeting Close working with divisions to manage these

Risks	Mitigations
Process need embedding	Weekly oversight and escalation

There is currently insufficient data on this metric for an SPC chart, until there are 15 data points this will therefore display as a run chart, i.e. there will be no process limits or special cause variation

Indicator: 100% of all upheld complaints to have evidence of learning by the 31 October 2021

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	**83.00%**	**100.00%**			



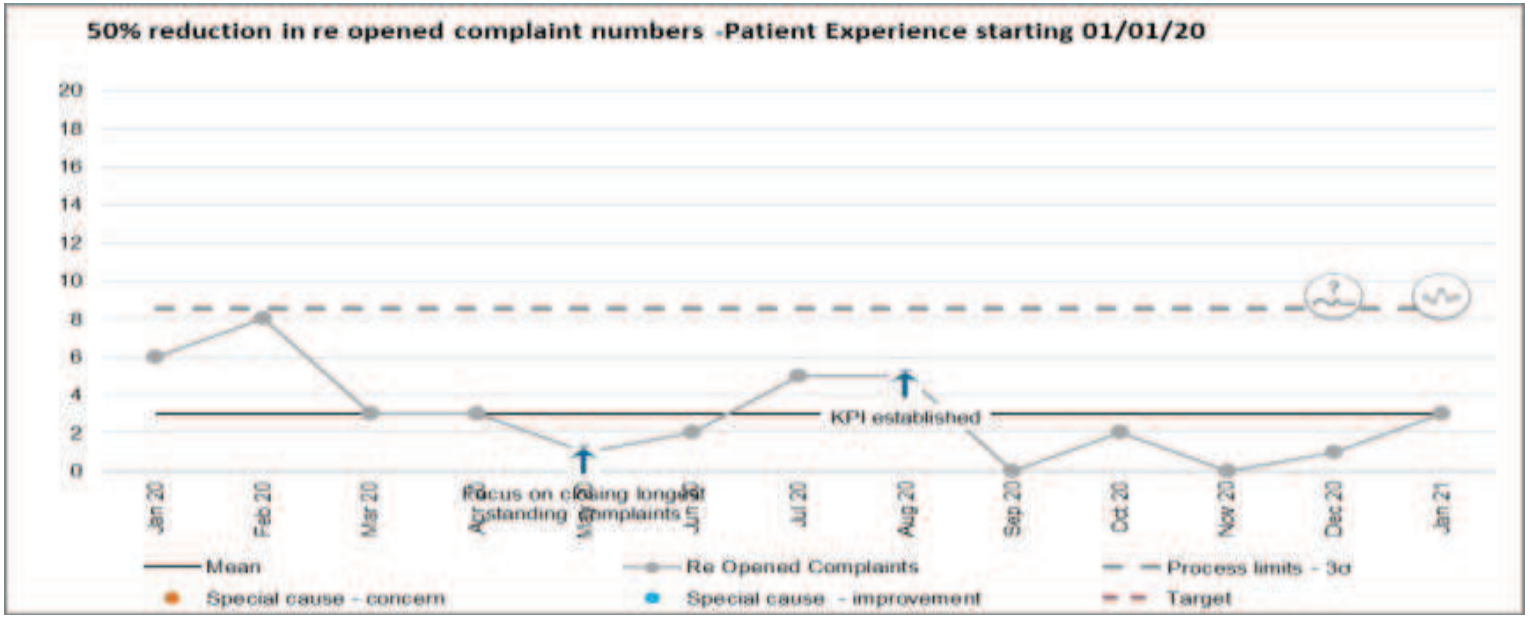
What Is The Chart Telling Us?			Actions
KPI was initially set but difficulties obtaining data from incident reporting system. Initial data obtained was not reflective of position and this can been seen once the system was reviewed and necessary changes made .	83% of closed complaints have evidence of learning recorded on Trust incident reporting system. Work continues to improve clarity of outcomes and provide monthly divisional reporting.	Incident reporting system was not set up to report data set accurately Central complaints team required training to understand learning principles development of single process of recording data in incident reporting system Clarity of complaint learning by Lead Investigator Learning to be detailed in all upheld complaint responses	Datix Team supported changes to learning module central complaints team training in supporting identifying of learning in new complaint process Training of Lead Investigators commenced All upheld complaint responses validated by senior nursing team for evidence of learning development of new divisional governance reports to share learning Central complaint audit of learning programme to be devised from march onwards

Risks	Mitigations
Capacity of Lead Investigators to be trained in complaints and specifically identifying learning Culture of learning	Project Lead and Pals and Complaints Manger to speak to all Lead Investigators - offering training Working with R&G lead and legal to triangulate learning

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: **50% reduction in reopened complaints by the 31 January 2021**

Period	Value	Target	Trajectory	Variance	Assurance
Jan 2021	3.0				



What Is The Chart Telling Us?	Background	Issues	Actions
KPI established to reduce numbers , indicating an improvement in satisfaction of responses	There has been an 80% reduction in reopened complaints since this KPI was established as quality checks have improved final responses. During January 2021 there has been a slight increase. Monitoring continues. There are now two clear pathways in place to manage re-opened complaints.	Refining of reopened process possible increase predicted as older complaints closed	All complaint responses quality checked by senior nurse team training of Lead Investigators to ensure learning and quality of responses weekly complaint support and challenge meeting to ensure timeliness of responses and escalation complaints satisfaction questionnaire implemented

Risks	Mitigations
Relatively low number of reopened complaints at start position means reduction is aspirational Embedding of reopened complaint pathway	Oversight of all reopened complaints by Pals and Complaint manager

NLG(21)067

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

DATE	6 April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Dr. Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance With submissions from: Jenny Hinchliffe, Deputy Director of Nursing Maurice Madeo, Deputy Director of Infection Control Jane Warner, Head of Midwifery
SUBJECT	Executive Report
BACKGROUND DOCUMENT (if any)	**None**
PURPOSE OF REPORT	**To inform the Board about the key areas of Governance of risk**
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This is the first iteration of the Clinical Executives Governance report. Work continues to focus on safety. The new Head of Safeguarding is reviewing existing processes, and a revised DoLS process commencing on 4 May will enable greater Trust oversight in this regard. Progress continues to be made on CQC actions, discussions have taken place on mitigation for those actions not yet delivered, and in how actions will continue to be monitored as business as usual to avoid any slip in the good progress made.

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

LINK TO STRATEGIC OBJECTIVES -				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates	The Quality and Safety Objectives

to within the BAF)	
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to consider the format of the paper, note the risks and mitigations and discuss any concerns identified.

Purpose

The purpose of this report is to ensure Board awareness of the key elements, risks and mitigations in respect of:

- Safe Staffing
- IPC
- Safeguarding
- CQC Action progress
- Maternity (CNST and Ockenden)
- Serious Incidents

Safe Staffing

Key Aims and Data

The aim is to ensure that the Trust can demonstrate compliance with safer staffing guidance. There continues to be ongoing changes to ward reconfigurations and zoning which make it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons in the future and may affect our staffing returns. As we continue to work outside of the pre-Covid ward configurations, any data should be viewedwith caution, for this reason we continue to review individual metrics and apply professional judgement.

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.

The full Nursing Assurance Report is on the agenda as an item for information.

Key Risks	**Mitigation**
There is a risk to the safe care of patients on the wards due to availability of staff: Shift fill rates are reported against ward establishments. The combined fill rate has been below 95% for the last 6 months as a result of increased sickness and absence due to Covid, and reduced ability to fill bank and agency requests. The significant challenges the nursing workforce have experienced throughout the	Daily Deputy Chief Nurse/Head of Nursing led staffing review meetings continue. SafeCare data reviewed enabling a review of patient acuity and dependency against staff availability. Additionally, staffing reviewed at 3 times daily operations meetings. Accelerated recruitment and on boarding of HCSWs is being supported through successful bids for funding to NHSE/I and a project group has been established by the Deputy Chief Nurse to manage this. It is anticipated that the Trust will achieve zero (operational) HCSW vacancies by the end of April 2021. The patient contact helpline and family liaison

pandemic has impacted on the experience of staff, patients and their families and this has been reflected in complaints and PALS.	assistants are supporting communication with families which is supporting frontline staff to prioritise bedside care. 3rd year student nurses are undertaking 12 week paid placements to support the nursing workforce. Use of bank staff with 20% incentive scheme. Nursing staff levels reviewed as wards are reconfigured to support Covid activity and recovery of elective work. A number of actions are in place to support staff wellbeing with both onsite and virtual services utilised.
In February the overall trustRN vacancy 10.32% which equates to 173.05 WTE, this compares 9.95% (166.81 WTE) in January. The highest area of RN vacancies remains in the Medicine Division with 87.64 WTE in February compared to 85.97 WTE vacancies in January. Surgery and Critical Care Division has anincreased vacancy of 35.40 WTE in February compared to 29.53 WTE in January.	19 overseas nurses joined the Trust at the end of October and a further 20 joined in December. They sat their OSCE exams in January and February 2021 and, having all now passed, NMC registrations are coming through. Not all of these new registrants are reflected in the February RN vacancy figures and many remain supernumerary due to their increased support and training requirements. A further 10 overseas nurses joined the Trust in February, 30 will join in March/April 2021
Staff stress due to pressures of Covid-19	Trust wellbeing offer is easy to access and available to all. Professional Voice email address introduced by the Chief Nurse to allow staff to raise concerns and share ideas. Leadership training is being offered to equip staff with skills to lead through this challenging period.

IPC

Key Aims and Data

The aim is to minimise the risk of cross infection within Trust premises. So far the Trust has had 26 ward closures due to COVID-19 since October 2020. Many of the issues identified suggests asymptomatic staff, detection of COVID on day 6 which would mean other patients will be exposed and classed as contacts, as a result many then went on to develop COVID. There were also some issues with PPE compliance and DATIX have been submitted to highlight repeat offenders.

The IPC assurance framework detailing the Trust IPC measures last went to the Quality and Safety Committee in March 2021.

Key Risks	Mitigation
COVID outbreaks risk will occur due to poor infrastructure, surge of admissions and laboratory turn-around time and asymptomatic staff. In December new variants of the Coronavirus were identified that are believed to be 70% more transmissible. • Risk 2794 (ECC cross infection) • Risk 2697 (Risk of staff contracting Covid)	Following national guidance in relation to Covid-19 The Trust now has x30 Redirooms to act as additional isolation capacity to nurse yellow B and Red patients and Cubiscreen, (a plastic curtain that will provide a shield between patients and especially useful where Redirooms cannot be used due to space restrictions e.g. HASU). Work continues to increase single room availability to reduce the risk, this has been supported by the arrival of redirooms and Cubi screens.The Trust has submitted an order for additional cubicles in the form of architectural walls. These have been installed on B3, wd23 with additional installations due on wd28, IAAUB SGH and B3. The lateral flow testing is up and running with over 5500 kits distributed. Currently a low positive prevalence of approx. 1%. This testing should help to reduce the impact of asymptomatic staff spread although the uptake is variable within patient facing staff. The number of COVID positive patients is decreasing so currently reviewing RED capacity and converting to GREEN
Given the surge of patients and movement from ECC to IAAU and then short stay a patient could have 3 moves before results are available which will impact on containment	The use of Redirooms will help to mitigate some of this risk but not remove it completely. Currently the reported HCAI rate for COVID patients is around 0% which is a substantial improvement from >20% a few week prior. The prevalence in community at NEL is significantly lower than NL and this is reflected in the positive number of in-patients currently being seen.

Safeguarding

<u>Key Aims and Data</u>

Safeguarding Children and Adults remains a key Trust priority and ensuring that it is ‘everybody’s business’ to ensure we keep our patients and staff safe from abuse and neglect. A robust safeguarding dashboard is under development which will give the Vulnerabilities and Oversight Board key information relating to a suite of indicators that will inform the Trust of its key priorities.

Key Risks	Mitigation
There has been a reduction in level 3 safeguarding adults training due to a large number	The Named Nurse for Adult Safeguarding is reviewing and progressing with training and development to deliver this training for new

of new starters in the Trust.	starters and professional due out of compliance. We are scoping the numbers of staff over the next 12 months to prevent this from occurring again.
The team do not have oversight of all DOLS applications in the Trust.	From the 4th May the process for referring a DoLS will change and the safeguarding team will have oversight of all applications to the Local Authority. This will enable the MCA DoLS lead to begin planning for the introduction of the Liberty Protection Safeguards anticipated April 2022

CQC Action Progress

Key Aims and Data

The aim is to ensure all CQC Must and Should do's are completed and that in the interim, until the action is completed, there is mitigation in place to ensure the safety of all clinical areas for patients and staff. Focused discussions have been on completing templates for sign off and in the last month, on ensuring the mitigation is clearly articulated where actions, such as mandatory training, are red. Month by month comparison is more difficult for November, December and January as during these months actions have been combined, rewritten or closed and removed. Removing signed off actions has helped make the improvement plans more manageable and has facilitated the focus on the work that is left to do. In addition, new sub-actions have been added to help achievement of the overall action and timescales have been refreshed to reflect the second wave of COVID 19. These have now been agreed with the CQC, further discussed at the Quality Board 10th March and will be finalised through the Divisions and TMB.

Month of Impact Report	Oct	Nov	Dec	Jan	Feb	Mar
No. Blue Actions/ combined actions	16	22	38	40	46	49
Total actions on plan	144	144	120	115	116	119
Blue	11% (16)	15.3% (22)	11.6% (14)	9.6% (11)	15.5% (18)	20.2% (24)
Green	45% (65)	40.3% (58)	61.7% (74)	68.7% (79)	63.7% (74)	52.1% (62)
Amber	15% (22)	11.1% (16)	4.5% (5)	3.5% (4)	12% (14)	19.3% (23)
Red	26% (38)	31.9% (46)	21.7% (27)	18.2% (21)	7.8% (9)	7.6% (9)
Need update / on Hold	2% (3)	1.4% (2)	0%	0%	0.9% (1)	0.8% (1)

There are still 10 actions that remain red, these can be largely themed into 3 groups:

Key Risks	Mitigation
The difficult to maintain actions which dip in times of increased patient demand, staff sickness and/or annual leave such as mandatory training and appraisals.	Prioritisation of individuals who have not done the training at all, or who are longer out of date. Factoring in mandatory training into staffing rotas Focused push on areas of low compliance
Diagnostics due to available capacity	Risk Stratification Additional capacity where feasible through mobile diagnostics Agreed referral priority
Areas where additional resources are required to meet the standards e.g. Community nursing.	Staffing review complete, business case in progress. Daily monitoring to ensure safe service.

Maternity (CNST and Ockenden)

Key Aims and Data

An independent review of maternity services was requested and undertaken at the Shrewsbury and Telford Hospital NHS Trust. The first report published 10 December 2020 follows 250 cases and forms seven immediate and essential actions. There will be a further report published due to total cases examined of 1862 cases. The aim of the actions is to improve safety in maternity services across England. Following approval of the original 12 urgent clinical priorities of which we submitted compliance with 10 of the 12 a further more comprehensive assurance assessment tool which draws together the 7 Immediate and Essential Actions along with NICE guidance relating to maternity, compliance against the CNST safety actions and a current workforce gap analysis which is set out below. The Trust Board approved submission to NHSE/I detailing the gap analysis as below.

Key Risks	Mitigation
Safety in maternity units	Implementing Local Maternity System SOP with sharing of Serious Incidents. Establishing submission to Trust Board of Serious Incidents
Listening to Women and families	Provision of independent senior advocate role (awaiting further detail). Further develop of Safety Champions
Staff training and working together	Comply with MDT training compliance across all staff cohorts – need to meet 90%, currently 83%
Managing complex pregnancy	To develop a pathway and SOP for referral to Regional Maternal Medicine Centres once national guidance released.
Risk Assessment throughout pregnance	To establish National Antenatal Risk Assessment process once guidance released
Monitoring fetal wellbeing	To comply with Saving Babies Lives Care Bundle v2, multiple criteria required to be met – on-going work on CO monitoring, pre-term birth clinic, uterine artery Doppler scanning.
Compliance with CNST safety actions	Work on-going with Standard 4 Clinical Workforce, 6 Saving Babies Lives v2 (as above), 8 MDT training (as

	above), 9 Safety Champions (as above)
24/7 theatre access, maternity SGH	24/7 theatre (SGH) access commenced 1/1/2021for caesarean sections and trial of instrumental births.

Serious Incidents

Key Aims and Data

Maternity Serious Incidents and other key Serious Incidents were reported to the Quality & Safety Committee. The key aim is to deliver quality investigations within the nationally agreed timeframe by trained investigators.
There are currently 19 Serious Incidents under-investigation. Of these 14 out the 19 are currently within the 12 week investigation timescale. However 5 investigations are delayed due to the following reasons:

1. STEIS 20484 - The Associate Director for Quality Governance had some queries on the report which requires a little further investigation
2. STEIS 24237 – Delays with Lead Investigators due to operational pressures and personal circumstances
3. STEIS 2071 – Delays due to requiring information back from 3 tertiary centres
4. STEIS 1032 – Delays in assigning a Lead Investigator and the investigation involving staff from 2 separate divisions.

A total of 13 Serious Incident Investigations were sent to CCG's for assurances between the period of 1st February 2021 and 31st March 2021 with 11 of these returning as assured. This gives an assurance percentage of 85% assured on first review for that period.

Key Risks	**Mitigation**
The investigations will not be good quality and therefore the organisation risks not learning.	Regular training on investigation skills Review process on Serious Incidents through divisional sign off to dental Governance challenge and Executive sign off. Challenge to recommendations and actions at SI Panel
Insufficient learning following a Serious Incident	Learning on a Page to all wards and departments Learning Strategy Serious Incident Review Group to look at any further action needed Learning Group commenced to devise key themes for sharing
Unnecessary delays in investigation	Key dates initiated at the outcome Early booking of interviews and RCA meeting Escalation of delays via SI Panel Risk & Governance Facilitators monitoring timescales

DATE	6th April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ab Abdi, Acting Chief Operating Officer
CONTACT OFFICER	Ab Abdi, Acting Chief Operating Officer
SUBJECT	Operational Performance Update
BACKGROUND DOCUMENT (if any)	Not Applicable
PURPOSE OF REPORT	Information, Discussion and Assurance
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The impact on the current pandemic both in the trust and nationally has affected delivery against the constitutional standards. The Emergency Department are currently seeing levels of patients which is more or less at the pre-covid levels and the department still faces pressure in moving patients through the system as a result of zoning and swabbing as well as challenges with the workforce in terms of number and skill mix across the Trust which has impacted upon delivery of the patient flow and A&E 4 hour target. Performance of the 12 hour trolley wait standard has improved though the breaches are directly attributable to flow out of the Emergency Department and the Inpatient exit block compounded by the acuity of patients requiring longer length of stays. This is demonstrated in the Ambulance handover performance over 60 minutes. The Trust's average LoS across the Trust has improved to 3.99 as at end of March 2021. The Trust's performance for 21 day + LoS currently reported at 10% remains under the national ambition of 12% and is one of the best performing within the North East and Yorkshire region RTT continues to see an increasing number of patients waiting resulting in performance of 63.65%. There are 1243 patients that have waited in excess of 52 weeks as at 24th March 2021. The performance is as a direct result

	of the reduced elective operating capacity due to the theatre and anesthetic response to supporting the high acuity of COVID-19 patients and the social distancing and patient choice. Significant progress has been made in creating additional capacity which includes both the use of Goole District Hospital and the Independent sector where the initial focus is on the treatment of urgent and cancer patients. It is also worth mentioning that elective work at SGH was reintroduced from the 15th March 2021 which involves ring fenced beds on ward 19. Cancer 2ww standard continues to be achieved at 97.88% though there are some pressures in achieving the 31 day standard which fell short at 94% and the 62 day standard was 55.20%, again this is as a result of capacity, primarily within the diagnostic modalities. Diagnostic services has seen a further decrease in performance which is related to treating patients on urgent and cancer pathways and limited capacity in some modalities, which has been partially addressed through the opening of the new scanning facilities at DPoW in month and the further opening of additional capacity in May 2021. The service continues to explore additional capacity options which include use of the independent sector and community diagnostic hubs.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	1) Risk of non-delivery of constitutional performance targets
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report

Emergency Department Waits and Ambulance Handovers

Highlights	Lowlights	Risks
• Overall year to date performance of 80.7%, an improvement on last year's 2019/20 performance of 78.0%. However month to date 72.6%. • Extensive Improvements on our paediatric pathways , with our EDs seeing over 4,000 paediatric patients YTD with a 96.8% performance against the 4hr target. The average total duration for ED paediatrics within ED this year has been only 2 hours 11 mins • Staff have responded remarkably to implementing significant service changes during the covid-19 pandemic and transitioning to new ways of working throughout the year, with upgrades to the IT systems, the triage process becoming paperless, and new pathways including IAAU/SDEC • The new ED builds will provide a modern fit-for-purpose environment for both the patients and staff, increasing the clinical cubicle capacity and doubling the resus capacity at each site. • NHS111 First initiative has been rolled out during late 2020 with both EDs now having patient arrival slots bookable directly by NHS111 phone service or online by the patient • Good progress is being made on recruitment due to the launch of a new ED medical staffing recruitment strategy and nurse training and development plans. • A system-wide improvement plan has seen significant progress in the development of alternative pathways to avoid ambulances queuing for ED	• The impacts of covid-19 on ED are still providing additional challenge for waiting room capacity due to social distancing, delays in diagnostics due to increased cleaning regimes, additional PPE requirements, and delays to admission • staffing numbers remain a challenge as covid-19 heavily impacted the recruitment pipeline • Additional medical staff have been injected into ED to improve patient safety throughout the department • Ambulance handovers have been a targeted focus throughout 2020/21, with a direct correlation between high bed occupancy levels and 60 min+ ambulance handovers.	• An overcrowded department due to high bed occupancy levels leading to a lack of patient flow and exit block in ED consequently resulting in in delays for patients in ED and drop in 4hr performance as well as delays in off loading from ambulances and 60 min + handovers • Workforce skillmix – Reliance on locum bank and agency specialty doctors and nursing

ED Streaming, Integrated Acute Assessment Unit and Same Day Emergency Care

Highlights	Lowlights	Risks
• During 2020/21 YTD the Integrated Acute Assessment Unit has seen over **24,000 patients** Trust wide and provides input in to the ED to review incoming admissions and identify appropriate patient pathways • The IAAU went live in October 2020 integrating Medicine, Surgery and Gynaecology acute assessment and SDEC services • The percentage of non-elective patients discharged within 24 hours of admission improved to 31.33% in Q1 2020/21 compared to 26.66% in Q1 2019/20 • Additional investment into the medical staffing for IAAU has been made during the year, allowing an increase in the service provision out of hours to support SDEC services • New direct EMAS streaming went live during March 2021 that enables EMAS crews to speak directly with a Consultant Acute Care Physician for clinical advice and a decision on whether to directly stream patients to SDEC services • Advice and guidance services for Acute Medicine and General Surgery SDEC is now in place that allows primary care to speak directly with a Consultant Acute Care Physician for clinical advice and access in line with national 111 First direction of travel • The final phase of the IAAU will be the move into the newly refurbished units located next to the new ED builds and the additional workforce required to increase the service hours	• Although significant recruitment has taken place, demands on the workforce remain high and work is ongoing to fill all posts required to deliver the service • The Acute Medicine team has taken on significant increases in workload during the year, with an increased number of beds coming under their remit and the introduction of covid/non-covid acute assessment wards • The 3+ days length of stay for non-elective patients has fluctuated throughout the year linked to acuity and the number of patients admitted	• Reliance on sufficient daily discharges to enable flow out of IAAU is required • Turnaround times for covid-19 swab results impacts on ability to move patients on from IAAU into green/red wards • Continued pressures on the acute workforce in maintaining both covid/non-covid IAAUs • Workforce skillmix – Reliance on locum bank and agency specialty doctors and nursing

Discharge to Assess (D2A)

Highlights	Lowlights	Risks
• The Trust's performance for 21 day + LoS currently reported at 10% remains under the national ambition of 12% and is one of the best performing within the North East and Yorkshire region • The Trust's average LoS across the Trust has improved to 3.99 as at end of March 2021. • Improvement work at rapid pace has taken place to enable the whole northern Lincolnshire system implement and embed the Hospital Discharge Service: Policy & Operating Model. • Most ward now have senior consultant presence at board rounds before 10am • The trust have responded remarkably under the ongoing pressures , all wards are now able to report if and when a patient no longer has a criteria to reside in an acute hospital bed • System wide improvement plan in place and we have seen significant progress in the improvements made to the discharge process • Working with our system partners daily to ensure patients who require care when leaving the acute trust receive this within 24 hours of identification with a full escalation plan for delays in place • Introduction of weekend system calls to ensure there are no discharge delays over a weekend • The team carried out two accelerated system wide discharge event which has seen the trust long length of stay reduce significantly, this was recognised at a national level and the system have since recorded a POD cast and acknowledged by the beneficial change programme • The Trust is working with ECIST and the system partners to launch a 4 week frailty service pilot at the Grimsby hospital in May 2021.	• Medical and Nurse staffing numbers remain a challenge and this impacts on the overall flow on all sites • Although there have been significant improvements for senior presence on all wards before 10am there is a vast amount of work that now needs to take place to improve the effectiveness of board rounds to ensure every patient has a plan • Work needs to be carried out on ensuring the identification of patients being placed on an end of life pathway is carried out in a timely manner to ensure the appropriate ongoing care can be put in place dependant on the patient and relative needs and wishes	• Turnaround times for covid-19 swab results impacts on ability to move patients to community beds and placements • Continued pressures on the acute workforce resulting in delay in decision making and timely discharge • Continued IT system & reporting improvements required to ensure all data is captured and reported accurately

Electives and Cancer

Highlights	Lowlights	Risks
• Volume of patients waiting longer than 104 days in Cancer is improving since July 2020. • Overall out-patient attendances above plan for the Trust, only a small number of specialities in Medicine and Surgery are below. • Most specialities on track to achieve 52+ week risk stratified by 31st March • All new patients risk stratified • A number of specialties are hitting the Outpatient Follow Up backlog trajectory • Continued use of Independent Sector will aid with recovery work • Elective work at SGH was reintroduced from the 15th March which involves ring fenced beds on ward 19	• Volume of patients waiting longer than 104 days in Cancer is 28 (trust wide – all tumour sites except Breast & Gynaecology (23rd March 2021)) • Elective recovery is below plan due to lack of theatre capacity and elective beds • The number of 52+ weeks waiters continues to grow • RTT Performance continues to be low	• Workforce risk around significant vacancy gap • Workforce risk around carried over annual leave • Potential wave 3 of COVID-19

NLG(21)070

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6th April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Michael Proctor – Non-Executive Director
CONTACT OFFICER	Michael Proctor – Non-Executive Director
SUBJECT	Highlight Report from the Quality and Safety Committee – February and March
BACKGROUND DOCUMENT (if any)	Approved (February) and draft (March) minutes of QSC
PURPOSE OF REPORT	To highlight the work, actions, key issues and concerns arising from the work of the QSC
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report is brief and acts as an Executive Summary of the QSC meetings

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

LINK TO STRATEGIC OBJECTIVES -				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Relates to quality risks
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Note and discuss the highlight report

Quality and Safety Committee Meetings – February/March 2021

Highlight Report.

February Meeting Summary

Issues referred from other sub-committees

From F&P – Ophthalmology performance and outpatient follow up backlog growth.The Committee resolved to commission the QGG to investigate and report further with particular focus on: size of backlog, nature of conditions, the length of wait andin particular the extent of patient harms.

Update from March meeting – The Quality Governance Group had begun to investigate this issue but highlighted the problem of reviewing the significant number of glaucoma patients on the outpatient backlog for harm. The report on this issue from QGG to QSC is expected in May but the concerns regarding glaucoma patients in particular must be considered a gap in assurance.

From ARG – Trust document control and potential safety issues to use of documents which required review. The Committee was assured by the CEO of further management action which would resolve the issue.

Update from March meeting – The Committee received a presentation from the Medicine Division which demonstrated significant reductions in document control.

Regular Reports to QSC.

Complaints Litigation and Incident Report - The thematic triangulation was notedand welcomed. Committee members made suggestions for the future development of the report which included more explicit links to the impact of mitigations on risks. Reference was also made to the links between information received in this report and the developing Integrated Performance Report.

Update from March meeting – A meeting was being set up in April.

Board Assurance Framework – The Committee was assured that the BAF reviewwas making progress but the work was not yet complete. The Committee looked forward to receiving the revised BAF and Integrated Performance Report at future meetings which would facilitate greater understand of Risk and mitigations.

Update from March meeting – The Committee did not review the BAF in March

Patient Impact Report – the PIR has, throughout the Covid outbreak, provided

anoverview of the clinical risks and mitigations. Some risks had reduced in relation tothe pressures in the Emergency Department (12 hour waits and long ambulance delays) when compared to the Wave 2 peak. However, staffing pressures and staffwellbeing were ongoing concerns and considered a daily challenge. Extended waiting times which continued to rise was also a significant concern.

Quality Priorities – 2021/22. The 5 priority themes; End of Life, Deteriorating Patient and Sepsis, Reduction in Medication Errors, Safety of Discharge and Diabetes Management were agreed and would be recommended to the Board for approval.

Additional Highlights from the March Meeting

Maternity Serious Incidents. The Ockenden Report demands that the Board of Directors review maternity SI's. The QSC undertakes the detailed review of these on behalf of the Board (the reports received at QSC if considered in public may lead to confidentiality breaches).

The Committee considered individual reports on three intrauterine deaths, for each the report included; the incident trigger, the root cause and key learning. There was discussion and assurance was received about the role of sonographers in refusing clinical requests for scans. There was also was a discussion and assurance was provided about the support given to parents and families of those involved in SI's.

Integrated Performance Report. The Committee was pleased to receive for the first time the quality section of the revised IPR. The membership agreed that this was an important development and welcomed the progress made but would like to see the report expand to include an increased number of Quality KPI's utilized within the report in order to put as many performance measures together 'under one roof'.

SLA Approval. The Committee was asked to approve an SLA that covered the interim clinical plan and the clinical pathways that were shared between NLAG and Hull University Teaching Hospital and gave a guide to how we would work with regards to quality governance. This was agreed subject to ongoing review of how the SLA worked in practice.

Mortality. The Committee noted the maintenance of the Trust's SHMI improvement but concerns remained about the disparity between in and out of hospital SHMI. It was acknowledged that some of the improvement required actions outside the Trust and that we were working with the CCG and others to encourage further progress.

Infection Prevention Control (IPC). The updated IPC BAF was received by the committee for assurance on the work undertaken to ensure robust Infection Prevention measures following recent national changes and guidance.

Mike Proctor
Chair of Quality and Safety Committee (QSC)
April 2021

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)071

DATE	6 April 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Neil Gammon, NED / Chair of Finance & Performance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**F&P Committee Highlight Report – February & March 2021 – PERFORMANCE ONLY**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF THE REPORT	Issues from the Finance & Performance Committee meetings requiring escalation by exception to the Trust Board
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises the key issues presented to, and discussed by the Finance & Performance Committee at its meetings on 24 February and 31 March 2021 and worthy of highlighting to the Trust Board.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	BAF Risks 1, 8 & 9
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report and consider the need for any further actions to address issues highlighted in the report.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 April 2021
Report From:	Finance & Performance Committee held on 24 February & 31 March 2021

Highlight Report:

Performance Report – 24 February 2021

CQC Progress Report

- The CQC Report demonstrated an improving trajectory, with more actions closed.
- Evidence of open, transparent contacts with CQC relationship managers.
- Despite Covid-19 pressures, teams were engaged.
- Diagnostics remained Red rated due to lack of capacity.
- Move from addressing and closing various actions to creating sustained improvement plan.
- Committee encouraged clear linkage with risk register.

Performance

- Much improved report in terms of clarity and relevant detail.
- Covid-19 impacts continue with effect of delivery on constitutional targets.
- RTT, slight further deterioration, significant additional capacity being created using GDH and Independent Sector initially for urgent and cancer patients.
- Diagnostic services show further performance decreases. Additional capacity being sought, plus new scanning availability due on line at DPOW in May 21.
- ED performance improved from previous month in terms of 12 hour waits and ambulance handover 60 minute breaches. However, pressure to move patients through system continues.
- Cancer 2 week wait performance maintained; other standards under pressure as diagnostic capacity is main limiting factor.

Estates and Facilities

- Committee finally approved Estates Strategy, following incorporation of changes suggested at earlier review at 27 January F & P Meeting and February Trust Board presentation. Committee highly impressed with final document.
- Committee approved and recommended to Trust Board NLAG Green Plan with no amendments.
- Committee approved and recommended to Trust Board award of new contract for Site Security and Car Parking.
- Committee received report on NLAG Water Systems. View was that report did not do justice to risk mitigation work in place and underway.

Performance Report – 31 March 2021

CQC Report

- Committee received confident CQC progress report. Despite Covid-19 pressures, movement continues in right direction. Committee emphasised importance of continuing to capture and embed evidence and potential to re-visit report format upon arrival of new CQC Improvement Delivery Manager.
- Work continues to move towards improvement network rather than simple focus on CQC actions.
- Demand exceeding capacity leaves diagnostic action rated red.

Outpatient Transformation Programme

- Committee received very positive report on Outpatient Transformation Programme.
- Body of evidence demonstrating successful pilot Connected Health Network for Cardiology with PCN; increasing online consultations; digital letter roll out; growing PIFU uptake plus funded and underway GP risk stratification reviews of follow-up back log waiting list.
- Committee commended the work and supported planned next steps.
- Noted that such transformation brings associated finance and infrastructure strategic considerations.

Performance

- Covid-19 impacts continue on achievement of constitutional standards.
- Key concerns are ED pressures, patient flow both in and out, staff vacancy numbers, skill mix and cumulative weariness.
- Cancer performance as last month.
- Additional capacity, including SGH elective work now, continues to hold up and is making a difference.
- Work to improve position includes system wide daily and weekly reviews to assess progress and implement further refinements; focus on early in the day, MDT board rounds; early identification of patients for discharge; greater adherence to national hospital discharge policy and escalation as required.
- Committee welcomed and supported this good work with associated improvements such as exemplary average length of stay but noted the candid acknowledgement that there is still much more to do.
- Committee noted Phase 3 Recovery work, supported by evidence, which showed considerable progress in many areas.

Estates and Facilities

- Committee approved Action Plan to implement requirements of 23 March 2021 NHSE/I letter on Patient Car Parking concessions.

Confirm or Challenge of the Board Assurance Framework:
Although the BAF is still in a transitional stage to its new format, each executive lead was able to confirm that the management and mitigation of their strategic risks, and thus assurance to the Trust Board, remained in a satisfactory position.
Action Required by the Trust Board:
The Trust Board is asked to note the issues highlighted, the key points made and consider whether any further action is required. **Neil Gammon** **Non-Executive Director / Chair of Finance & Performance Committee**

NLG(21)072

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	06 April 2021				
REPORT FOR	Trust Board of Directors (Public)				
REPORT FROM	Christine Brereton, Director of People				
CONTACT OFFICER	Christine Brereton, Director of People				
SUBJECT	Executive Report – Workforce Update				
BACKGROUND DOCUMENT (if any)	N/A				
PURPOSE OF REPORT	For Trust Board assurance and consideration				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This report provides an update on the People Directorate activities which in the main have been focussed on supporting staff during the continued pandemic. Focus has been on the vaccination programme and health and wellbeing.				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	To be a good employer				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: • Note the contents of the report and update on the areas of work within the People Directorate				

Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Update – January – March 2021

Christine Brereton, Director of People

6th April 2021

Contents

1.0 Executive Summary....3

2.0 Strategic Objectives, Strategic Plan and Trust Priorities....4

3.0 Introduction / Background....4

4.0 COVID Support....4

5.0 Health and Well-being 5

6.0 Risk Assessments 6

7.0 Shielding Staff 6

8.0 Sickness Absence 7

9.0 Staff Survey 7

10.0 Recruitment 10

11.0 Workforce Metrics 11

12.0 People Directorate Priorities 12

13.0 Review of Workforce Committee 12

14.0 Risks 12

15.0 Outcomes 13

16.0 Recommendations....13

1.0 Executive Summary

This report provides an update on activity within the Directorate during the period January – March 2021. The main focus of our activity continues to be supporting the Trust and its staff with responding to Covid-19 mainly through the roll out of the vaccination programme, lateral flow testing and Health and Wellbeing support.

We have in place a large number of Health and Wellbeing offers for our staff including the continued support for psychological wellbeing and shortly greater investment in financial wellbeing. Two main areas of activity have been to ensure that we follow revised guidance on shielding staff and ensure that risk assessments for staff, especially those that are vulnerable, are in place. The completion of risk assessment had been a risk as reported to Board in January but focussed attention on this has seen an improvement to the process, which means that for new employees the risk assessment is completed at recruitment stage.

Sickness levels had been a case for concern with an increase due to anxiety and depression. In total our absent rate was 6.66% in November 2020 which has now reduced to 5.83% for January 2021. The spike in sickness absence can be attributed in the main to COVID related illness and shielding.

Our 2020 staff survey results were published on 11th March 2021. The headlines are Health and Wellbeing, and Safety Culture, themes has statistically significantly improved, Team Working theme has statistically significantly deteriorated, the remaining seven themes have remained largely unchanged from the 2019 survey score.

Recruitment and retention continues, specifically for Healthcare Support Assistants (HCSA, also known as Healthcare Support Workers HSCW) as this is a national initiative with an ambition to have zero vacancies by 31st March 2021. As of the end of March 2021 the recruitable vacancy position was 88.4 WTE. All of these posts have now been recruited too with new employees starting throughout March and into early/mid-April.

We are also continuing efforts to recruit internationally across a variety of staff groups including nursing, medical, and AHPs.

2.0 Strategic Objectives, Strategic Plan and Trust Priorities

The report relates to Objective 2 'To Be a Good Employer' and within the Board Assurance Framework.

3.0 Introduction / Background

3.1 The Workforce Report provides the Board with an overview of activity within the People Directorate during Quarter 4 January – March 2021 and highlights our activities to support Covid and wider workforce priorities.

4.0 COVID Support

4.1 Lateral Flow

The Director of People continues with the role of Senior Responsible Officer for the lateral flow programme. Two WTE fixed term posts were recruited and have been extended for a three month period. They are currently carrying out the distribution of kits onto wards and all other areas of the trust for all staff who are encouraged to participate. This has resulted in 9789 kits to date being issued to staff. Text reminders continue to be sent to staff as a regular reminder to submit results. We have implemented a result return option that provides evidence for community staff entering care homes.

4.2. Vaccination Programme

The first phase of the covid vaccine was successful delivered in line with JCVI guidelines and all of our front line staff and wider Health and Social Care Community were offered the first dose of the Pfizer vaccination. Clinics were in place at both DPOW and SGH with a one off pop up clinic at Goole. This first phase ran from 4th January until 19th February total number vaccinated overall was 11557.

Phase 2 to adminster the second dose commenced from the week beginning 29th March 2021. Arrangements are in place, as per the first phase, to run two clinics from SGH and DPOW with one pop up clinic from Goole. Following adminstration of the second dose,which is currently scheduled for completion on 14th May 2021, the hosptial hub will stand down due to mass vaccination centres now up and running across the region.

We used a survey approach through email/comms to ask staff that had not come forward for vaccination to inform us of whether they had received the vaccination elsewhere. We have had over 400 responses and these will be added to the overall final figure when the vaccinaiton programme is completed.

Following a national request to ensure we were addressing staff concerns about the vaccine to increase uptake we offered a mix of virtual and face to face Q & A sessions with our team of vaccinators and pharmasists. The face to face sessions were in the vaccine clinincs to promote private conversations. Sessions were promoted through broad communication routes.

5.0 Health and Wellbeing (HWB)

The Health and Wellbeing of our staff has remained a top priority for the Trust and People Directorate. Health and Wellbeing had a significant investment from April 2020 to support staff when they needed it the most; including but not limited to:

- New Employer Advice Platform (EAP) support providing 24/7 counselling and new pathways created with all external providers including self-help guides on numerous topics to help staff and families
- HWB Group created to oversee the Mental Health Agenda
- Wobble Rooms created
- Staff donations and welfare packs created
- Wellness Wednesday launched to support mental, physical and financial health
- Virtual counselling sessions created for face to face support
- Group counselling sessions arranged following on from traumatic events
- Extensive upskilling of managers to support staff
- New risk assessment process with wellbeing conversations embedded – as at 30th March 2021 6961 risk assessments have been completed

It is pleasing to note (please see section 9 below) that scores relating to HWB have improved in the staff survey results.

The current offering is accepted as broad, wide ranging and has access routes by phone, text, email, manager referral, virtual meetings, CBT workbooks, and covers staff and families in a wide range of topics e.g. debt advice. The mental health offering in place uses the 'stepped care' approach and all external partners have worked together to provide a clinical pathway and all work in collaboration for the benefit of staff. 'Fast Track' pathways are in place to ensure our staff are not delayed in accessing local mental health support.

To help the continued promotion during February, staff from across the Trust were asked to provide their feedback on the current HWB offer, informing us if they know where to look for support, have time to access support, how they would prefer to access it and what more as a Trust we could do to help them help themselves, using our staff Facebook platform. They were also invited to join focus groups to help guide the long-term HWB offer.

In March, we have through campaigns championed by the CEO continued to promote our Health and Wellbeing offer to our staff through our communication channels. Both Vivup and Remploy our counselling services report that our uptake numbers are lower than other Trusts although they feel that the promotion work delivered by the Trust is one of the best.

In line with the recently discussed Trust priorities, a long term health and wellbeing plan will be developed via the HWB group for approval via the Executive Team and Workforce Committee. This will set out plans for the next two years. We will also take account of recent staff survey results which has a

focus on health and wellbeing to identify any areas whereby action should be focussed. It is further anticipated that we will utilise the NHS Health and Wellbeing Framework diagnostic tool to undertake a self-assessment (currently being updated) on our current state for HWB and to identify future requirements. This will help to shape the plan and will involve stakeholders at all levels to ensure that we have engagement at the right level and at the right time, as previously discussed at the Executive team.

This work will be supported by HWB resource to facilitate the development and delivery of the plan as funded by the Health Tree Foundation and will form part of the restructure proposals for the People Directorate.

6.0 Risk Assessments

As reported to the Board in January, outstanding risk assessments for our staff remain an area of concern. Through focussed work the number of outstanding risk assessment has reduced by around 100, leaving a total outstanding of around 572, 255 (44%) of which are bank staff. We continue to write and contact these staff, especially those who are actively engaged at the time to undertake a risk assessment.

HR Business Partners are working through the remaining 317 with a targeted approach with the appropriate line managers which continue to be monitored through the PRIM monthly meetings.

Since last reported, the Trust has now implemented a risk assessment process at the point of recruitment meaning that the risk assessment is carried out by the recruitment team with the candidate as part of the recruitment checks process. This reduces the management time required to maintain the risk assessment and stops the potential of an increase in the risk assessment position as a result of new starters.

7.0 Shielding Staff

The Trust has been following government guidelines for shielding staff and has supported staff to shield where notified to do so by their GP during the latest shielding period which commenced in January 2021.

The Trust have worked with this staff group via their line managers to ensure contact is maintained and where possible that they are enabled to carry out their role or other duties from home.

This guidance has now been updated as part of the government's road map out of lock down, meaning that all shielding staff will return to work as of the 1st April 2021. The HR team has written to all individuals affected and is working with line managers to enable returns to transitionally work. Core to this is continuing to maintain the safety of any extremely clinically vulnerable staff whereby a possible outcome of the Trust risk assessment process may be to remain at home.

There has been no update to guidance as of yet in relation to the vaccination reducing the risk score of extremely clinically vulnerable staff, awaiting further information.

8.0 Sickness Absence

The Trust wide sickness position currently stands at 5.83% (January 2021). Unfortunately due to a lag in reporting later data is not available at the time of writing this report. This is outside the Trust target of <4.10%, however, historically the trend data shows that the Trust's sickness rates are significantly higher during the winter months (November through to February). It is predicted that the sickness rate will continue to fall over the next few months. Over the last 3 months the sickness rates have decreased and are now close to pre-Covid levels for this time of year.

The sickness position has reduced from 6.66% in November 2020 to 5.83% in January 2021. In comparison, last year's sickness rate for January 2020 stood at 5.59%.

The reason for the decrease in the sickness rate from December 2020 to January 2021 is due to a reduction in long term sickness FTE days lost (from 11,472.13 FTE days lost in December 2020 to 10,305.49 FTE days lost in January 2021). The highest sickness reasons in January were due to 'anxiety/stress/depression/other psychiatric illnesses' (3,572 calendar days lost), 'cough, flu – influenza' (including COVID-19 sickness cases) (2,597 calendar days lost) and 'musculoskeletal problems' (1,144 calendar days lost).

9.0 Staff Survey

On 11th March 2021, our staff survey results from 2020 were published by NHS England. From this:

- Our response rate was 36% (2,420 returns) which was 3% lower than our 2019 survey.
- Our comparator benchmark response rate was 45%. The benchmark group is all Acute & Acute Community Trusts.

- The 2020 survey findings report outlines 10 themes (Appraisals theme was removed for 2020 due to the pandemic) and COVID specific questions. The outcome of the 10 themes is below:

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	5.8	6.4	5.9	7.4	7.8	9.4	6.4	6.6	6.2
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	2,369	2,380	2,384	2,361	1,926	2,328	2,368	2,373	2,395	2,364

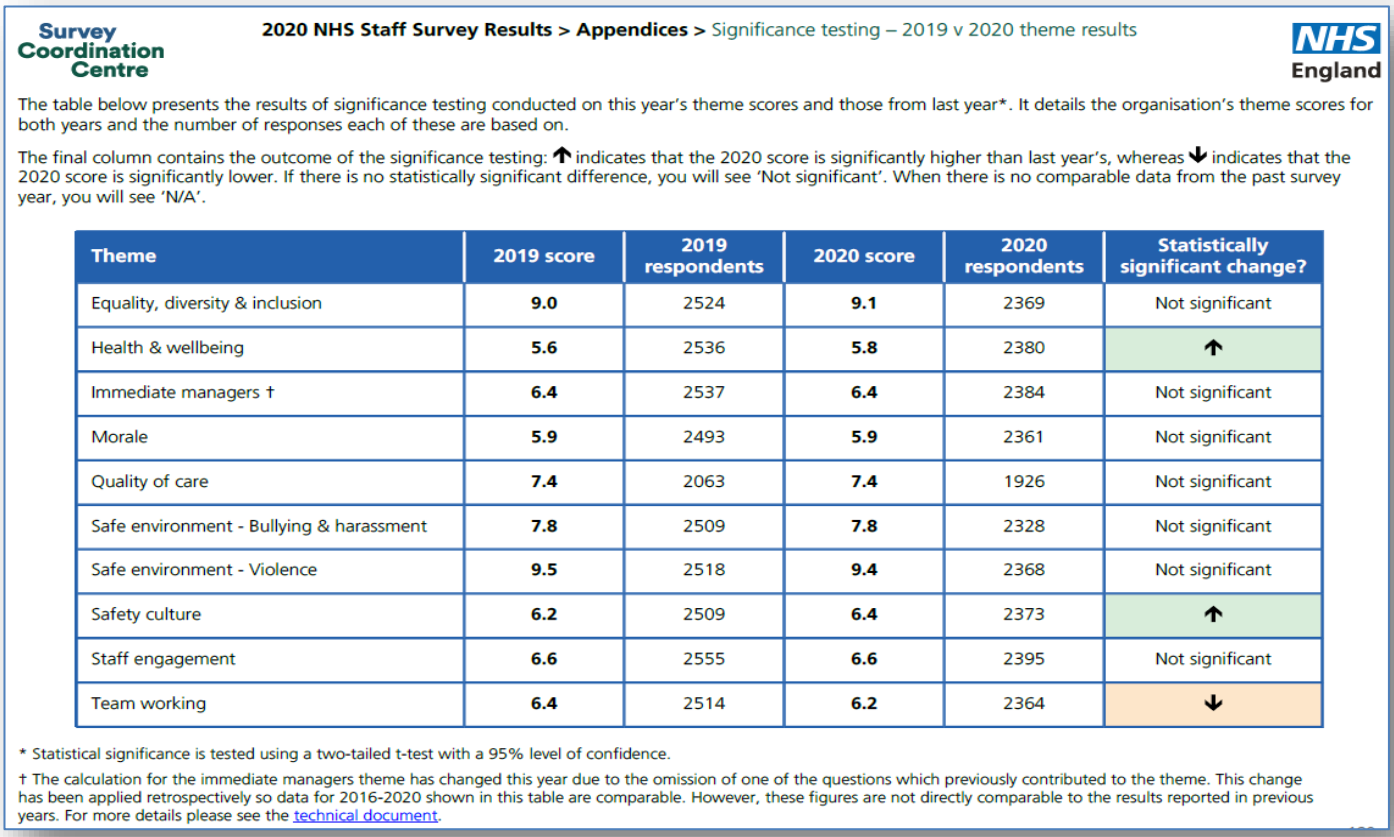
The Trusts full set of Staff Survey findings – Trust wide and Directorate specific reports – can be downloaded below:

NHS_staff_survey_2020_RJL_full.pdf

NHS_staff_survey_2020_RJL_directorate.

Reviewing the themes reveals:

- Health and Wellbeing, and Safety Culture, themes has statistically significantly improved
- Team Working theme has statistically significantly deteriorated.
- The remaining seven themes have remained largely unchanged from the 2019 survey score
- Full scores per theme, with statistical analysis below:



Survey Coordination Centre

2020 NHS Staff Survey Results > Appendices > Significance testing – 2019 v 2020 theme results

NHS England

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's, whereas ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.0**	2524	**9.1**	2369	Not significant
Health & wellbeing	**5.6**	2536	**5.8**	2380	↑
Immediate managers †	**6.4**	2537	**6.4**	2384	Not significant
Morale	**5.9**	2493	**5.9**	2361	Not significant
Quality of care	**7.4**	2063	**7.4**	1926	Not significant
Safe environment - Bullying & harassment	**7.8**	2509	**7.8**	2328	Not significant
Safe environment - Violence	**9.5**	2518	**9.4**	2368	Not significant
Safety culture	**6.2**	2509	**6.4**	2373	↑
Staff engagement	**6.6**	2555	**6.6**	2395	Not significant
Team working	**6.4**	2514	**6.2**	2364	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

Key Observations:

As well as the areas that have statistically significantly improved evaluation of the survey reveals staff report:

- Their managers are taking a positive interest in their health and wellbeing up from 60.2 per cent in 2019 to 62.7 per cent.
- We will be further developing our HWB offer during 2021/22 as we being compare our HWB offer against the NHS HWB framework as provided by NHS Employers. This will enable us to create a c.2year HWB development programme.
- That they felt they are treated fairly when involved in an error or near miss, and that action is taken when you do report something, and that they are given feedback about changes made in response to errors, near misses or incidents. This in turn has resulted in them feeling more secure in raising a concern, increasing from 60.2 per cent in 2019 to 64.4 per cent.

When asked if staff would recommend NLaG as a place to work or if a friend or relative needed treatment would they are happy with the standard of care provided by the Trust we found improvements in both scores. The responses to these have crept up from 51 per cent and 53 per cent to 53.4 per cent and 54.1 per cent respectively.

Equality and diversity is a central measure within the survey and reviewing these findings shows 82.5 per cent of staff feel 'my organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, and disability of age'.

Concerns workplace pressures felt by staff the survey showed:

- A decrease in the number of people coming to work despite not feeling well enough to perform their duties from 60.5 per cent down to 48.3 per cent
- 51 per cent (2019 – 56.6 per cent) – the team I work in often meets to discuss the team's effectiveness (this question was the critical answer that led to the 'Team Working' theme being classified as a statistically significantly deterioration)
- 44.7 per cent (2019 – 39.9 per cent) – felt unwell as a result of work related stress.

Work is presently underway to link strategic actions, from the NLaG People Strategy to the staff survey in order to ensure the People Directorate objectives are focused on the areas needed to improve staff working life's as well as contributing to the Trusts priorities.

10.0 Recruitment

10.1 International Nursing Recruitment

The recruitment of international nurses is being run as a project by the Chief Nurse Directorate, supported by the Recruitment Team and Finance. 57 nurses sourced from overseas have started at the Trust since 30th October 2020, with a further 18 scheduled to start week commencing 23rd March 2021. All of these nurses have been sourced via the Talent Acquisition Team undertaking recruitment campaigns and through referrals under the Trust refer a friend policy.

National funding has been secured to support recruitment activity in relation to international nurses, supporting recruitment and on boarding costs, and additional CPD team staffing to support training and OSCE preparation. A further 60 nurses are planned to start in post between May and October 2021, and work is currently underway to source candidates from various parts of the world including India and the Middle East to diversify the pool of candidates available.

Over the next few months we should see the vacancy factor reduce due to passes of OSCE examination. We are recruiting a further 60 WTE by October 2021. We have recruited 54 NQN nurses which will commence in October/November 2021; further interviews are taking place week commencing 29th March to appoint further NQNs which is predicted to increase the number of appointed NQNs to circa 70 WTE. Further work is underway with Nursing and Finance colleagues to triangulate establishments, pipeline and predicated turnover to agree a proposed vacancy position taking the above recruitment and pipeline into account.

10.2 Health Care Assistants

The recruitment of HCAs is being run as a project by the Chief Nurse Directorate, supported by the Recruitment Team and Finance. National funding has been secured to achieve an operational zero vacancy rate for this staff group by March/April 2021.

Candidates have been sourced through traditional online advertising and a targeted campaign in conjunction with INDEED (job website supporting NHSI/E) aimed at encouraging candidates without previous formal healthcare experience into the profession. A joint piece of work was undertaken by Recruitment, Chief Nurse's Directorate, and Finance to establish the recruitable vacancy position to establish posts to be recruited to, which established a vacancy position at the beginning of March 2021 of 88.4 WTE.

At the time of the report all HCA vacancies have now been appointed to and allocated departments. This pool currently stands at 45.60 WTE appointed and undergoing pre-employment checks, which will cover turnover ongoing and will be recruited to periodically to ensure a ready supply of HCAs to cover turnover.

As a result we will meet our overall target for recruitment of HCA and continue to have a supply in our pipeline. March has 57.33 WTE confirmed for start, with a further 21.87 WTE confirmed to start in April. A further 3.84 WTE are yet to confirm start dates, but these are likely to be in April.

10.3 Medics

The medical and dental vacancy position improved at the end of February to 13.82% (100.52 WTE) and is now back within the target range. Crucial vacancies will continue to be covered by agency staff. Sourcing of medical and dental staff has continued, although starts have been difficult to achieve in recent months due to travel restrictions and visa offices/official institutions overseas running at reduced capacities. This situation is now easing and the pipeline of appointed medical staff is converting to starts.

The pipeline of doctors appointed waiting to start between April and July 2021 currently stands at 38 WTE doctors. The February 2021 training doctor intake saw a fill rate of 80 % of all training posts filled. Recruitment continues for all grades of doctors, utilising online platforms, and additional bespoke campaigns for particularly hard to fill roles to build the pipeline further.

11.0 Workforce metrics (quality and measurement)

Work is now underway to develop a set of key Workforce metrics which demonstrates delivery of both the NHS People Plan and People Strategy. These metrics will inform the IPR and wider KPIs for workforce delivery. We are reviewing the data quality of ESR developing standard and consistent SOP on denominators and ensuring that it reconciles with other systems, i.e. finance ledger and e-rostering to ensure that data reporting internally and externally is

correct and provides the right level of board assurance. Full utilisation of ESR will continue through our plans which will enable both manager and self-service improving data quality and information outputs.

12.0 People Directorate Priorities for 2021/22

The Trusts People Strategy was signed off by the Board in June 2020 and the NHS People Plan was formally launched in July 2020. The key principles and priorities of these plans align setting a clear direction of travel for the Trust on People priorities.

To some extent the deliverables have be put on hold with the pandemic, but in other areas such as HWB – activity has increased. To support implementation of both of these strategies, deliver against the Trust priorities on "To be a good employer" and to provide the Directorate with some clear focus, an implementation of People Directorate priorities is being developed. This will be submitted to the Executive Team in April for the year 21/22 for approval. The main priorities being identified by the Director are as follows:

- Develop restructure plans for the People Directorate including investment
- Improve our approach to HR case management/Governance of HR processes, including workforce data (get the basics right)
- Identify our priorities and activities on Culture and Leadership models and review and renew our approach
- Scope out an Apprenticeship Model for Nursing
- Continued focus on Recruitment and Retention
- Develop a Health and Wellbeing plan for the next two years
- Development of an overarching Leadership Strategy Framework/approach
- Improved Partnership working with our Trade Unions
- Partnership working within the ICS

13.0 Review of Workforce Committee

Work is underway (with the support of the Chair of the Workforce Committee) to review the terms of reference ensuring that the Committee focusses on the delivery of the People Strategy and NHS People Plan and ensures that it is discussing and reviewing the right things at the right level. This will help us determine the outputs for governance as appropriate including Board approval, information and assurance. This will also include development of a set of Workforce Metrics aimed at demonstrating improvement and identifying risks and areas for improvement.

Proposals for discussing on the Workforce Committee will be discussed at its next meeting in April.

14.0 Risks

- Covid 19 restrictions in relation to international recruitment could create delays in recruitment processes.

- Continuation of support from the People Directorate in the delivery of phase 2 of Covid vaccinations and continued lateral flow roll out. Core people activities are running with minimal staff.
- Assurance and control activities identified within the BAF are at risk and Director of People is currently assessing the alignment of resources within the directorate against priorities.
- Unknown factors which could delay the start dates of recruited health care assistants.

15.0 Outcomes

Further work to support the delivery of the agreed People Strategy and NHS People Plan will be developed and discussed at Workforce Committee. Any measures developed will demonstrate achievement against our key Workforce priorities determined for 2021 and beyond. Highlight reports to the Board will reflect progress as discussed at the Workforce Committee.

16.0 Recommendations

The Board are asked to note the contents of the report and update on the areas of work within the People Directorate.

Compiled By: Christine Brereton, Director of People and Claire Low, Deputy Director of People

Date: 30th March 2021

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)073

DATE	6th April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Michael Whitworth, Chair Workforce Committee
CONTACT OFFICER	Michael Whitworth, Chair Workforce Committee
SUBJECT	Workforce Committee Highlight Report and Board Challenge
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF REPORT	To report assurance highlights and risks and matters for Board escalation.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Committee held a transitionary meeting on 23rd February 2021. This was the first meeting since October 2020 and had a shortened agenda to reflect the Covid work pressures affecting the whole Trust team. There were 2 matters for ratification and assurance: • The Modern Day Anti-Slavery Statement Report which was recommended to the Board for Approval. • The Gender Pay Gap Report which was recommended to the Board for Approval subject to data quality checks to be undertaken. The focus of the rest of the meeting was on the forward workplan for the Committee and the re-introduction of full assurance activity.

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

LINK TO STRATEGIC OBJECTIVES				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and long term. Ineffective staff engagement and ownership of the Trust agenda affects morale and failure to change and improve the culture.
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report

Workforce Committee Highlight Report

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 Background

2.1 The Committee held a transitionary meeting on 23rd February 2021. This was the first meeting since October 2020 and the introduction of temporary governance arrangements across the Trust.

2.2 A shortened agenda was agreed and focussed on the key business items requiring scrutiny before the March Board Meeting, and a look forward to next year's work plan and return to normal assurance arrangements.

3 Items for Ratification and Assurance

3.1 There were 2 items for ratification and assurance ahead of the March Trust Board Meeting as follows:

<u>The Modern Day Anti-Slavery Statement Report</u>

3.2 This important document was recommended to the Board for Approval. The key factor for the Trust is ensuring that our procurement and contracting arrangements meet our commitment to anti-slavery through our suppliers. The Committee recommended that the key elements of the report were turned into an actual "Statement" that could go on the Trust website and be available to staff, patients and the public.

<u>The Gender Pay Gap Report</u>

3.3 The Committee reviewed the report, however, potential data quality / data interpretation issues were discussed. The Committee recommended the report to the Board for approval subject to:

- Data accuracy being checked
- Clarification on the narrative to ensure it reflected the requirements/obligations to report under the GPG requirements.

As the national submission date of the report had been moved from the end of March 2021 to October 2021 since the Committee papers had been circulated it was recommended that the report be moved to a Board meeting later in the year if the review of the figures had not been completed in time for the March session.

Following the meeting the data was validated and appropriate adjustments made to enable the final report to be presented to the Board in April.

Other Matters of Note Raised

A Committee action relating to Pride and Respect training that had been on hold since September 2020 due to the relevant officer being redeployed as part of the Covid-19 response was discussed. The Committee were advised that a different approach was being developed that would form a second phase of Pride and Respect for the Trust based on the learning to date. This was welcomed by the Committee and details will be brought to a later meeting.

Assuring workforce data quality was also discussed. It was agreed that the Committee should play a key role in assuring the quality of workforce data being submitted to the Board. Plans will be developed to progress this.

Review of Working Arrangement
The Committee discussed working arrangements for 2021/22.

The key points raised were:

- The need for a KPI dashboard giving an overview of workforce performance from both an internal and external perspective.
- The workplan to be refreshed to reflect:
    - The Trust priorities for 2021/22
    - The Trust and national People's Strategies
    - The Board Assurance Framework
    - CQC priorities

It was requested that feedback on the workplan be given at the April Committee meeting.
Updates on statutory training and personal development reviews and Staff retention were also highlighted as prioritises for Committee consideration.

NLG(21)075

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	06 April 2021				
REPORT FOR	Trust Board of Directors (Public)				
REPORT FROM	Christine Brereton, Director of People				
CONTACT OFFICER	Liz Houchin, Freedom To Speak Up (FTSU) Guardian				
SUBJECT	FTSU Guardian Report Q3 2020-21 – October-December 2020				
BACKGROUND DOCUMENT (if any)	N/A				
PURPOSE OF REPORT	For Trust Board assurance and consideration				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The FTSU Guardian Q3 Report for 2020-21 gives an update from the last Trust Board report, an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by the Trust's FTSU Guardian.				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	To be a good employer				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: • Note the report and it is for assurance				

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q3 – October – December 2020

Liz Houchin

24th March 2021

Contents

1. Executive Summary 3
2. Strategic Objectives, Strategic Plan and Trust Priorities 3
3. Introduction / Background 3
4. Assessment of concerns 3
5. National and Regional Information and Data 8
6. Proactive Work during Q3 8
7. Conclusion 9
8. Recommendations 9

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q3 2020-21 (which covers the period October – December 2020). 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.

3.2 A board development session is provisionally planned for summer 2021 and will be supported by NHSI; work is in progress to discuss the outline of the training and to gain formal agreement for the session.

4. Assessment of FTSU Concerns Raised

4.1 In Q3 2020-21 the number of concerns received were 55.

- Four concerns were raised anonymously. National figures show that the average number of concerns for a NHS Trust for Q3 was 20.3. Data also shows that the rolling 12 month average of 53 would put the Trust in mid-high position with both the national and peer median being 34.

- The rolling 12 month average figure for concerns which involved an element of patient safety is 14 which places the Trust in the top quartile nationally, with both national and peer median being 6.

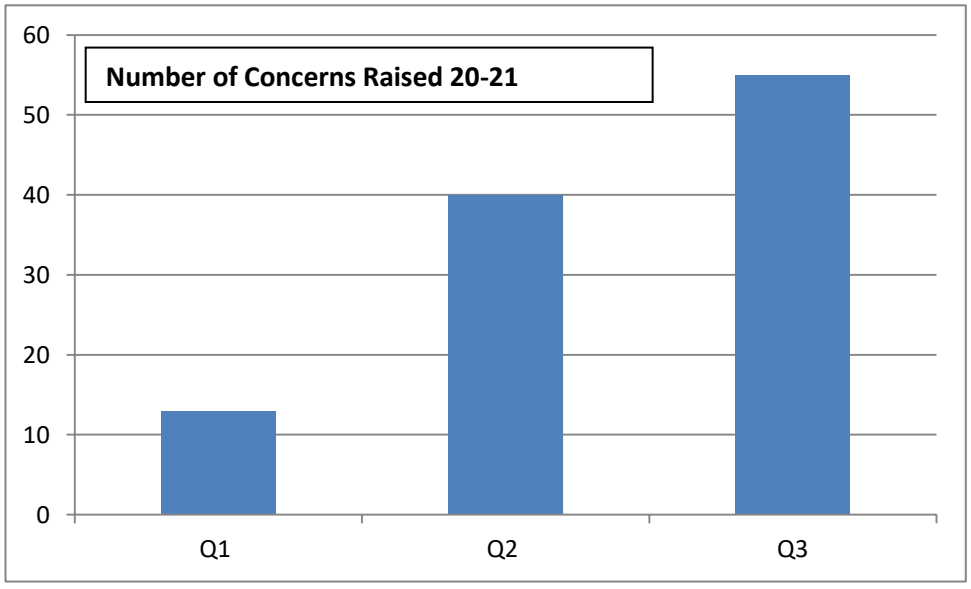
- The rolling 12 month average figure for concerns which involved an element of bullying and harassment was 15, which puts the Trust in the third quartile nationally, the national and peer median being 9.

4.2 The Q3 figure was a significant increase compared to previous quarters although during 20-21 the number of concerns reported have increased exponentially each quarter. The high number of concerns may be due to a combination of the publicity that the FTSUG did to highlight that October 2020 was 'Speak Up' month and that initial services and people were starting to do more business as usual work, so staff were back in their own teams.

4.3 The main themes raised were around staff and patient safety and behaviours. The increase in staff and patient safety may be related to staff raising concerns around COVID rules, staffing levels because of the number of staff isolating, shielding or on sick leave and the impact this may have on patient safety. The high number of concerns relating to behaviours may be an indication of the impact of the pandemic, and staff being exhausted and burnt out.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority of concerns were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the DOP /CEO for awareness and support if required.

4.5 FTSU Guardian is now producing 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.



Q2. 2020 21 (July September 2020)			Q3. 2020 2021 (Oct December 2020)
Concerns	**40**		**55**
Themes	Behaviour / relationships	16	29
	Bullying & Harassment	11	10
	Culture	2	8
	Leadership	0	0
	Patient Safety	11	13
	Process/Systems	14	11
	Personal Grievance	0	0
	Staff Safety	11	17
How Raised	Openly	9	21
	Confidentially	30	30
	Anonymously	1	4
Perceived detriment		0	0

NB. Please note some concerns may have more than 1 element.

Report Breakdown by Division and Role.

Q2. 2020 2021 (July September 2020)			Q3. 2020 2021 (October Dec 2020)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor	Medicine x 2 SCC x 2 Med Director	5	Doctor	S&CC x 2 Medicine x 6 W&C x 1	9
Nurse	Chief Nurse x 2 Surgery x1 CSS x 2 W&C x 1 Medicine x 2	8	Nurse	Medicine x 5 W&C x 2 Chief Nurse x 1 CSS x 1	9
HCA	CSS	2	HCA	Medicine x 3 CSS x 1 C&T x 1	5
Admin		6	Admin	CSS x 3 IT Digital x 3 W&C x1 Medicine x 4 S&CC x1 C&T x1 Med Director x1	14

AHP	CSS x 2 SCC x 7	9	AHP	C&T x 3 CSS x3 S&CC x1	7
Other		9	Other	W&C x1 POE x1 C&T x 2 CSS x 3 Medicine x 1 S&CC x 1 Facilities x 1	10
	Facilities	1	Midwife	W&C	1

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.

Quarter 2019 2020	Feedback received	Would you speak up again? Yes
Q1	2	2 x Yes
Q2	8	8 x Yes
Q3	13	13 x Yes
Q4		

Within the feedback received, the following are extracts of qualitative feedback received:

"I felt that the lady I discussed my issues with understood and was empathetic. She was calm and reassuring, as well as knowledgeable in finding a beneficial way for me to resolve my concerns. She listened and I felt that I had been heard and not simply fobbed off or dismissed".

"The response was amazing and I don't think I would have remained at work without the support of Liz Houchin our Speaking out Guardian".

"Liz provided a lot of support throughout the process understanding the problem from our perspective whilst maintaining a balanced view of the matter. I was greatly encouraged by the way she handled the matter".

4.7 Case Study

The inclusion of a case study in the report is a new feature. This 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.

FTSU Guardian was contacted by a staff member concerned that some patient transfers across the Trust were unsafe because they were not clinically led.

The staff member felt that they raised this to managers on several occasions but nothing had happened, they raised the concern openly because they were keen to be involved in finding a solution. FTSU Guardian identified the most appropriate person to address this issue and a meeting was arranged, the staff member asked for the FTSU Guardian to attend to support. At the meeting the issue was discussed and a plan was put in place to ensure that staff could escalate any inappropriate transfers at the time, which would then be discussed prior to the transfer. Staff member was pleased with the outcome and felt listened to.

5. Regional and National Information and Data

5.1 National update

The National Guardians Office (NGO) has now released the second module of its e-learning package for healthcare workers. This has been developed in partnership with Health Education England. The module is titled 'Listen Up' and is for managers only. POE directorate will be looking to incorporate this into future leadership training.

The NGO have published a draft 5 year strategy for comments, the FTSU Guardian has sent comments to the Regional Chair.

Q3 data for 2020-21 has been submitted to the NGO by the Guardian.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent meetings have included presentations about the importance of offering a comprehensive 'Health & Wellbeing' package to staff particularly during and post pandemic. It focused on ensuring that organisations are aware of their ICS offer and that all FTSUGs were aware of this. The regional network is also looking at developing a 'gap analysis' tool for NGO case reviews.

6. Proactive work of the FTSUG during Q3

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Agreement from COO to include FTSU information into PRIMs via HRBPs
- Completion of protocol for Local Fraud Specialist and FTSUG
- Attendance at Trust inductions for Doctors, Overseas Nurses and Staff who are currently shielding

Future Plans

- Work of future combined Champions to include Pride and Respect and Health and Wellbeing is being considered by the People Directorate and the identification of appropriate training.
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian
- Work with the Health & Wellbeing Guardian
- Use social media to raise awareness of FTSUG and the role

7. Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

The Trust Board is asked to:

a) Note the report for assurance
b) Approve the report

Compiled By: Liz Houchin, Date: 24th March 2021

DATE	06 April 2021
REPORT FOR	Public Trust Board
REPORT FROM	Christine Brereton, Director of People
CONTACT OFFICER	Karl Portz Equality, Diversity and Inclusion Lead
SUBJECT	Gender Pay Gap Report
BACKGROUND DOCUMENT (if any)	This report provides the Trust Board with a report against the Gender Pay Gap reporting standard, which legally it must publish each year.
PURPOSE OF REPORT	The Trust Board are asked to approve the content of this report and agree that the information within this report can be published on our website, on the UK Government website and shared with our commissioners.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not applicable.
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	New regulations that took effect on 31 March 2017 (The Equality Act 2010 - Specific Duties and Public Authorities - Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information annually. The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of earnings and it is a measure of disadvantage.

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

LINK TO STRATEGIC OBJECTIVES				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Strategic Objective 2 – To be a Good Employer, this is a statutory requirement.
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to approve the content of this report. Once approved agreement given that the information within this report can be published on our website, on the UK Government website and shared with our commissioners.

Gender Pay Gap Report – April 2021

Christine Brereton, Director of People

April 2021

Contents

1. Executive Summary……..4

2. Strategic Objectives, Strategic Plan and Trust Priorities……..……..4

3. Introduction / Background..……..4

4. Discussion / Issues……5

5. Implications / Impact……..9

6. Outcomes……9

7. Conclusion…… 9

8. Recommendations……10

Appendix 1……..11

1. Executive Summary

1.1 New regulations that took effect on 31 March 2017 (The Equality Act 2010 - Specific Duties and Public Authorities - Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information annually. The gender pay gap shows the difference between the average (mean or median) earnings and average bonus payments (mean and median) of all male and all female employees.

1.2 Once calculated the data which reflects both average earnings and average bonus payments for males and females must be uploaded to the Government website, shared with our commissioners and published on our website.

1.3 The headline data can be seen in appendix 1 and this is displayed in the format which requires publishing on the Government website. It shows that the average female hourly rate of pay is 33.84% lower than it is for male staff. The average bonus payment for female staff is 64.87% lower than it is for male staff.

1.4 The Board are asked to approve this data for publication as detailed in 1.1. This data should be published by 30 March 2021. However, due to the adverse impact of Covid 19 this date has been extended to the 6 October 2021.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 As stated within our strategic objectives NLaG is a ‘good employer’ and therefore, must achieve our Public Sector Equality Duty (Equality Act 2010) - Specific Duties and Public Authorities - Regulations 2017 which requires all public sector organisations in England employing 250 or more staff to publish gender pay gap information annually.

3. Introduction / Background

3.1 New regulations that took effect on 31 March 2017 (The Equality Act 2010 - Specific Duties and Public Authorities - Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information annually.

3.2 The gender pay gap shows the difference between the average (mean and median) earnings of all male and all female employees. It is expressed as a percentage of earnings and it is a measure of disadvantage.

3.3 The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same.

A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

3.4 Closing the gender pay gap is not just about achieving gender equality but also about boosting the economy given the cost of the under-utilisation of women's skills to the UK economy, and the impact on productivity. The Government anticipates that reducing the gap at a workforce level will help to narrow the gap at a national level.

3.5 Additionally, nationally there is demand, by regulators and the public, for a move to greater pay transparency. The Government believes that increasing transparency around the differences in pay between men and women will make employers more accountable and encourage them to scrutinise their own recruitment, remuneration, reward and staff development practices and ensure that steps are being taken to close any gender pay gaps identified by the reporting process. Over time it is anticipated that reporting might be extended to race, disability or age.

3.6 Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other includes unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

4. Discussion / Issues

4.1 Reporting Requirements

The Trust is required to publish annually six gender pay gap measures:

- Mean pay gap – the difference between the mean hourly rate of pay (excluding overtime) of male and female employees
- Median pay gap – the difference between the median hourly rate of pay (excluding overtime) of male and female employees
- Mean bonus gap – the difference between the mean bonus paid to male and female employees who received a bonus in the relevant pay period
- Median bonus gap – the difference in the median bonus pay for male and female employees who received a bonus

- Bonus distribution by gender – the proportions of male and female employees who received bonus pay

- Pay distribution by gender – the proportion of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands.

4.2 The measures are calculated using a 'snapshot date'. For public sector organisations this is the pay period which includes 31 March 2020. The figures must be calculated using the mechanisms and guidance set out in the gender pay gap reporting legislation and does not reflect the Trust's total headcount as specific parameters are applied for just reporting 'full pay relevant employees'.

The snapshot date used for our data was 31 March 2020 is calculated for staff that were in receipt of full pay, so will not include staff on maternity leave, sick leave, temporary contracts, zero hours contracts, bank or agency staff. For the bonus pay data the period of 1 April 2019 to 31 March 2020 was used hence why the headcount figures differ.

4.3 The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2021) and by the same date every subsequent year. However, due to the adverse impact of Covid 19 this date has been extended this year and this year only to the 6 October 2021. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format (see Appendix 1).

4.4 There is no legal requirement to publish any accompanying narrative or commentary to explain what the figures mean, what the Trust believes are the factors behind the gender pay differences and what the Trust intends to do to close the gap. However guidance produced by ACAS and the Government Equalities Office emphasises the importance of employers producing a supporting narrative.

4.5 <u>Trust Data and Analysis For Trust Pay</u>

The Trust's Gender Pay Gap Data 2020/21 for mean hourly rates and median rates are set out below and compared to the 2018/19 and 2019/20 figures:

Gender	Mean Hourly Rate			Median Hourly Rate		
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21
Male	£18.8682	£19.2138	£19.7186	£14.0384	£14.3449	£14.8877
Female	£12.2841	£12.6599	£13.0449	£10.1531	£10.4578	£10.7806
Difference	£6.5842	£6.5539	£6.6737	£3.8854	£3.8871	£4.1071
Pay Gap %	**34.89**	**34.11**	33.8448	**27.67**	**27.09**	27.5871

4.6 The data show that this year male staff earn on average £6.67 per hour more than female staff, and as a percentage male staff earn 33.84% more than female staff.

4.7 The median hourly rate for male staff is £4.11per hour higher than female staff, and that the median hourly rate for male staff equates to 27.59% higher than that of female staff.

4.8 In comparison the figure trends over the last three years for the mean and median hourly pay rates are very similar for both males and females.

4.9 The Trust's workforce headcount as of the 31 March 2020 (using the principles in 4.2 of staff that were in receipt of full pay, so will not include staff on maternity leave, sick leave, temporary contracts, zero hours contracts, bank or agency staff) stood at 6864 of which 5518 (80.4%) are female and 1346 (19.6%) are male (ESR data). The distribution of pay by gender is broken down into quartiles as below. Quartile 1 reflects the lower pay bands and quartile 4 the higher bands.

4.10 It can be seen in the table below that in quartiles 1, 2 and 3 the percentage of female and male staff broadly match the female (80.4%) and male (19.6%) organisational percentages. However, in quartile 4 the higher pay quartile the females are only 65.06 % and the males are 34.94%. This disproportionality in quartile 4 is the one of the main reason for both the mean and median gender pay gap rates.

4.11 As a comparison to last year's data there are no significant changes.

Quartile		Female	Male	Female %	Male %
1	£3.90 - £9.31	1484.00 (1417.00)	230.00 (230.00)	86.58 (86.04)	13.42 (13.96)
2	£9.32 - £11.26	1476.00 (1537.00)	241.00 (222.00)	85.96 (87.38)	14.04 (12.62)
3	£11.27 - £16.20	1441.00 (1440.00)	275.00 (265.00)	83.97 (84.46)	16.03 (15.54)
4	£16.21 - £110.59	1117.00 (1129.00)	600.00 (576.00)	65.06 (66.22)	34.94 (33.78)

- *As a comparator the figures shown in ( ) are last year's figures. These figures are correct at 'snap shot' date 31 March 2020.*

4.12 Trust Data and Analysis for Bonus Payments

The percentage of female and male staff who receive bonus payments, the average amount each group receives and the median each group receives can be seen below.

	Employees Who Receive Bonus Payments	Total Employees Eligible	% Who Receive a Bonus
Female	52 (108)	6051 (6250)	0.86% (1.73%)
Male	92 (97)	1426 (1557)	6.45% (6.23%)

- *As a comparator the figures shown in ( ) are last year's figures. The total number of employees reflects the total number of staff who worked for the Trust in the **whole year**. This is a **full year effect** and includes in year leavers therefore headcount figure will not correlate to current headcounts as this is a total headcount (everyone) for the full year of 2019-2020.*

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£6,757.46 (7,155.02)	£3,015.96 (3,015.96)
Female	£2,374.18 (2,043.35)	£351.43 (731.25)
Difference	£4,383.28 (5,111.68)	£2,664.53 (2,284.71)
Pay Gap %	64.87 (71.44)	88.35 (75.75)

a comparator the figures shown in ( ) are last year's figures.

4.13 Bonus payments include things that relate to profit sharing, productivity, performance, incentives and commission. These are generally received in the form of cash or have a monetary value. For example we have included Clinical Excellence Awards, theatre list incentives and some other incentive payments.

4.14 The main outlier is the Clinical Excellence Awards (CEA) with only 10 females who receive these compared to 50 males. The CEA's are awarded to senior medical staff and range from values over £36,000 to £250. However, of these CEA 21 are for values over £10,000 and of these only 3 have been awarded to female staff. This is the main reason for the bonus pay gap.

4.15 It can be seen that the percentage of the workforce who receive bonus payments remains higher for males but has reduced for females. However, it must be noted that bonus payments are only received by a small number within the workforce and some of the payments are for high amounts therefore, small changes can have a significant impact.

4.16 On further analysis the improvement relating to the mean bonus payment relates to a reduction in female staff that attracted a lower bonus payment.

37 of the 52 female staff received a bonus payment was for less than £1,000 compared to 63 of the 108 in the previous year. Although further detailed analysis is still required.

5. Implications / Impact

5.1 Risk

It is a legal requirement to publish our gender pay gap data on or before the deadline each year. The Equality and Human Rights Commission have the power to take enforcement action against any employer who does not comply with their reporting duties.

The risk of failing to comply carries legal, financial and reputational risks.

6. Outcomes

6.1 Collecting this data meets our legal requirements however, to be of real benefit it will be necessary to develop a long term action plan and an approach to tackling the gender pay gap as part of our wider approach to equality and diversity.

7. Conclusion

7.1 Best practice suggests we focus on pay, progression, recruitment and flexibility.

- Pay – We will conduct a review of our locally determined pay and bonus pay frameworks and to consider these in line with the principles of the gender pay gap.
- Progression and Recruitment – To annually analyse equality data we hold on our staff in relation to all protected groups (Equality Act 2010) and to explore if there are any other existing or potential inequalities which effect different equality groups.
- Progression and Recruitment - To support our female staff in terms of career progression and to promote NLaG as a good employer of choice we are developing a Women's Staff Equality Network.
- Flexibility – To refresh the Trust's Equality Impact Assessment Policy and Procedure and ensure our policies/working practices are equality impacted assessed, to ensure we don't discriminate against any protected groups including gender and people with caring responsibilities.

7.2 The actions detailed in 7.1 will form part of the wider Trust's Equality and Diversity action plan and link to the NHS People Plan and NLaG's People Strategy, and Equality Objectives.

7.3 Progress against these actions will be monitored by the Trust's Equality, Diversity and Inclusion Lead and progress reported as part of the agreed NLaG People Strategy reporting system to the Workforce Committee. In addition, going forward each year we will publish our data on the Government Equality Website and our own Website.

8. Recommendations

8.1 The Committee are asked to note the contents of the report and agree that the contents of our gender pay gap data; then the brief analysis and suggested action can be published and shared with our commissioners by 30th March 2021 and the report is shared with Board for final assurance and sign off.

Compiled By: Karl Portz, Equality and Diversity Lead

Date: April 2021

Appendix 1

Northern Lincolnshire and Goole NHS FT – Gender Pay Gap Data

HOURLY RATE	
Female Hourly Rate is 33.84% Lower (Mean)	**Female Hourly Rate is 27.59% Lower (Median)**

PAY QUARTILES		
	Female	**Male**
Lower	**1484**	**230**
Lower Middle	**1476**	**241**
Upper Middle	**1441**	**275**
Top	**1117**	**600**

BONUS PAYMENTS	
Female Bonus Pay is 64.87% Lower (Mean)	**Female Bonus Pay is 88.35% Lower (Median)**
0.86% of Females Receive a Bonus Payment	**6.45% of Males Receive a Bonus Payment**

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)077

DATE	06 April 2020
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Christine Brereton, Director of People
CONTACT OFFICER	Karl Portz, Equality, Diversity and Inclusion Lead
SUBJECT	Anti-Slavery Statement
BACKGROUND DOCUMENT (if any)	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.
PURPOSE OF REPORT	The Trust Board are asked to approve this document which will replace last year's statement.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable.
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	There has been no change to the Modern Day Slavery Act or the way which the organisation responds to Modern Day Slavery therefore, the only changes required were minor such as dates and headcount. Once approved by Board this will required the signature from the CEO and Chairman.

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

LINK TO STRATEGIC OBJECTIVES				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Strategic Objective 2, To be a Good Employer. This is a legal requirement for the Trust.
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Approve this statement for publication on the

	Trust's website with the CEO and Chairman's signatures.

Northern Lincolnshire and Goole NHS Foundation Trust

Anti-Slavery Report & Statement

Christine Brereton, Director of People
April 2020

Contents

1. **Executive Summary** 5
2. **Strategic Objectives, Strategic Plan and Trust Priorities** 5
3. **Introduction / Background** 5
4. **Discussion / Issues** 5
5. **Proposal** 6
6. **Purpose** 6
7. **Implications / Impact / Risk** 6
8. **Consultation / Engagement** 6
9. **Outcomes** 6
10. **Conclusion** 6
11. **Recommendations** 6

Appendix One

Anti-Slavery Statement

1. Executive Summary

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.

2. Strategic Objectives, Strategic Plan and Trust Priorities

The approval of the Anti-Slavery Statement is aligned to Strategic Objective 2: To be a Good Employer and is a legal requirement for the Trust.

3. Introduction / Background

Section 54 of the Modern Slavery Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors.

The aim of the statement is to encourage transparency within organisations, although it is possible to comply with the provision by simply stating that no steps have been taken during the financial year to ensure that the business and supply chain is modern slavery free. It is worth noting that although this may be an acceptable approach for this year's statement, there is an expectation that further work will be undertaken to provide these assurances in years to come.

There are potential consequences for those organisations that do not appear to make progress in this area; especially for those that are funded wholly, or in part, by public money**.** However, there are no criminal sanctions for failure to produce an anti-slavery statement; however, the Government can apply to the High Court for an injunction to force an organisation to publish a statement. For most organisations, maintaining a good reputation is critical to an organisation's success. With viral news and social media, there is potential for significant reputational damage for organisations who do not take adequate steps to tackle modern slavery in their business.

4. Discussion / Issues

The approval of the Anti-Slavery statement is a legal requirement for Northern Lincolnshire and Goole NHS Foundation Trust and must be approved and uploaded onto the NLAG Website before October 2020. The original date for publication was March 2020 however; this has been extended due to the impact of COVID. However, as a Directorate the work has been completed and there is no requirement for delayed publication subject to approval.

5. Proposal

There has been no change to the Modern Day Slavery Act or the way which the organisation responds to Modern Day Slavery therefore, the only changes required were minor such as dates and headcount. The Anti-Slavery statement is shown within Appendix One of this report.

The Board are asked to approve the statement within Appendix One.

6. Purpose

The Trust will be required to review and/or prepare a similar statement on an annual basis. To support the production of the statement, assurance mechanisms will be put in place, including the use of Internal Audit to review the effectiveness of the assurances which underpin the annual statement. Internal Audit's work would include a review of the systems in use by the Trust that seek appropriate assurance form other organisations. Audit reports in turn will be submitted to and discussed at the Audit Committee.

Once approved by Board the statement will require the signatures from the CEO and Chairman prior to publication.

7. Implications / Impact / Risk

There is a legal requirement to publish a yearly anti-slavery statement and the Trust must comply with this.

8. Consultation / Engagement

The Anti-Slavery statement has been approved by the Workforce Committee prior to being presented at Trust Board.

9. Outcomes

Following Board approval and appropriate signatures the Anti-Slavery Statement will be published on the Trust internet site.

10. Conclusion

As above.

11. Recommendations

The Board of Directors are asked to consider and approve this statement and will continue to support the requirements of the legislation. The CEO and Chair are asked for their signatures to support the approval.

Compiled By: **Christine Brereton, Director of People**
Date: **April 2020**

Appendix One

MODERN SLAVERY ACT 2015 – STATUTORY STATEMENT

This statement is to be accepted as Northern Lincolnshire and Goole NHS Foundation Trust's response to the Modern Slavery Act 2015.

Background

The Modern Slavery Act 2015 Section 54 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.

The Modern Slavery Act makes provision to prohibit slavery, servitude and forced or compulsory labour and human trafficking and includes provision for the protection of victims.

A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude.

- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

Modern Slavery and Human Trafficking Act 2015 Actions Required

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

Where possible all members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

This statement will be published externally on the Trust's internet site and internal on the Hub.

Northern Lincolnshire and Goole NHS FT

Northern Lincolnshire and Goole NHS Foundation Trust provides services across North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and West and East Lindsey. The Trust's annual turnover for 2019/20 was over £400 million. The Trust employs 7654 permanent and fixed term, bank and contract staff (as of 28.02.2021). This also includes employees that are on maternity leave or absent due to sickness.

We have zero tolerance of slavery and human trafficking and are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation and to prevent slavery and human trafficking in our supply chain.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices, including through our managed service provider contract arrangements. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

In addition, the Trust is meeting its supply chain commitments on slavery and human trafficking by undertaking the following steps during the year:

- For all Terms and Conditions, including specific clauses that reflect our obligations under the Modern Slavery Act 2015

- Including a relevant pass/fail criteria for all Procurement led tender processes and new vendor requests for all goods and services above the OJEU procurement threshold as set out in the Public Contracts Regulations 2015
- The where possible uses procurement frameworks to provide assurance on key supplier metrics which meet our obligations under the Modern Slavery Act 2015
- We treat our employees fairly and consistently across the Trust adhering to UK employment law. The Trust pays above the national living wage i.e. the minimum wage set by the Government
- Risks to Northern Lincolnshire and Goole NHS FT associated with this Act are managed in accordance with the Trust's Risk Management Policy and will be included as appropriate on the Trust's risk register

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2021.

Chair Person Signature: …….. Date :……

CEO Signature: …… Date: ……

Equality Act (2010)

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

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

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

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

Further reading and additional information can be found here:
https://www.gov.uk/government/collections/modern-slavery

NLG(21)078

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021
REPORT FOR	**Trust Board of Directors (Public)**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICER	Brian Shipley, Deputy Director of Finance Matt Clements, Assistant Director of Finance, Financial Management
SUBJECT	**Finance Report 2020/21 – M11**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF REPORT	For discussion and review
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee – 31 March 2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	This report highlights the reported financial position of Month 11 of the 2020/21 reporting period.

ACTION REQUIRED

Approval	Information	Discussion	Assurance	Review

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to? Highlight the box this refers to

1. To give great care	2. To be a good employer	3. To live within our means	4. To work more collaboratively	5. To provide strong leadership

TRUST PRIORITIES - which Trust Priority does this link to? Highlight the box this refers to

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Risk 6
TRUST BOARD ACTION REQUIRED	The Board is requested to note the reported financial position. Identify key areas for challenge and review, and suggest further actions that they consider appropriate.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Finance Report Month 11

February – 2020/21

Executive Summary Month 11 2020/21

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

The Trust reported a £1.0m surplus in February, a £1.6m underspend versus plan. The year-to-date surplus as at the end of February was £3.9m, £5.6m favourable versus plan. Under the NHSI performance assessment metrics this is reduced by £1.7m for the recovery of non clinical income and therefore is reported as £3.9m surplus against plan year to date.

The Trust primary year end forecast has marginally improved on its month 10 estimated surplus against plan positon of £2.35m to £2.37m once adjusted for the allowable items of annual leave and non clinical income.

	PLAN YTD	ACTUAL YTD	VARIANCE	ANNUAL PLAN	ACTUAL FOT	VARIANCE
Surplus / (Deficit)	(2.41)	3.24	5.65	(4.59)	(5.43)	(0.84)
Lost Income	2.41	0.66	(1.75)	2.89	0.80	(2.10)
Annual Leave Accrual	0.00	0.00	0.00	1.70	7.00	5.30
Revised Position	**0.00**	**3.91**	**3.91**	**0.00**	**2.37**	**2.37**

The positive variance has been mainly driven by lower than planned Elective and Daycase activity, recovery on non-clinical income in Pathlinks and by slippage on the Capital programme and PDC payments. The Trust still intends to maximise its planned care capacity over the final month and maximise the use of extra weekend and insourced capacity.

The Trust incurred £1.7m additional expenditure relating to Covid-19 in month (£18.0m year-to-date). The provision of Staff meals and Bank incentives are the material items to note.

The key variances in the month are:

- £2.2m above plan on income – The trust continues to report higher than expected income recovery in the main from £0.6m additional top-up income for lost local income, additional Clinical income support for SDF, Covid-19 vaccination and testing £0.6m, £0.5m Health Education income grants ,£0.2m additional income for donated assets and £0.3m through Pathlinks income.
- £0.72m overspent on Clinical Pay – due to £0.4m additional covid costs including bank incentives, increased Nursing agency cover and additional anaesthetic middle grade cover.
- £0.39m underspent on Non-pay – Lower than planned activity levels drive underspends in Clinical Supplies and Purchase of Healthcare Services.
- £0.67m underspent on post EBITDA items – Depreciation (£0.25m) and PDC (£0.4m)

Income & Expenditure to 28th February 2021

Income & Expenditure	Annual Plan to 31st March 2021	Current Month			Year to Date			Primary Forecast	Forecast Variance
		Plan	Actual	Variance	Plan	Actual	Variance		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Income	378,413	34,483	35,167	684	343,931	345,635	1,704	380,325	1,912
Other Income	32,136	2,721	3,401	680	29,380	31,034	1,654	34,515	2,379
PSF/MRET and FRF and Top Up	27,092	0	0	0	27,092	27,092	0	27,092	0
Additional Top Up	5,833	0	0	0	5,833	5,833	0	5,833	(0)
Donated Income	101	0	199	199	47	518	471	518	417
Total Operating Income	**443,575**	**37,204**	**38,767**	**1,564**	**406,283**	**410,111**	**3,828**	**448,283**	**4,708**
Clinical Pay	(240,337)	(20,021)	(20,740)	(719)	(220,416)	(220,785)	(369)	(241,135)	(799)
Other Pay	(66,349)	(5,481)	(5,591)	(110)	(59,168)	(59,474)	(306)	(72,007)	(5,658)
Total Pay	**(306,685)**	**(25,501)**	**(26,331)**	**(830)**	**(279,584)**	**(280,259)**	**(676)**	**(313,142)**	**(6,457)**
Clinical Non Pay	(62,559)	(5,270)	(5,238)	32	(56,905)	(56,172)	733	(61,572)	987
Other Non Pay	(64,163)	(5,319)	(4,966)	354	(58,844)	(58,755)	89	(64,799)	(636)
Total Non Pay	**(126,722)**	**(10,589)**	**(10,203)**	**386**	**(115,749)**	**(114,927)**	**822**	**(126,371)**	**351**
Operating Expenditure	**(433,408)**	**(36,091)**	**(36,534)**	**(443)**	**(395,333)**	**(395,187)**	**147**	**(439,513)**	**(6,106)**
EBITDA	**10,167**	**1,113**	**2,233**	**1,120**	**10,950**	**14,925**	**3,975**	**8,769**	**(1,398)**
Depreciation	(10,442)	(1,045)	(789)	256	(9,374)	(8,414)	960	(9,266)	1,176
Interest Expenses & Other Costs	(233)	(18)	(9)	9	(213)	(182)	31	(202)	31
Dividend	(4,245)	(654)	(249)	405	(3,962)	(2,807)	1,155	(3,514)	731
Fixed Asset Impairments and Revaluations	0	0	0	0	0	0	0	(960)	(960)
Total Post EBITDA Items	**(14,920)**	**(1,717)**	**(1,048)**	**669**	**(13,549)**	**(11,403)**	**2,146**	**(13,942)**	**978**
Remove Capital Donated I&E Impact	159	0	(177)	(177)	190	(280)	(470)	(256)	(415)
I&E Surplus/ (Deficit)	**(4,594)**	**(604)**	**1,008**	**1,613**	**(2,409)**	**3,242**	**5,651**	**(5,428)**	**(835)**
Remove Annual Leave	1,700	0	0	0	0	0	0	7,000	5,300
Remove Lost Non Clinical Income	2,894	604	663	58	2,409	663	(1,747)	795	(2,099)
Revised I&E Surplus/ (Deficit)	**0**	**0**	**1,671**	**1,671**	**0**	**3,905**	**3,905**	**2,367**	**2,366**

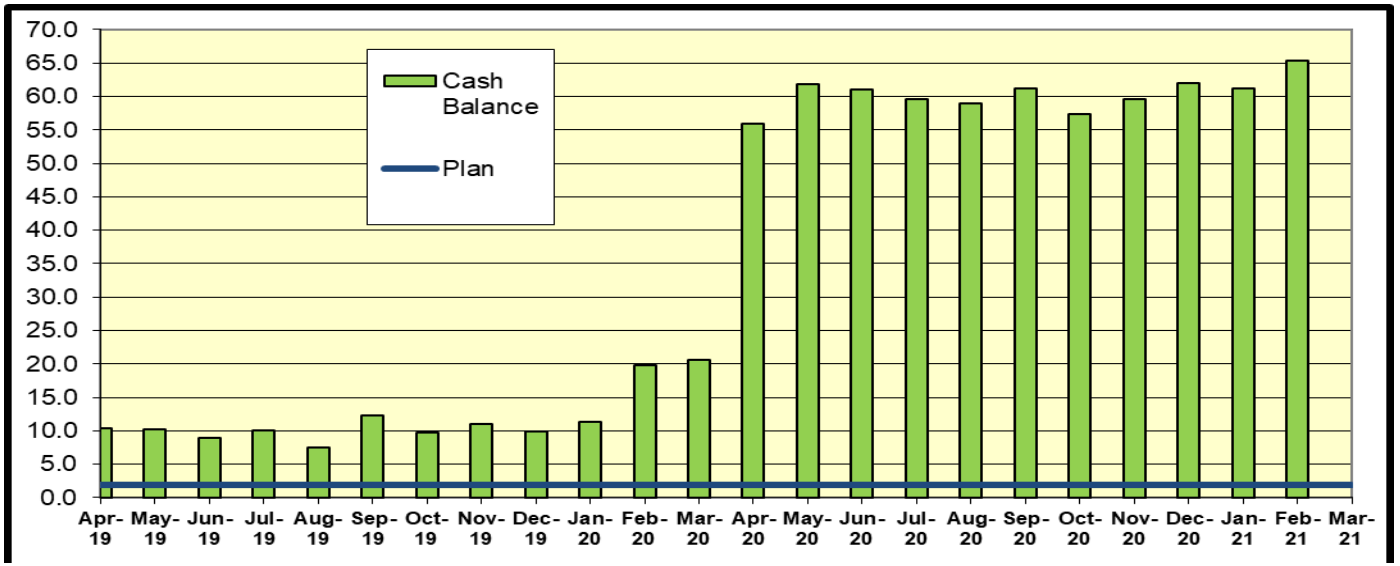
COVID-19 Expenditure

Expenditure Category	Year-to-date 20-21		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	3,461	10	3,471
Existing workforce additional shifts	7,206	0	7,206
Backfill for higher sickness absence	2,202	0	2,202
NHS Staff Accommodation - if bought outside of national process	0	6	6
PPE - locally procured	0	200	200
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	11	182	192
PPE - other associated costs	0	9	9
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	753	753
Remote management of patients	0	9	9
Support for stay at home models	0	0	0
Segregation of patient pathways	0	608	608
Plans to release bed capacity	0	0	0
Decontamination	0	335	335
After care and support costs (community, mental health, primary care)	0	290	290
Infection prevention and control training (community, mental health, primary care)	0	4	4
Remote working for non patient activities	0	420	420
Internal and external communication costs	0	49	49
Direct Provision of Isolation Pod	0	117	117
Other	0	1,635	1,635
COVID-19 virus testing - rt-PCR virus testing	7	27	34
COVID-19 virus testing - Rapid / point of care testing (for DHSC provided Samba2, DNA Nudge, Primer Design, LumiraDx and Abbott ID NOW)	0	283	283
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	84	15	99
COVID-19 Nightingale Harrogate Setup Cost Total (Gross)	1	0	1
COVID-19 Nightingale Harrogate Running Cost Total (Gross)	32	2	34
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure	280,259	114,927	395,187

Cash

The cash balance at 28th February was £65.4m, an in month increase of £4.2m.

Cash Balance as at 28th February		**65.40**
Commitments:		
WebV bank account	0.02	
Income received in advance	36.82	
Capital creditors	5.12	
In year capital underspend	12.29	
Capital funding due	-8.95	
Capital loan repayments	0.39	
PDC Dividend payment	1.54	
Dec PAYE/NI/Pension	10.47	
Invoices due for payment not yet authorised	5.20	
To support future months creditors	0.59	
		(63.50)
NHSi minimum balance		**1.90**



Balance Sheet as at 28th February 2021

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	183.63	186.12
Stocks & WIP	3.68	3.36
Debtors	9.89	9.39
Prepayments	7.29	6.15
Cash	61.20	65.40
Total Current Assets	82.07	84.30
Creditors : Revenue	29.22	29.90
Creditors : Capital	4.40	5.12
Accruals	16.41	15.75
Deferred Income	35.94	36.82
Finance Lease Obligations	0.00	0.01
Loans < 1 year	1.38	1.40
Provisions	0.95	1.24
Total Current Liabilities	88.31	90.23
Net Current Assets/(Liabilities)	(6.24)	(5.93)
Debtors Due > 1 Year	0.00	0.00
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	9.54	9.54
Finance Lease Obligations > 1 Year	0.02	0.02
Provisions - Non Current	5.38	5.38
TOTAL ASSETS/(LIABILITIES)	162.44	165.25
TOTAL CAPITAL & RESERVES	162.44	165.25

- The reduction in stock relates to pathology stock reagents and testing kits.
- Debtors have remained stable. The Trust is working closely with Hull University Hospitals to clear any outstanding debt, we have received confirmation that these will be paid March.
- Prepayments have now started to reduce, the reduction relates to CNST which is paid over 10 months.
- Revenue creditors and accruals have remained stable in month. The BPPC figures for February showed another increase in the value of non-NHS invoices paid with 30 days to 91.7%. The number of invoices paid also increased from 72% to 82%.
- Deferred income reflects March block , Health Education payments received in advance and NHSi income received in advance.
- The Trust has now paid all capital loan repayments due this year. The loan balance <1 year relates to the payments due within the next

2020/21 I&E Forecast

	M11 YTD Position £m	Primary Forecast £m
20/21 Plan Surplus/(Deficit)	**(1.83)**	**(4.59)**
Clinical Income	1.70	1.91
Non Clinical Income	1.65	2.38
Donated Income	0.47	0.42
Clinical Pay	(0.37)	(0.80)
Non Clinical Pay	(0.31)	(0.36)
Drugs	(0.55)	(0.54)
Clinical Supplies	1.29	1.53
Other Non-Pay	0.09	(0.64)
Post EBITDA (Depreciation & Interest)	2.15	1.94
Post EBITDA (Impairment)	0.00	(0.96)
Annual Leave Provision	0.00	(5.30)
Remove Excluded Items (Donated Income)	(0.47)	(0.41)
Surplus / (Deficit)	**3.24**	**(5.43)**
Variance to Plan	**5.65**	**(0.83)**
Add back Annual Leave Adjustment	0.00	5.30
Add back Non Clinical Income Adjustment	(1.75)	(2.10)
Surplus / (Deficit)	**3.90**	**2.37**

Risks

- Ongoing "Flowers" legal case. This is estimated to be circa **£6.0m** if extended to all staff groups**.**

Mitigations

- Planned additional capacity slippage **£0.50m.**

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)079

DATE	6 April 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Neil Gammon, NED / Chair of Finance & Performance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**F&P Committee Highlight Report – February & March 2021 – FINANCE ONLY**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF THE REPORT	Issues from the Finance & Performance Committee meetings requiring escalation by exception to the Trust Board
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises the key issues presented to, and discussed by the Finance & Performance Committee at its meetings on 24 February and 31 March 2021 and worthy of highlighting to the Trust Board.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	BAF Risk 6
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report and consider the need for any further actions to address issues highlighted in the report.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 April 2021
Report From:	Finance & Performance Committee held on 24 February & 31 March 2021

Highlight Report:

Finance Report – 24 February 2021

- Trust ahead of Financial Plan at Month 10, with forecast adjusted deficit of £2.35m vs planned deficit of £4.59m.
- Non-clinical income ahead of plan mainly caused by Pathlinks & HEE subsidies.
- Clinical pay pressure rising; various causes.
- Clinical supplies favorable as result of lower than expected planned care.

Finance Report – 31 March 2021

- Trust ahead of Financial Plan at Month 11, caused primarily by Covid-19 impact on activity delivery and slippage in Capital programme and expected PDC payments.
- Year to date adjusted I & E surplus of £3.91m vs a planned deficit of £2.41m.
- Year-end primary forecast outturn of £2.37m ahead of NHSE/I break even requirement.

Further Finance Issues

- Committee received brief on NLAG underlying financial position, starting at outturn 2019-20 position of £21.94m deficit.
- Bridge chart demonstrates, including assumptions made prior to planning guidance issue, continuing underlying deficit at 2021-22 outturn.
- Above causes focus on risk areas of future income for first half of 2021/22 and beyond; savings plans and delivery thereof; investment; inflation and Covid-19. Many uncertainties, some assumptions made.
- Further paper demonstrated 2021/22 Financial Planning Process deriving interim budget allocation framework for first 6 months of financial year, which committee approved.
- Further work required to take account of underlying financial position, in context of system and recently issued planning guidance, to derive coherent financial plan for second half of year.

Committee was assured, by evidence provided and discussion, that financial plan for FY 2020/21 would be achieved. Further work required for 2021/22 and beyond.

Confirm or Challenge of the Board Assurance Framework:

- Low risk of non-delivery in year.
- Higher risk for future as result of underlying financial position.
- Plan to split in-year and future years' financial risks in next BAF iteration.

Action Required by the Trust Board:

The Trust Board is asked to note the issues highlighted, the key points made and consider whether any further action is required.

Neil Gammon
Non-Executive Director / Chair of Finance & Performance Committee

NLG(21)080

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ivan McConnell, Director of Strategic Development
CONTACT OFFICER	Ivan McConnell, Director of Strategic Development
SUBJECT	**Executive Report - Strategic & Transformation**
BACKGROUND DOCUMENT (if any)	**NA**
PURPOSE OF REPORT	**To provide the Board with an overview of Strategic Development – including HASR**
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	NA
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Board is asked to note: • The leadership role that the Trust is undertaking in the Humber Acute Services Review • The Governance and timelines associated with this significant change programme • The commitment of NLAG Executive, operational and clinical colleagues to the HASR Programme • The continued delivery of key actions within Strategic Development

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

LINK TO STRATEGIC OBJECTIVES -				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Note the Summary Paper

Executive Report - Strategic & Transformation

Trust Board Public – 6 April 2021

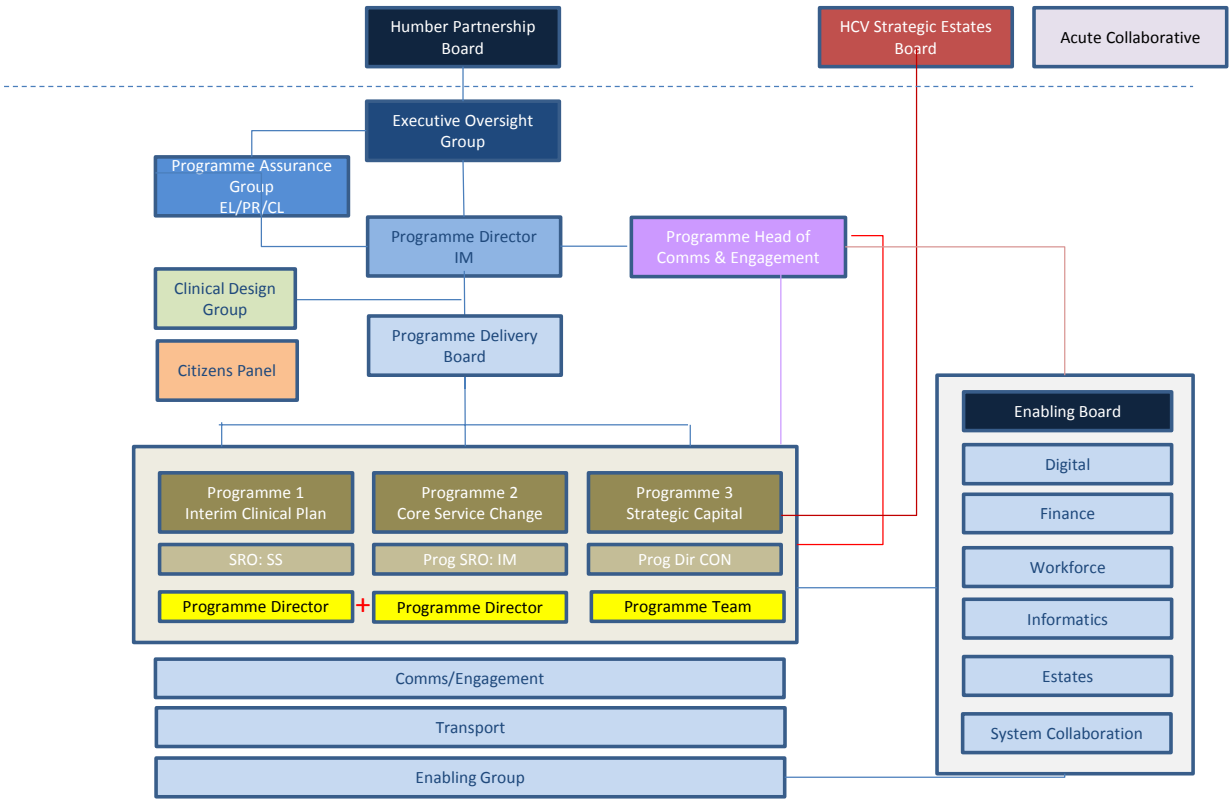
Background

1. The Humber Acute Services (HAS) Programme is designing hospital services for the future across the Humber region in order to deliver better and more accessible health and care services for the population. The programme involves the two acute trusts in the Humber – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) – and the four Humber Clinical Commissioning Groups (CCGs). The Programme has multiple dependencies including the development of primary and community care pathways, out of hospital services, and the development of the emerging ICS and ICPs.

Humber Acute Services Programme – progress and next steps

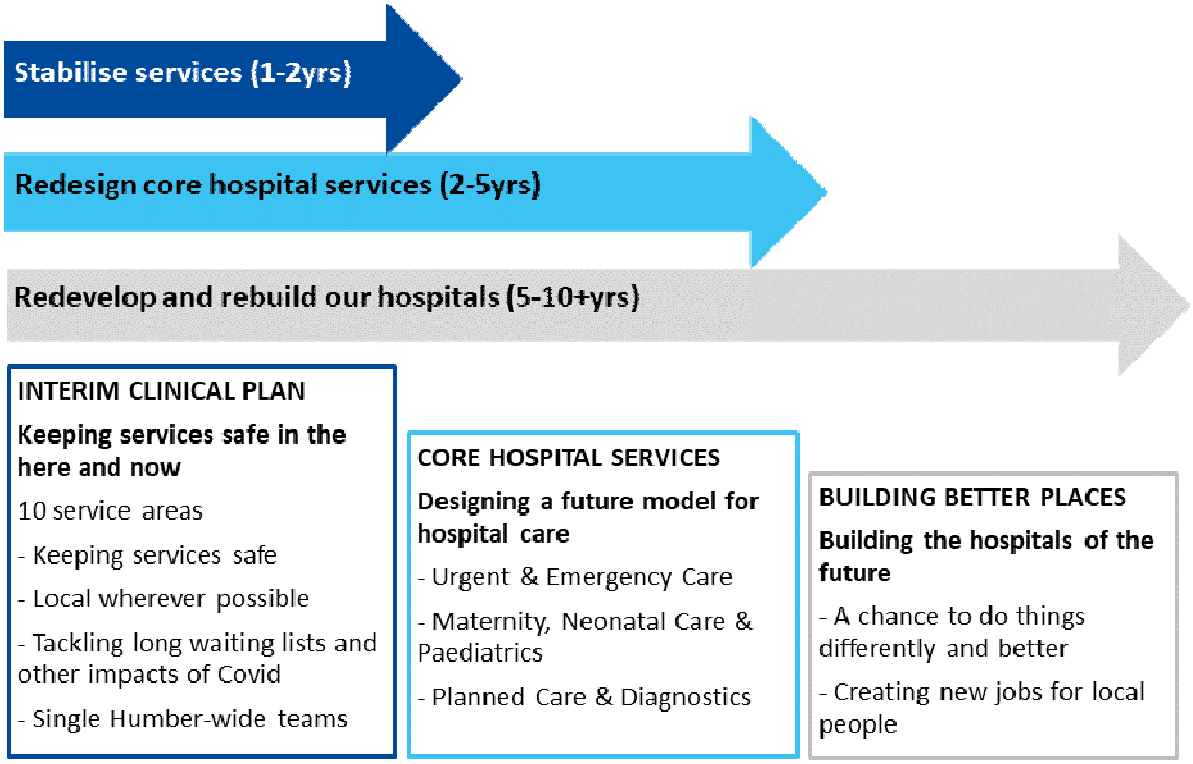
2. The Humber Acute Services Review is now moving from a stage of Review to one of Design and Implementation.

3. To support this move the Programme Executive Oversight Group approved a revised Programme Governance and delivery structure. The revised governance structure is set out in the diagram below.



4. The programme is now actively designing solutions to support the implementation of new models of care and infrastructure across three distinct but inter-related programmes of work. As at the end of March the Programme team has now been mobilised in the line with the agreed Programme Milestone Plan set out below. The three elements of the Programme are:

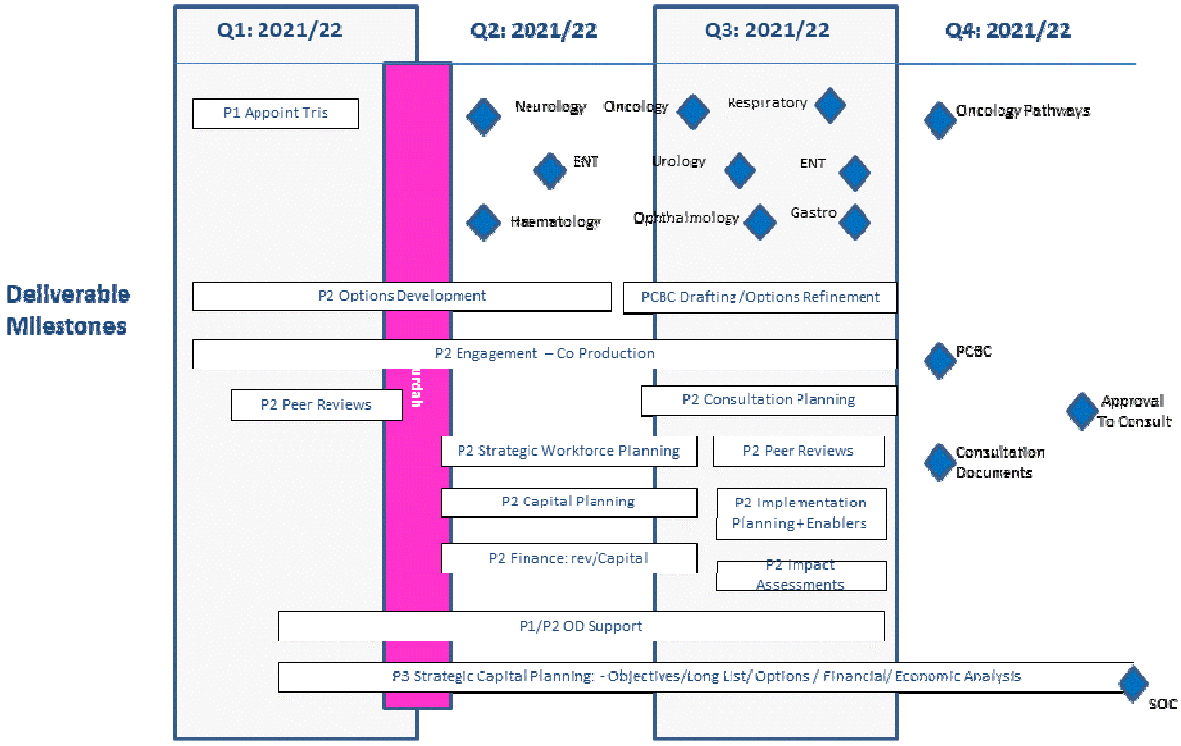
- Interim Clinical Plan (Programme One) – stabilising services within priority areas over the next couple of years to ensure they remain safe and effective, seeking to improve access and outcomes for patients. (SRO Shaun Stacey)
- Core Hospital Services (Programme Two) – long-term strategy and design of future core hospital services, as part of broader plans to work more collaboratively with partners in primary, community and social care. (SRO Ivan McConnell)
- Building Better Places (Programme Three) – working with a wide range of partners in support of a major capital investment bid to government to develop our hospital estate and deliver significant benefits to the local economy and population. (SRO Ivan McConnell/ Lead Director Chris O'Neill)



5. This work is now moving at pace despite the pandemic and has made significant progress since December. This includes:
    - Development of a comprehensive Programme Plan setting out tasks and key milestones for a rolling 12 month period – Set out below
    - Allocated dedicated resources to support programme delivery including – Programme Director, Transformation Leads, OD Lead, Communications and Engagement leads and Clinical leads
    - Undertaken wide ranging external engagement including – OSCs, CCGs, Local authorities, NHS partners
    - Undertaken a number of clinical workshops for the design of urgent and emergency care, maternity and paediatrics and planned care pathways with approximately 450 staff from across secondary, primary and community services
    - Undertaken a stocktake of pathway alignment with out of hospital and primary care transformation programmes

- Launching a survey of "What matters to you" to identify key issues – 3,500 responses received after two weeks by 31/3/21
- Regular NHSE/I assurance reviews of work undertaken and proposed workplans
- Team attending NHSE/I national training pilot training programme on Reconfiguration

6. This activity has created a significant momentum which will support the delivery of key programme milestones during 2021/2022. A high level delivery plan is set out below.



Additional Work Programme

7. The Board is asked to note the significant progress that the team from Strategy and Development have made in supporting the delivery of:

- The Trusts Clinical Strategy and supporting plans and future development of monitoring framework
- The submission of business cases to NHSE/I and DHSC to support continued investment in:
    i. Diagnostics
    ii. Urgent and emergency Care- AAU/ED
    iii. Infrastructure
- Undertaking the Programme Director role for the ED/AAU scheme
- Supporting colleagues in Estates and Facilities on a number of emerging capital schemes
- Supporting operational teams in delivery of:

i. Capacity/demand models for Phase 1 and 2 Covid Recovery Planning
ii. Surge Planning
iii. NHSE/I submissions on activity

- Active participation in Humber Acute Collaborative
- Active participation in emerging ICPs
- Engagement with out of hospital and primary care transformation programmes

Board Recommendation

The Board is asked to note the role that the Strategy and Development team are undertaking on both organisational and system wide transformation.

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)081

DATE	06 April 2021
REPORT FOR	Trust Board (Public)
REPORT FROM	Ivan McConnell, Director Strategic Development
CONTACT OFFICER	Kerry Carroll, Deputy Director Strategic Development
SUBJECT	Clinical Strategy 2021-2025 – Final
BACKGROUND DOCUMENT (if any)	*Supporting slides*
PURPOSE OF THE REPORT	For approval
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	• Trust Board (approved on 2/3/21) • Trust Management Board (approved on 15/2/21) • Finance & Performance Committee (approved 24/2/21) • Governors and Non Executive Directors Briefing (3/2/21) • NHSEI briefing (9/2/21) • Healthwatch • CCG's • Divisions and Directorates
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached Clinical Strategy 2021-25 is the public facing condensed version of the detailed Clinical Strategic Plan. Our approach to developing the strategy has been to use its content to act as the "Golden Thread" which pulls together the outcomes set out within our recovery and Divisional Strategic Plans. We have additionally focussed on the priorities set within our other Strategies; for example the People and Digital ones. We have reflected the requirements framed within the NHS Long Term Plan, NHS People Plan, proposed legal changes to CCGs and the system wide changes that are being developed under the Humber Acute Services Reivew (HASR). We have also included the new and emerging discussions that are taking place for the implementation of local Integrated Care Partnerships which have a focus on "Place Based" care. Our Clinical Strategy focuses on the intentions, aims and deliverables within the HASR. This will deliver a Pre Consultation Business Case and Statutory Consultation for change during 2021/22, with a primary objective of securing approval to a decision to move forward in 2022. Our strategy will be significantly influenced by any change agreed within the HASR and we will keep our objectives, priorities and outcomes under constant review. Given the complexities of impending change over the coming years we will continually evolve our Clinical Strategy on a six monthly basis. Given the complexity of these changes and the need to ensure that we have a document which is the "Golden Thread" that reflects all our strategies we have developed two key documents: • ***Clinical Strategy (shortened Public version***) – sets out the context, our objectives for change, what we will deliver and how we will assure delivery • Detailed ***Clinical Strategic Plan*** (detailed internal plan including Divisional summaries) – sets out individual detailed delivery schedules, critical milestones, dependences and resourcing

	There are various, pivotal dependencies that underpin the successful delivery of our clinical strategy. These are: • Humber Acute Service Review • Acute Collaborative • Primary Care Networks • Out of Hospital programmes • Clinical Commissioning Group changes • Strategic Capital investment Our Clinical Strategy has a complex relationship with our enabling strategies as it sets a context for those whilst also implementing the changes set out within them. Our enabling strategies are reflected in the Clinical Strategy and detailed within our Clinical Strategic Plan, these include: • Quality strategy • Peoples/workforce strategy • Nursing strategy • Digital strategy • Estates strategy • Financial strategy As implementation progresses we will ensure that our Governance processes monitor and assure delivery and that we learn from our experience of progressive implementation.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	*Strategic Risk 8: Inability to pursue a clear organisational strategy that staff and stakeholders are aware of and support* *Strategic Risk 9: Lack of an integrated ICS, Humber and Trust clinical strategy which delivers long term system, service and organisational sustainability including the ability to attract inward investment*
BOARD COMMITTEE ACTION REQUIRED	The Trust Board is asked to approve the Clinical Strategy final v1.7 noting the: • intention to review 6 monthly

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Clinical Strategy

2021-2025

Kindness • Courage • Respect

Contents

Executive Summary	4
Foreword	5
Introduction	6
National Policy and Guidance	7
Partnership Working across the Region	8
Humber Acute Service Review	9
Principles	10
Programmes	11
Capital Investment	12
Northern Lincolnshire and Goole NHS FT Overview	13
Enabling Strategies	14
The Trust Priorities	15
Our Clinical Services	16
Our Plans and Milestones	17
Conclusion	22

Executive Summary

This Clinical Strategy sets out our ambition to deliver a high quality service and experience to the population that we serve. This must be set within the context in which we operate. Despite having made significant progress over the past 18 months the Trust remains in double special measures for both finance and quality. We will continue to focus our efforts on ensuring that we improve the efficiency, effectiveness and safety of our services.

The strategy recognises that our local health system faces many challenges and that we need to work with our partners to do things differently. Our pathways of care often rely on in-house provision.

As we move forward we must focus on how we can work across primary, community and social care to deliver more services for you that are either closer to or at home.

We must harness the changes that are taking place in the use of technology to deliver services. This will improve our efficiency and effectiveness and provide new ways in which you access services.

Recruiting and retaining staff remains a significant issue across our health economy.

We must invest and continue to look to new ways of working and to promoting our Trust as an "Anchor Organisation" within our local economy.

We must look to partner with local institutions to build our reputation and to recruit, train and develop more local staff.

We must accelerate the need to look to new types of staff who can operate across many pathways, for example Advanced Care Practitioners and implement recruitment, training and development pathways for those roles.

We must also recognise that we will need to partner across organisations to recruit and retain specialist staff. Only by doing this will we be able to provide them with the opportunity to build their careers.

We must not lose focus on the fact that we are the largest employer within North and North East Lincolnshire.

We must build on our expanding local partnerships with schools, colleges and partners to build a local workforce across the 150 plus roles that we have.

Our ambition must be set within the context of national and regional policy whilst also being focused on delivering services at pace. There are many changes taking place whether through the requirements of the National Long Term Plan or People Plan.

There are also changes taking place within the NHS Commissioning Landscape along with wide changes across the Humber. These provide us with significant opportunity to harness our collective endeavours to deliver and implement change that will improve access to and quality of health and care services.

Our Clinical Strategy describes how we will develop our clinical services. We will ensure that no matter what we do that we are consistent with our Trust vision ***'committed to caring for you'.***

As we deliver our strategy we will ensure that we reflect the following principles:

- Right care, right place, right time
- Patient centred care
- Whole system thinking, whole system practice
- Transformation of services where appropriate

Our aim is to maintain our Trust vision and to deliver our priorities. The strategy outlines the challenges, type and range of clinical services we want to provide, how we will provide those and the outcomes we will seek to achieve.

Given the nature of the changes that are taking place around us nationally and locally we recognise that this strategy must be kept under review. We will therefore provide updates to the framework and our plans on a six monthly rolling basis. Only by doing this, will we maintain our focus to deliver improvement in what is a rapidly changing environment.

Foreword

This Clinical Strategy sets out our ambitious commitments to ensure the people who rely on our services receive high quality and accessible care and treatment. For our Trust to achieve this, the way services are currently delivered will need to change. Proposals have been designed with the needs of patients central to our thinking.

These changes are required for a number of reasons set out in this document. They relate to staff availability, the health needs of the population we serve, the fact we are not currently delivering timely care to all our patients, and the poor state of our building and information technology.

We recognise that we have been unable to provide assurance that we are providing the care and treatment that we should be, which is not acceptable. We know from conversations that people are concerned and nervous about what the changes will mean for some that use our services, as well as those that deliver them.

We will listen to concerns and of course make changes where we see there is opportunity to build on the work done so far. However, we suspect that not everyone will want to support making changes to deliver the improvements necessary.

This doesn't mean we shouldn't change though. By embracing necessary change, we believe we will be able to provide sustainable, safe services for our local population and improve the quality of the care and experience we provide. It is a big task which will take several years to achieve.

It is also complicated because we need to work with our partners as we cannot do what we need to on our own. However, by working together we can create the catchment area of patients we need to offer rewarding and interesting specialist jobs for future doctors, nurses and other health care professionals and ultimately improve patient care.

As we write this foreword the NHS, nationally and locally, is starting to emerge from the most significant crisis it has ever faced – the Coronavirus pandemic.

In the past few months our Trust has been tested like never before. To respond to this meant doing things differently. We did that and it worked.

These changes have given us a strong foundation to build on over the next three to four years to ensure we provide the safe, high quality and sustainable clinical services that our community deserves.

Our ambition is to deliver the best care to our patients and in doing so we believe our regulators will recognise those improvements. This document sets out in more detail how we intend to do this and will be reviewed as we progress over the next 12-18 months.

Terry Moran
CB Chair

Dr Peter Reading
Chief Executive

Introduction

We understand that we do not always deliver the timely care and treatment we should. Tackling this problem means looking at our clinical services differently. We have made many improvements over the past 18 months but we must continue our focus and drive for continuous improvement in our clinical services.

As an organisation we face many and multiple challenges. This strategy sets out not only the nature of the challenge we face but the actions we will take to respond and the impact that we will seek to have.

These actions are focused on ensuring that we deliver high quality, safe and accessible services for all when you are in need.

Challenges	Where we are now	Where we will be	How we will get there
Workforce	• Recruitment of multiple grades and types of specialist staff • Challenges with recruiting and retaining non-specialised staff	• Accelerate to recruit local, national and international • Training partnerships • Continue to 'grow our own' where we can with the right investment and infrastructure	• Develop new roles with partners • Different ways of working • Training partnerships • Local recruitment • Cross provider specialist recruitment • Working with Health Education England to support new courses
Quality of Care	• Long waiting times to be seen and treated • Lengths of stay in hospital • People at end of life not consistently identified • Advanced care planning between community and hospital services is sometimes inconsistent • Addressing challenges in the care and outcomes for mental health care	• Delivery of national access waiting times • Improved partnerships with community, primary and social care to reduce length of stay in hospital and end of life support • Maintain the progress made with the hospital level mortality indicator • Embedded mental health care as part of core services	• New models of care • Integrated pathways of care • Increased use of digital healthcare – self-help, monitoring, early intervention • Partnerships with community and other providers • Utilise benchmarking and best practice models • Working collaboratively across organisations to implement the five year forward view for mental health
Estates and Infrastructure	• £97.7m backlog maintenance across our hospital sites • Ageing infrastructure • Buildings which are not environmentally sustainable	• Invest in our existing infrastructure to reduce backlog • Access national funding to redevelop our hospital sites	• Continuous funding applications – digital, Emergency Departments, specialist, sustainability • Strategic Capital Business Cases
Digital Technology	• Lack of investment in Digital Technology • Lack of interoperable Information and Communications Technology • Limited use of technology to deliver services • Reliance on paper based systems	• Access digital accelerator funding to drive infrastructure improvement • Look to implement technology solutions to improve efficiency and access • Increased access to IT equipment	• Digital Accelerator Funding • Interoperable ICT Platforms • Investment in Patient Administration System • Investment in Informatics and Analytics • Use of Artificial Intelligence technologies
Service Sustainability	• Inconsistent pathways of care in some areas • Poor deployment of specialist resources • Updated the outgoing Sustainable Management Plan with the Trusts Green Plan	• Integrated pathways of care • Improved out of hospital services • Implementation of Humber Acute Services • Have a clear defined action plan to achieve carbon reduction in line delivering a "Net Zero" National Health Service	• Implementation of the Humber Acute Services Review • Implementation of the Out of Hospital Programmes • A clear action plan of work completed, ongoing, and scheduled to reduce all scopes of carbon emission areas
Finances	• Underlying cost base challenges	• Improved cost management to ensure delivery of control total • Sustainable financial position • Minimised variation on service delivery	• Shared corporate services • Reduced overheads • Reduced agency spend • Clinical productivity and pathway improvements

National Policy and Guidance

Our Clinical Strategy reflects national policy and guidance:

The environment within which the NHS operates is changing. Our population is increasingly ageing, there are significant advances in medicine and surgery, patient expectations are changing and there is a need to harness research, innovation and technology in delivery.

We need to focus on how we support the delivery of out of hospital services and that our population only access secondary care when they need to do so. Our services must be provided more closely to home, or indeed at home.

The NHS Long term plan published in January 2019 sets out the policy context and guidance for the delivery of services over the next 10 years. Our experience during the pandemic has resulted in changes in practice, new ways of working and introduced use of technology.

The NHS Long term plan framework below provides a summary of the principles, priorities and initiatives that we will be considering as we implement our Clinical Strategy;

Integrated Approach to Strategic and Operational Planning Principles	Deliver a New Service Model	Priority Areas	Ensure a Sustainable System
• Clinically led • Locally owned • Realistic workforce plans • Financially balanced • Place based on local need • Reduced variation • Focused on prevention • Delivers innovation • Engaged with partner local authorities • Quantified impacts • Mental Health services • Addressing inequalities	• Transformed out of hospital care • Support for Primary Care Networks • Relieve pressure on emergency departments • Give people more choice about their care • Research and innovation based • Maternity Services	• Increased focus on population health • Better care for major conditions • Cancer • Cardiocascular disease • Diabetes • Respiratory conditions • Focus on long term conditions • Smoking • Obesity • Alcohol • Air pollution • Anti-microbial resistance	• Ensure that the NHS is the 'Best Place to Work' • Improve leadership and culture • Transforming the workforce • Investing in digital transformation • Improving productivity • Reducing variation • Ensuring that research and innovation drives new models of care

Our strategy is set within not only national requirements but also the programme of change within our region which includes the Humber Acute Service Review and the potential changes and investment that may be made within Urgent and Emergency Care, Maternity and Paediatrics and Planned Care programmes, Out of Hospital transformation programmes and Capital Developments.

https://www.longtermplan.nhs.uk

Partnership Working Across the Region

We are working with partners on a wide ranging programme of change across the Humber to strengthen in and out of hospital delivery.

The Humber Coast and Vale Health and Care Partnership is a collaboration of health and care organisations who became an Integrated Care System in April 2020. This strengthens our collaboration with local councils and other health and care partners.

The principal aim of the partnership is to "improve the health and wellbeing of the population it serves through collective responsibility of managing resources to deliver health and care services"

As we strengthen the collaborative working across the health system, our priority is to improve patient access, reduce duplication, use technology and strengthen our workforce through;

- Developing primary care – so that every neighbourhood has access to a single team of health and care professionals who can meet a wide range of their needs locally;
- Joining up services outside of hospital – so that care is designed around the needs of the person not the needs of the different organisations providing it;
- Developing our unplanned care services – so that appropriate care, advice and support is available to citizens of Humber, Coast and Vale when they need it unexpectedly;
- Securing a long-term, sustainable future for our hospital services – so that our hospitals are working together to provide high quality care for our populations when they need to be in hospital.

Our Clinical Strategy cannot be created or delivered in isolation. The changes taking place across the health and care system mean we must look to strengthen how we work with partners including Primary Care Networks, voluntary sector, social care and all other health and social care partners.

https://humbercoastandvale.org.uk/partnership-long-term-plan

Humber Acute Services Review

A major element of the Clinical Strategy will be the implementation of the Humber Acute Services Review;

The Humber Acute Services Review commenced in 2018 across Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals Trust.

The review is focused on ensuring that we improve access to deliver high quality care for patients. We must improve access to services, patient outcomes and experience whilst also harnessing new ways of working if we are to deliver a sustainable model of healthcare in the future.

The review produced a Case for Change in February 2020 detailing the challenges and reasons to review the acute services across the Humber. This was subject to a review by the Clinical Senate review and published report in May 2020.

We are now moving at pace to develop the potential options for service change. These will be coproduced with commissioners, patients, carers, partners and staff during 2021, resulting in the publication of a Pre-Consultation Business Case and statutory consultation during late 2021 early 2022.

This will address the potential options for future service delivery with a focus on models of care, workforce, infrastructure and financial sustainability.

The review will have a focus on a number of challenges including:

- The low volume of patients for many services across this rural and coastal geography leading to the difficulty of specialists maintaining their skills
- The inability to meet many core NHS standards and waiting times
- Understand mortality rates and address quality of care concerns where appropriate
- The limitations of our estate and the lack of access to the latest information technology and equipment

The review will consider how we can provide the best possible care for local people who need to use acute hospital services within the resources (money, staffing and buildings) that are available to the local NHS. This may include delivering some aspects of care out of hospital in GP surgeries or other community settings to better meet local people's needs.

As a health and care system we face significant challenges in our workforce. A critical element of the review is focused on ensuring we recruit, retain, train and develop our staff.

We need to look at our approach to recruitment and work more closely with our local communities and partners more effectively to "grow our own" whilst also recognising we need to enhance our approaches to building academic partnerships and international relationships.

Only through this approach will we ensure we have a high quality sustainable workforce for the future.

Across the Humber we experience shortages of specialist staff within a number of services. This impacts our ability to meet national clinical standards, to support effective training rotas and to deliver services in a high quality manner, across multiple sites, on a 24 hour, 7 day week basis.

The work we are undertaking will look at how we can ensure that we deliver safe pathways of care which meet national standards whilst also ensuring we meet local patient needs.

This is not an easy process and one in which we must ensure we continuously engage. We will ensure that we use multiple approaches to engage with you as the options for this important review are developed during 2021.

https://humbercoastandvale.org.uk/wp-content/uploads/2020/02/HASR-Long-Case-for-Change/Final-for-Publication.pdf

http://www.yhsenate.nhs.uk/modules/reports/protected/files/YH%20Senate%20Report%20-%20HASR%20-%20Final%20May%202020.pdf

Humber Acute Services Review – Principles

There are a number of principles, agreed in 2018, which underpin how the Humber Acute Services Review will be co-designed and implemented.

These principles will underpin how we engage with you not only during the review but also as we develop our Clinical Strategy within the Trust.

Principles

- Patient-focused, safe and sustainable services – meeting the needs of our population now and in the future
- Clinically-led review of services
- Evidence-based – taking into account best practice
- Focus on hospital services – not hospital buildings and organisations
- Take account of developments in out-of-hospital care – developing solutions that join up different types of care
- A transparent, collaborative and inclusive approach – engaging with key stakeholders
- Plans for future provision will be developed in accordance with the levels of human, physical and financial resource expected to be available
- Plans for future provision will include Urgent and Emergency Care and Maternity Care in Hull, Grimsby and Scunthorpe
- The review will follow an agreed programme plan that sets out objectives, processes, timescales and resources.

Humber Acute Services Review – Programmes

The review is made up of three major programmes of change consisting of:

Programme 1	Programme 2	Programme 3
Interim Clinical Plan	Core Service Change	Strategic Capital
• 11 Specialties within both organisations	• Urgent and Emergency Care • Maternity and Paediatrics • Planned Care	• Strategic Capital Investment
Delivery 2021	Implementation 2022	Business Case 2023

Our strategy will reflect the outcomes that are delivered through the implementation of this important review.

Programme 1: Interim Clinical Plan is focused on delivering improved access, sustainability and performance within 11 specialties. All of these have issues with numbers and skills of staff, patient demand, access, waiting times and clinical outcomes. We will take actions to improve to integrate pathways of care, pool resources and improve access during 2021.

Programme 2: Core Service Change is focused on delivering long term change in our models of urgent and emergency care, maternity and paediatrics and planned care. We will co-produce and implement new models of care which will address key performance issues, reflect the need to deliver new and evolving national standards of care, and allow us to address our workforce challenges.

Programme 3: Strategic Capital – is focused on how we maximise our ability to access significant capital funding – circa £750 million – to build new hospital infrastructure in both Northern Lincolnshire and Goole Hospitals and Hull University Teaching Hospitals.

Humber Acute Services Review – Capital Investment

Strategic Capital Investment

Our estate is not fit for purpose. We have significant issues with backlog maintenance – circa £97.7 million across our sites. This impacts upon our ability to invest in new service models of care and limits our ability to maximise our use of new and emerging technologies.

Given this is one of the main challenges the Humber is facing, there is a commitment within our region to committing significant capital investment to build a healthier future for the Humber.

We want to ensure our infrastructure can meet the ever-changing demands of 21st century healthcare and COVID-19 requirements such as isolation facilities, whilst also supporting an improved level of environmental sustainability, improved research and innovation and partnering along with being an attractive place to work to support improved recruitment and retention.

Capital investment in our hospitals will act as a catalyst for the continued regeneration of the region, because of the opportunity a cash injection brings in terms of employment, education and mental and physical well-being for local people.

It also provides an opportunity to build on the regions skills and expertise in green energy to develop a lower carbon future for our healthcare facilities and support the development of green jobs in the region.

Healthcare facilities that are fit for the future will significantly improve patient care whilst also promoting research, innovation and greater employment prospects.

We will transform our current hospital estate using leading edge design to provide new state-of-the-art health and care campuses, as part of wider plans for the development of local areas, driving employment opportunities, collaboration, learning and innovation across the region.

Our investment plans are:

- Creation of a brand new hospital and healthcare facilities in Scunthorpe
- Development of new inpatient, diagnostic and treatment facilities at Hull Royal Infirmary
- Development of facilities on hospital sites at Grimsby, Goole and Castle Hill

Developments are in progress with new builds for additional diagnostic scanners, emergency departments and acute assessment units within Grimsby and Scunthorpe.

https://humbercoastandvale.org.uk/wp-content/uploads/2020/05/HASR-Capital-Development.pdf

Northern Lincolnshire and Goole Hospitals Overview

We operate across a wide complex geographical footprint;

Northern Lincolnshire & Goole NHS Foundation Trust provides services across the North and North East Lincolnshire area and the boundaries of East Riding of Yorkshire and Lincolnshire to a population of 450,000.

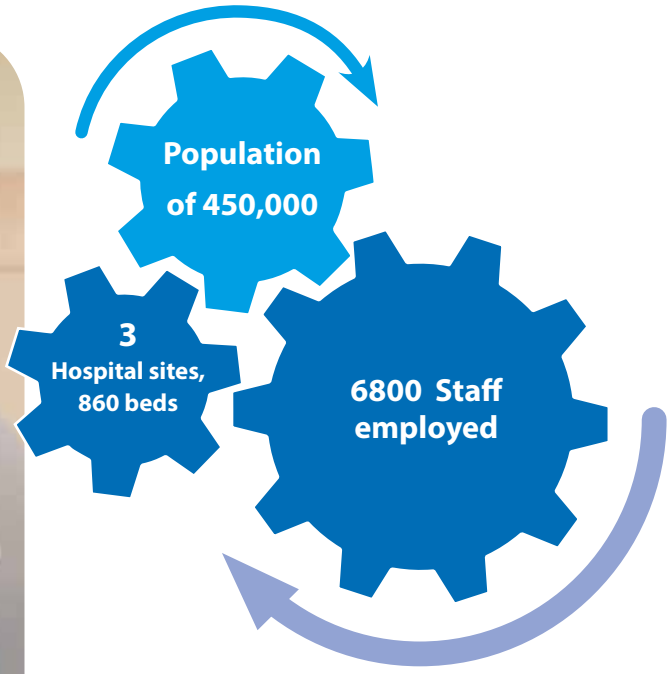
It is important to set our Clinical Strategy and plan to deliver within the overarching health and care landscape and in the context of the existing challenges and more recently, the challenges that COVID-19 brings to the organisation.

The Trust employs 6800 staff and operates from three hospital sites with two acute district general hospitals; Diana, Princess of Wales Hospital, Grimsby, Scunthorpe General Hospital and Goole District Hospital.

Diana, Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital both provide acute hospital care and a range of community services across North and North East Lincolnshire with Goole District Hospital predominantly providing outpatient, diagnostic, planned surgery and rehabilitation.

Locally the Trust is part of the Northern Lincolnshire health system working with local commissioners, primary care, community and local authorities and providers of health care to continuously build upon improvements in health care provided to the local population.

Our success will be dependent on working together.



Enabling Strategies

Our Trusts Strategic Framework and Enabling Strategies

The Trust has worked with patients, staff and stakeholders to develop and revise our Strategic Plan, Quality Strategy, People Strategy (workforce), Digital Strategy, and Estates Strategy.

These all underpin this Clinical Strategy and are significant enablers success.

The Trust Priorities

Our Trust Strategic Framework developed in 2019 is shown below (this will be subject to review in 2021):

The six Trust Priorities will be evolving through transformation over the next four years, formulating into the Clinical Strategy and driven by the Clinical Divisional plans.

Our Clinical Services

The Trust operates through five Clinical Divisions. The Clinical Divisions provide a range of clinical services and are supported through a number of corporate functions as set out below:

Medicine Division	Surgery and Critical Care Division	Family Services Division	Clinical Support Services Division	Community and Therapies Division
• Emergency Department • Acute Medicine • Cardiology • Stroke • Respiratory • Diabetes and Endocrinology • Gastroenterology • Clinical Haematology • Dermatology • Rheumatology • Palliative Care • Neurology • Elderly Medicine	• Critical Care • Theatres • Acute Surgery • Anaesthetics • General Surgery • Trauma and Orthopaedics • Colorectal • Upper Gastroenterology • Urology • Ophthalmology • ENT • Maxillo Facial Surgery	• Obstetrics • Gynaecology • Paediatrics • Community Paediatrics • Breast Services • Neonatal Care	• Radiology • Endoscopy • Pharmacy • Pathology • Medical Physics • Audiology • Medical Illustration • Mortuary • Outpa tients • Cancer • Medical Engineering	• Physiotherapy • Occupational Therapy • Nutrition and Dietetics • Speech and Language • Community Dental • Podiatry and orthotics • Neuro Rehabilitation Centre • Rehabilitation • Nursing - Community and Specialist • Community Response Team • Psychology • Equipment Stores • Wheelchair Services

People & Organisational Effectiveness | Estates & Facilities | Strategic Development | Chief Nurse Directorate | Medical Director's Office | Finance | Digital Services

Our Clinical Divisions are at the heart of delivering front line services to our patients to achieve our six Trust Priorities and each Division has a detailed operational plan.

Divisional plans articulate the visions, challenges, aims and objectives which are built from the Trust Strategic Framework and priorities aligning to Care Quality Commission requirements and quality priorities. These plans underpin the delivery of the vision set out in this strategy.

Our Plans and Milestones

We cannot deliver this alone; we will need to work collaboratively across the Health and Care system, community and public;

Our Clinical Strategy will be delivered through multiple approaches to the delivery of transformational change. This change will take place at three levels: Integrated Care System, Humber wide and locally-based population health strategies.

These are summarised below:

Integrated Care System

- Strategic Workforce Planning
- Digital Solutions - System inter-operability
- Regional Diagnostics / Rapid Diagnostic Centres
- Acute Collaborative
- Outpatient Transformation
- Primary Care Transformation
- Mental Health Transformation

Humber

- Interim Clinical Plan (Fragile and vulnerable services) (2020-22)
- Acute Services Review - Urgent & Emergency Care, Maternity & Paediatrics, Planned Care (2020-26)
- Large scale capital investment in the Humber hospitals - Creating a healthier Humber (2020-31)
- Humber Workforce Planning

Local

0-2 years

- Integrating care pathways across Primary, Community & Secondary Care
- Urgent & Emergency Care - Acute Assessment Units
- Diagnostics - Increase in MRI and CT scanners
- Outpatients & Cancer Service Transformation

2-4 years

- Reorganise our specialties and hospitals to address the challenges

- Clinical Divisional plans (Trust priorities)
- Enabling Strategies (i.e. People Plan, Digital, Estates, Finance)

Our Plans and Milestones

Where We Are Going To Be;

We have a number of really great health and care services in our area and many people have excellent experiences of the care they receive. However, our current services are under increasing pressure due to rising demand and in many cases are finding it extremely challenging to adequately staff and resource all the services that are provided in their current form.

Our Clinical Strategy is set within the context of achieving the six Trust Priorities to deliver the following outcomes;

Trust Priorities	Outcomes						What Will be Different
	Improved Patient Experience	Improved Clinical Outcomes	Reduced Waiting Times	Equity of Access for Patients	Safe Services	Sustainable Services	
1. Integrated Urgent and Emergency Care	✓	✓	✓	✓	✓	✓	Reduced attendance, waiting times, out of hospital care, decreased ambulance conveyance, improved environment and reduced length of stays in hospital
							Reduced waiting times. Virtual and telephone consultations. Primary Care partnerships and increased provision of services out of hospital
3. Working in Partnership with Primary Care Networks	✓	✓	✓	✓	✓		Redesigned clinical pathways – more locally based services and one stop shops. Community provision and seamless working
4. Reconfigure Specialities to One Site Where Appropriate							Consolidation of speciality services to provide 7 day continuous care. Reduced waiting times and improved outcomes
5. Restructure Cancer Services	✓	✓	✓	✓	✓	✓	Improved times to diagnosis and treatment. Quicker access
		✓	✓		✓	✓	Utilisation of space and increased services across the region. Decreased length of stay in hospital
Along with the six Trust priorities,the Clinical Strategy will align to improving quality standards							
	✓	✓	✓	✓	✓	✓	Improved performance standards/ waiting times and length of stay in hospital

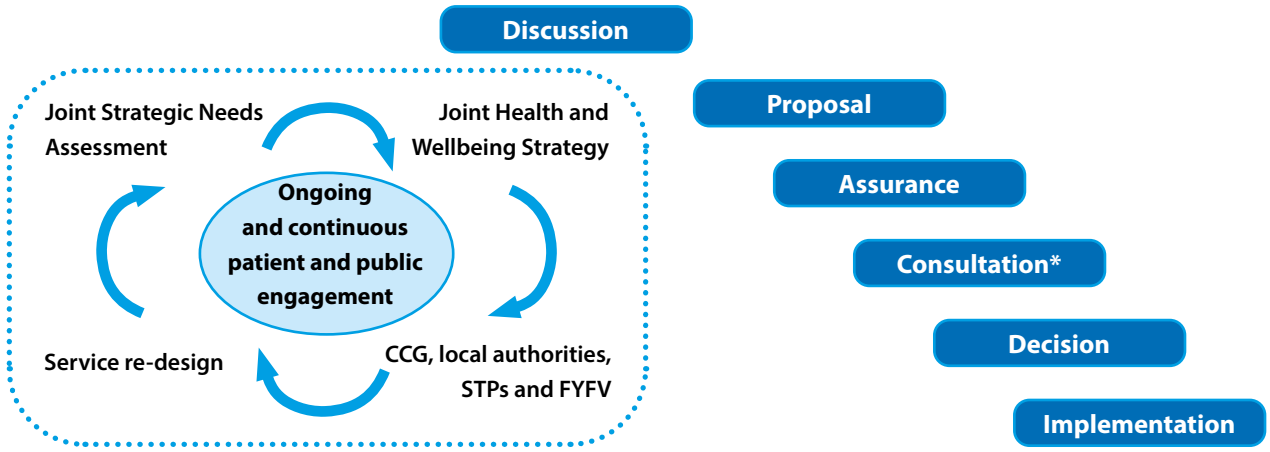
Our Plans and Milestones

We will ensure that we have robust governance to deliver our changes;

As we move forward new models of care will emerge. Clinical pathways may change the way we deliver care and it will be essential that change is planned, reviewed and impact assessed.

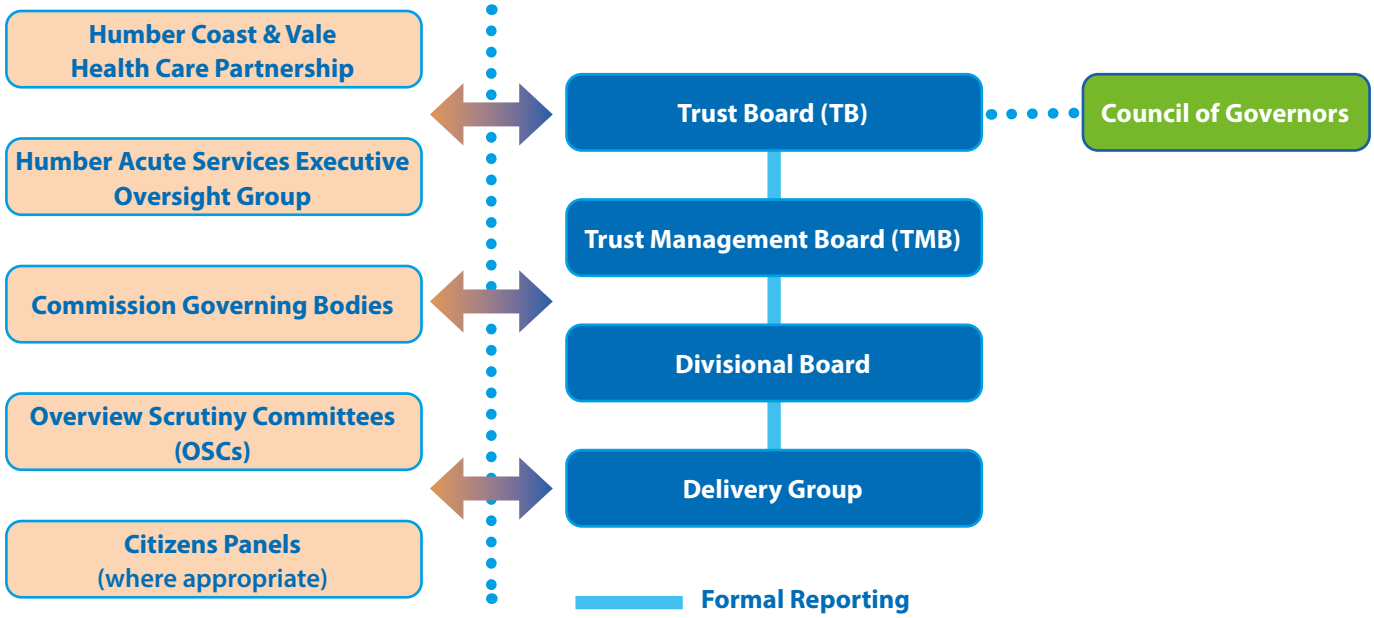
Any proposed changes will be carried out following full engagement with colleagues, patients and the wider public. We will ensure that our decisions are clinically led and engage the right stakeholders at the right time making sure service changes align to the system plans.

Our programmes of change will be assured and managed both internally and externally. The external assurance will be provided though the Integrated Care System, Humber Acute Services and NHS England and Improvement assurance process set out below;



** Public consultation may not be required in every case. A decision about whether public consultation is required should be made taking into account the views of the local authority.*

Our Trust governance and assurance structure set out below will ensure that any proposed changes are subject to assurance reviews, that implementation is reviewed and that post implementation outcomes are scrutinised to ensure we not only learn from experience but that we have delivered the outcomes we proposed.



Our Plans and Milestones

Whilst we develop and progress our Clinical Strategy within the Region and the Humber, we will continue to progress with the following local transformation;

Integrating Urgent and Emergency Care

- Increase rapid access to assessment with prompt review, diagnosis and treatment
- Same Day Emergency Care
- Ambulatory Care
- Improve support in flow in hospital and out of hospital
- Purpose build new Emergency Departments and Acute Assessment Units
- Developing Frailty models across the system

Integrating Care Pathways across Primary and Secondary Care

- Partnership working
- Focus on preventing admissions to hospital
- Improving discharge to out of hospital
- Redesign of planned care pathways

Increasing Diagnostic scanning capacity

- Incorporating additional MRI and CT scanners to support demand for both and planned care
- Additional CT scanners at both DPoW & SGH (2021)
- Additional MRI scanner and new suite build in DPoW (2021)
- Additional MRI scanner and extension in SGH (2022)

Outpatient and Cancer Transformation

- Increase used of non face-to-face appointments
- Improve waiting times
- Improve timeliness of cancer diagnosis and treatment
- Clinical service redesign with system partners

Our Plans and Milestones

Milestones:

Our timescales and the improvements that will be achieved through delivering our Clinical Strategy, set within the context of achieving our six Trust Priorities, our Quality Priorities and the progression of the Humber Acute Service Review, are summarised below;

Priorities	Timescales		
	2021-2022	2022-2023	2023-2025
Integrated Urgent and Emergency Care (U&EC)	• Implement an Urgent Care Hub • Increase access to Same Day Emergency Care and Ambulatory Care • Reduce the length of stay in hospital • Implement Talk before you Walk, Frailty model and Community Response Team	• A new dedicated Acute Assessment Unit and Emergency Department at both DPoW and SGH • Implement Humber Acute Service Review models of care	• Continue to work in partnership to improve performance levels
Transformed Outpatient Services	• Expand the use of non face-to-face appointments • Reduce the back log of follow up appointments • Reduced waiting times and progressed recovery from COVID • Increased digital technology to manage patient pathways	• Developed digital devices and systems to support patient record sharing • Implemented joint pathways with Primary care • Patient initiated follow ups and patients apps	• Increased virtual and community clinics • Reduced 30% of face-to-face appointments • Eliminated overdue follow ups
Worked in Partnerships with Primary Care Networks	• Implement Cardiology clinics within the community	• Develop shared training, recruitment and retention approaches	• Formation of teams within each location, sharing skills across the system
Reconfigured Specialities to one site where appropriate	• Deliver the HASR Interim Clinical Plan • HASR Core service change: • Completed pre-consultation engagement • Submission of pre-consultation business case	• Implement Humber Acute Service Review models of care	• Continue to work in partnership across the Humber to improve the delivery of patient care
Restructured Cancer Services	• Explore and develop new models of care to ensure faster diagnosis and treatments • Implement additional CT and MRI scanners in DPoW	• Implement additional MRI scanner in SGH • Alignment of histopathology service to support faster diagnosis • Implement all stratified pathways	• Full deployment of digital pathology and digital outsourcing
Created a Sustainable Hospital at Goole	• Ensure full utilisation of our theatres and clinics to meet demand	• Reshape the workforce working in different ways to effectively use specialist skills of staff	• Continue to work in partnership with local and regional partners
Quality Priorities	• Improved quality and timeliness of patient discharges to appropriate safe environments • Better support patients at end of life and reduce admissions to hospital where this could be avoidable through improved care planning in collaboration with primary care networks to improve effectiveness of care • Reduction in the out of hospital Summary Hospital Level Mortality Indicator (SHMI) • Increase of patient observations recorded on time in line with policy • Increase of clinically indicated patients to have a sepsis six screening • Improved administration of insulin within the required time and a reduction in medication omissions	• Eliminate 40 week waiting lists • Reduce 26 week waiting lists • Reduce overall referral to treatments • Continued reduction of the number of patients at the end of life phase having emergency admissions in the final 3 months of life • Continued reduction in the out of hospital Summary Hospital level Mortality Indicator (SHMI)	• Maintained better support for patients at end of life and maintained reduced admissions to hospital where avoidable through strengthened planning in collaboration with primary care networks • Maintained the Summary Hospital level Mortality Indicator (SHMI)

Conclusion

The challenges we face are multiple and the solutions for improvement will require not only us but our partners to work in new ways, to pool resources and to implement new models of care.

We are actively working with our partners in the Integrated Care System and have a leading role within the design and implementation of the Humber Acute Services Review.

We are actively engaged in the development of local Place Based services with our partners in Primary, Community and Social care.

We are focused on ensuring that we implement new models of care which improve access ensuring that you get access to services in a timely manner and that those services can be delivered either closer to home or at home where appropriate.

We are focused on ensuring that we maximise our use of technology to deliver improved self-care, early intervention and monitoring.

We are also focused on implementing new in-hospital pathways, which make use of new ways of working and deliver not only an improved patient experience, but also shorter lengths of stay and improved outcomes.

We recognise that this cannot be achieved in isolation and that we must look further to recruit, retain and develop our workforce.

We will accelerate working with local partnerships to recruit and develop our local workforce whilst also ensuring that we provide an attractive environment for specialist staff recruitment aligned to enhanced training, development and research and teaching opportunities.

Our infrastructure is not fit for purpose and we will work to secure national funding to allow us to address our issues of backlog estate maintenance and digital infrastructure whilst also seeking to gain national support for strategic capital investment in our major hospitals.

In doing so we will be working with our local authority and academic partners to ensure we align our strategies for economic development, local sustainability and local regulation.

The environment within which we operate is dynamic and requirements are changing regularly. This strategy will be subject to ongoing review and challenge with updates being undertaken every six months.

Only through this approach will we ensure that we deliver our aspirations and that we implement the changes that we are committed to.

Contact Us:

Telephone: **03033 303035**
Email: **nlg-tr.comms@nhs.net**
Visit: **www.nlg.nhs.uk**

NHSNLaG

NHSNLaG

Kindness · Courage · Respect

Northern Lincolnshire and Goole NHS Foundation Trust

CLINICAL STRATEGY 2021 - 2025

Trust Board – Public
Tuesday 6th April 2021

Ivan McConnell, Director of Strategic Development
Kerry Carroll, Deputy Director of Strategic Development

Overview

- The Clinical Strategy sets out our ambition to deliver a high quality service and experience to the population that we serve.

- The strategy recognises that our local health system faces many challenges and that we need to work with our partners to do things differently:

    - Workforce
    - Infrastructure
    - Capacity/demand
    - Models of care
    - Sustainability

- Our ambition is set within the context of national and regional policy whilst also being focussed on delivering services at place.

- The strategy sets out the nature of the challenges we face and the actions we will take to ensure we deliver high quality, safe and accessible services

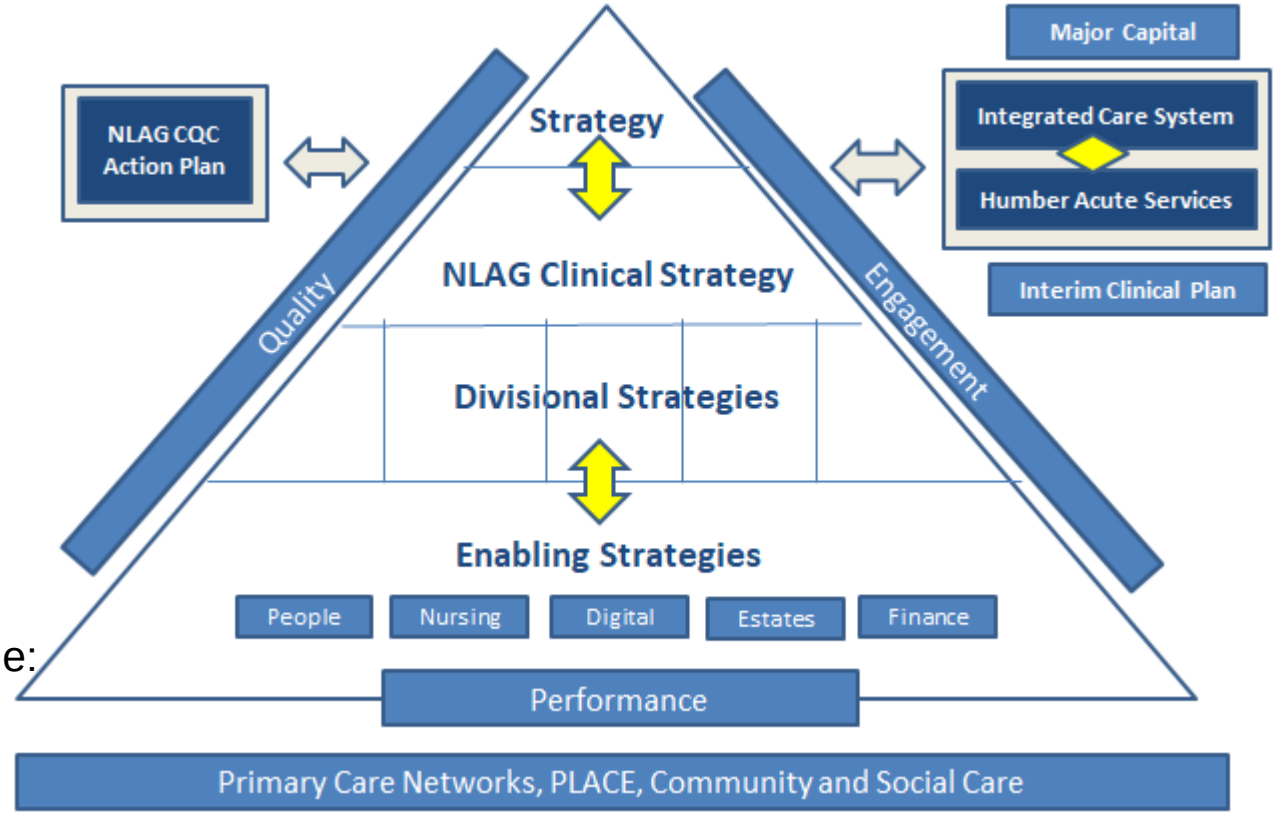
.

Why do we need a Clinical Strategy?

- Our Clinical strategy provides the ‘Golden Thread’ of how we will organisationally respond to the challenges we face

- We need to demonstrate the impact and actions of the significant changes taking place within health and care:

  - Integrated Care System/Integrated Care Partnerships
  - Population based health care
  - Increased Collaboration
  - “Left Shift” – out of hospital
  - Major change programme: Humber Acute Services
  - Capital Investment



Challenges – the context:

Challenges	Where we are now	Where we will be	How we will get there
	• Recruitment of multiple grades and types of specialist staff • Challenges with recruiting and retaining non-specialised staff	• Accelerate to recruit local, national and international • Training partnerships • Continue to 'grow our own' where we can with the right investment and infrastructure	• Develop new roles with partners • Different ways of working • Training partnerships • Local recruitment • Cross provider specialist recruitment • Working with Health Education England to support new courses
	• Long waiting times to be seen and treated • Long lengths of stay in hospital • People at end of life not consistently identified • Advanced care planning between community and hospital services is sometimes inconsistent • Addressing challenges in the care and outcomes for mental health care	• Delivery of national access waiting times • Improved partnerships with community, primary and social care to reduce length of stay in hospital and end of life support • Maintain the progress made with the hospital level mortality indicator • Embedded mental health care as part of core services	• New models of care • Integrated pathways of care • Increased use of digital healthcare – self-help, monitoring, early intervention • Partnerships with community and other providers • Utilise benchmarking and best practice models • Working collaboratively across organisations to implement the five year forward view for mental health
Estates and		• Invest in our existing infrastructure to reduce backlog • Access national funding to redevelop our hospital sites	• Continuous funding applications – digital, Emergency Departments, specialist, sustainability • Strategic Capital Business Cases
Digital Technology	• Lack of investment in Digital Technology • Lack of interoperable Information and Communications Technology • Limited use of technology to deliver services • Reliance on paper based systems	• Access digital accelerator funding to drive infrastructure improvement • Look to implement technology solutions to improve efficiency and access	• Digital Accelerator Funding • Interoperable ICT Platforms • Investment in Patient Administration System • Investment in Informatics and Analytics
Sustainability	• Inconsistent pathways of care in some areas • Poor deployment of specialist resources • Updated the outgoing Sustainable Management Plan with the Trusts Green Plan	• Integrated pathways of care • Improved out of hospital services • Implementation of Humber Acute line delivering a "Net Zero" National Health Service	• Implementation of the Humber Acute Services Review • Implementation of the Out of completed, ongoing, and scheduled to reduce all scopes of carbon emission areas
Finances		• Improved cost management to ensure delivery of control total • Sustainable financial position • Minimised variation on service delivery	• Shared corporate services • Reduced overheads • Reduced agency spend • Clinical productivity and pathway improvements

Enabling Strategies

The Trust has worked with patients, staff and stakeholders to develop and revise our Strategic Plan, Quality Strategy, People Strategy (workforce), Nursing, Midwifery and Allied Health Care Professionals Strategy, Digital Strategy, Estates Strategy and Financial Strategy. These all underpin this Clinical Strategy and are significant enablers to ensure its success.

Our Plans and Milestones

Our Clinical Strategy is set within the context of achieving the six Trust Priorities to deliver the following outcomes;

	Outcomes						What Will be Different
						Sustainable Services	
1. Integrated Urgent and Emergency Care	√	√	√	√	√	√	Reduced attendance, waiting times, out of hospital care, decreased ambulance conveyance, improved environment and reduced length of stays in hospital
2. Transformed Outpatient Services	√	√	√	√	√	√	Reduced waiting times. Virtual and telephone consultations. Primary Care partnerships and increased provision of services out of hospital
3. Working in Partnership with Primary Care Networks	√	√	√	√	√		Redesigned clinical pathways – more locally based services and one stop shops. Community provision and seamless working
4. Reconfigure Specialities to One Site Where Appropriate		√	√		√	√	Consolidation of speciality services to provide 7 day continuous care. Reduced waiting times and improved outcomes
5. Restructure Cancer Services	√	√	√	√	√	√	Improved times to diagnosis and treatment. Quicker access
6. Create Sustainable Services at Goole		√	√		√	√	Utilisation of space and increased services across the region. Decreased length of stay in hospital
Along with the six Trust priorities, the Clinical Strategy will also align to improving quality standards							
Improve Quality Standards	√	√	√	√	√	√	Improved performance standards/waiting times and length of stay in hospital

Our Plans and Milestones

We cannot deliver this alone, we will need to work collaboratively across the Health and Care system, community and public

Our Clinical Strategy will be delivered through multiple approaches to the delivery of transformational change This change will take place at three levels: Integrated Care System (ICS), Humber wide and Locally based population health strategies. These are summarised below:

Integrated Care System

- Strategic Workforce Planning
- Digital solutions - system inter-operability
- Regional Diagnostics / Rapid Diagnostic Centres
- Acute Collaborative
- Outpatient Transformation
- Primary Care transformation
- Mental Health transformation

Humber

- Interim Clinical Plan (unsustainable services) (2020-22)
- Acute Services Review: Urgent & Emergency Care, Maternity and Paediatrics, Planned Care (2020-26)
- Large scale capital investment in the Humber's hospitals - Creating a Healthier Humber (2020-31)
- Workforce planning

Local Local

- **0-2 years:**
  - Integrating care pathways across Primary , Community and Secondary care
  - Urgent and Emergency Care - Acute Assessment Units
  - Diagnostics - Increase in MRI and CT scanners
  - Outpatients and Cancer Service transformation
- **2-4 years:**
  - Reorganise our specialities and hospitals to address the challenges

- Clinical Divisional plans (Trust priorities)
- Enabling Strategies (i.e. People Plan, Digital, Estates, Finance)

Our Plans and Milestones

Our timescales and the improvements that will be achieved through delivering our Clinical Strategy, set within the context of achieving our six Trust Priorities and our Quality Priorities, are summarised below;

Priorities	Timescales		
	2021-2022	**2022-2023**	**2023-2025**
Integrated Urgent and Emergency Care (U&EC)	• Implement an Urgent Care Hub • Increase access to Same Day Emergency Care and Ambulatory Care • Reduce the length of stay in hospital • Implement Talk before you Walk, Frailty model and Community Response Team	• A new dedicated Acute Assessment Unit and Emergency Department at both DPoW and SGH • Implement Humber Acute Service Review models of care	• Continue to work in partnership to improve performance levels
Transformed Outpatient Services	• Expand the use of non face-to-face appointments • Reduce the back log of follow up appointments • Reduced waiting times and progressed recovery from COVID • Increased digital technology to manage patient pathways	• Developed digital devices and systems to support patient record sharing • Implemented joint pathways with Primary care • Patient initiated follow ups and patients apps	• Increased virtual and community clinics • Reduced 30% of face-to-face appointments • Eliminated overdue follow ups
Worked in Partnerships with Primary Care Networks	• Implement Cardiology clinics within the community	• Develop shared training, recruitment and retention approaches	• Formation of teams within each location, sharing skills across the system

Our Plans and Milestones Continued…

Priorities	Timescales		
	2021-2022	2022-2023	2023-2025
Reconfigured Specialities to one site where appropriate		• Implement Humber Acute Service Review models of care	• Continue to work in partnership across the Humber to improve the delivery of patient care
Restructured Cancer Services		• Implement additional MRI scanner in SGH • Alignment of histopathology service to support faster diagnosis • Implement all stratified pathways	• Full deployment of digital pathology and digital outsourcing
Created a Sustainable Hospital at Goole	• Ensure full utilisation of our theatres and clinics to meet demand	• Reshape the workforce working in different ways to effectively use specialist skills of staff	• Continue to work in partnership with local and regional partners
Quality Priorities			

Conclusion

- Our Clinical strategy provides the **‘Golden Thread’** of how we will organisationally respond to the challenges we face

- Its sets out the plans and actions of the significant changes taking place within health and care through the:

  - Integrated Care System
  - Increased Collaboration
  - “Left shift” – out of hospital
  - Major change programme: Humber Acute Services
  - Capital Investment

- The environment is dynamic and requirements are changing regularly. This strategy will be subject to ongoing review and challenge with updates being undertaken every six months.

- Only through this approach will we ensure that we deliver our aspirations and that we implement the changes that we are committed to.

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)082

DATE	6 April 2021
REPORT FOR	Trust Board of Directors
REPORT FROM	Neil Gammon, NED / Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICER	Ellie Monkhouse – Chief Nurse Dr Kate Wood – Medical Director
SUBJECT	HTF Trustees' Committee Highlight Report – 8 March 2021
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF THE REPORT	Issues from the Health Tree Foundation Trustees' Committee meeting requiring escalation by exception to the Trust Board
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The attached highlight report summarises key issues presented to, and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 8 March 2021 and worthy of highlighting to the Trust Board.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 April 2021
Report From:	Health Tree Foundation Trustees' Committee held on 8 March 2020

Highlight Report:

- Meeting held with new Patron, Sir Reginald Sheffield on 17 March 2021; publicity to follow.
- HTF Committee now has nominated Governor, to enhance linkage with CoG.
- Covid-19 induced fundraising interruption has resulted in production of interim 1 year financial plan, which was approved. Usual 3 year plan will be submitted to Committee in September 2021, once way ahead clarified.
- Sparkle work reduction, caused by staff vacancies, should be reversed as jobs are now out to advertisement.
- 2019/20 Annual Report formally presented to Committee.
- HTF Team Salary Reviews were presented and approved.

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
Non-Executive Director / Chair of Health Tree Foundation Trustees' Committee

NLG(21)083

DATE	Tuesday, 6 April 2021
REPORT FOR	Trust Board (Public)
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Dr Peter Reading, Chief Executive
SUBJECT	Chief Executive's Briefing
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF THE REPORT	To present a briefing from the Chief Executive and provide an overview on key matters.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The report details an overview of the following: • NHS White Paper • NHSE/I Planning Guidance for 2021/22 • Pandemic response and key operational pressures • Progress on key capital developments

ACTION REQUIRED:

Approval	Information	Discussion	Assurance	Review
	✓			

LINK TO STRATEGIC OBJECTIVES

1. To give great care	2. To be a good employer	3. To live within our means	4. To work more collaboratively	5. To provide strong leadership
✓	✓	✓	✓	✓

TRUST PRIORITIES:

Leadership and Culture	Workforce	Quality and Safety	Access and Flow	Finance	Service and Capital Investment
✓	✓	✓	✓	✓	✓

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	• Achievement of the constitutional performance targets. • Risk of non-delivery of agreed quality and clinical improvements. • Adverse impact of external events on business continuity.
BOARD ACTION REQUIRED	The Trust Board is asked to note the report.

Chief Executive's Overview

The Future of Health and Care (NHS White Paper)

The government published its White Paper on the NHS on 11 February 2021. Key points from and observations relating to the White Paper are as follows:

- The White Paper represents 'evolution' rather than 'revolution' and sets out the architecture of the NHS for the future and the duty to collaborate. However, further work will follow which elaborate the dynamics of the proposed new system (e.g. financial flows, hierarchy of priority setting, etc).
- More of the resource allocated will be controlled on a 'shared basis' rather than, as now, on an 'organisational basis' and this will require trusts (and their Boards) to understand better how to manage risks and benefits across their own organisations and their partners. Greater trust and transparency will be required so as to build shared understanding and enterprise.
- There may be more direct control of the NHS from the Secretary of State.
- Integrated Care Systems (ICSs) will become statutory bodies in their own right. However, the mechanisms for accountability (including financial) are still in development.
- Provider Collaboratives will form a key part of the architecture, as will Place.
- The balance of accountability and control of resources between ICSs, Collaboratives and Place has yet to be determined.
- There will be significant changes to procurement including repealing section 75 of the 2012 Health and Social Care Act (and subsequent regulations), replacing it with a new procurement regime.
- The new procurement arrangements (including for major capital schemes) hint at a greater role in the selection criteria for social value creation. This may be significant for NLaG as an 'anchor institution' in each of North and North East Lincolnshire.

NHS Priorities and Planning Guidance 2021/22

The NHS Operational Planning and Contracting Guidance for 2021/22 was published on 25 March 2021. It contains a number of key elements of direct relevance to NLaG :

- Wellbeing of front line staff to be prioritised by trusts.
- Integrated Care Systems (ICSs) are expected to maximise capacity across hospitals and reduce the elective care backlog that has built up during the pandemic.
- A £1 billion Elective Recovery Fund (ERF) is established to support systems that surpass activity funded from core system funding.
- £500 million additional investment is provided to mental health care.
- ICSs are expected to deliver the Covid vaccination programme and continue to support care of patients with Covid (including 'Long Covid').
- ICSs are expected to restore cancer activity levels.
- Implement the recommendations of the Ockenden report on maternity services, supported by an additional £95 million for these services.
- Transform urgent and emergency care.
- Interim financial arrangements introduced for 2020/21 will be rolled over for the first 6 months of the new financial year.

Pandemic response and operational pressures

The Trust continues to respond strongly to the pandemic although the number of Covid positive inpatients was 20 (with one in ICU) on 30 March 2021, the lowest number since early autumn 2020. The Trust has vaccinated (first dose) over 11,000 staff (half of whom work for partner organisations in the local health and care community) and has now commenced second dose vaccinations.

A&E pressure has been intense for some time (including for example 118 ambulance attendances in one day compared to a typical daily average of 70), but the trust has nonetheless restored elective work rapidly as capacity allows.

A key constraint and concern is the health and wellbeing of staff due to the continued pressures of the pandemic and pandemic responses.

Progress on Capital Developments

The Trust is now aiming to deliver a capital programme of £130 million over the two years from the end of 2020. Key milestones in this programme over recent weeks have included:

- £40.3 million secured from the Public Sector Decarbonisation Fund for Green improvements on all three hospitals sites, including replacement of the Goole and District Hospital boiler, one of the last two coal fired boilers in the NHS. This £40.3 million is the largest grant from this Fund to any trust in the country.
- Planning approval from North and North East Lincs Councils for the new Emergency Departments at Scunthorpe and Grimsby hospitals, respectively.
- Outline Business Case approval from NHSE/I for the two new Integrated Acute Assessment Unit developments on the two acute sites.
- Delivery of two new MRI scanners to Grimsby hospital.
- Confirmation of £2.5 million funding to the Trust through the national Digital Aspirant scheme.

NLG(21)084

DATE OF MEETING	6 April 2021
REPORT FOR	Trust Board – Public
REPORT FROM	Dr Peter Reading, Chief Executive Helen Harris, Director of Corporate Governance
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Board Assurance Framework development: Strategic Objectives, Strategic Risks, Risk Scoring Approach and Risk Appetite Statement
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF REPORT	The purpose of this report is to: a) ask the Trust Board to approve the revisions to the strategic objective descriptions, the strategic risks, the risk scoring approach and the risk appetite statement 2021-22 as part of the development and implementation of a revised approach to the Board Assurance Framework (BAF) b) ask the Trust Board to consider and agree whether the reporting requirements of the Board Assurance Framework to Trust Board and Sub Committees should be monthly, bi-monthly or quarterly c) note the full detail of controls and assurances against each strategic risk will be developed with the Executive Directors in conjunction with the Director of Corporate Governance and presented for agreement to the next Public Board meeting.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Trust Board Development Session – February 2021 Chief Executive Executive Directors
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The strategic objective descriptions, risk descriptions, the risk scoring approach and risk appetite statement within the BAF have been fully revised following a review at the Trust Board Development Session in February 2021 and a further review by the Chief Executive and Executive Directors. Appendix 1 provides the full details of the proposed changes to these areas.

	Discussions have also been held with the Chair of Audit Risk and Governance to strengthen the risk appetite statement. This process has enabled the Trust to clearly demonstrate its commitment to improving the quality of care, experience and engagement with patients, the culture of the organisation and workforce diversity, system and sub-system working, partnership working and being innovative. In order to achieve all this, the Trust will ensure it provides good leadership at all levels, to the highest standards possible.

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	The report links to all risks in the Board Assurance Framework
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report

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, continous 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 Scoring Approach

Strategic Risk Assessment

Strategic Objective	Strategic Risk	Risk Appetite
1 To Give Great Care	The risk that the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.	Low (4 to 6)
	The risk that the Trust fails to deliver constitutional and other regulatory performance or waiting time 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.	Low (4 to 6)
	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.	Low (4 to 6)
	The risk that the Trust's estate, infrastructure and 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.	Low (4 to 6)
	The risk that the Trust's digital infrastructure (or the inadequacy of it, including data quality) 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.	Low (4 to 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).	Low (4 to 6)
2 To Be A Great Employer	The risk that the Trust does not have a workforce which is adequate (in terms of numbers, skills, skill mix, training, motivation, flexibility, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.	Low (4 to 6)
3 To Live Within Our Means	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.	Moderate (8 to 12)
	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.	Moderate (8 to 12)
4 To Work More Collaboratively	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.	Moderate (8 to 12)
5 To Provide Good Leadership	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.	Moderate (8)

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)

NLG(21)085

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	Tuesday, 6 April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Dr Peter Reading, Chief Executive
SUBJECT	Trust Priorities 2021-22
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF REPORT	The purpose of presenting this report is to seek approval for the Trust's Priorities for 2021/22, as a commitment to staff and stakeholders for what the Trust will deliver.
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	• Senior Leadership Community (SLC) • Executive Team meetings • Trust Board development sessions • All staff through the weekly CEO message
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	As in previous years, the Trust Board has been developing its core organisational Priorities for the next financial year (2021/22). After a number of discussions at Board development sessions and sharing the outline Priorities with the Senior Leadership Community (SLC) and also with staff through Peter's Monday Message, the final proposal for the Trust's Priorities for 2021 is attached and is recommended for formal approval by the Trust Board. Please note the Priorities are presented in the form of a commitment to staff and stakeholders for what the Trust will deliver in 2021. Detailed milestones and measurable objectives are being developed as part of the business planning process which will underpin these published Priorities.

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

LINK TO STRATEGIC OBJECTIVES				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to approve the Trust Priorities for 2021-22.

What we will do in 2021-22

Our promise to our staff and our stakeholders

NLaG Trust Priorities 2021-22

FINAL 15.3.21

Trust Priority 1 – Pandemic Response

- We will play a full part (both acute and community) in the NHS's **response to the Covid-19 pandemic**, offering the best and safest service possible to patients, staff and public, including maintaining the highest standards of infection prevention and control.

- We will maintain and deliver as full an **urgent and elective service** as resources allow during and after the pandemic, including:
  - delivery of our agreed recovery plans (currently Wave 3);
  - an emergency response through our Emergency Departments of 80% of patients managed within 4 hours;
  - community Single Point of Access (SPA) with 70% of patients receiving a crisis response within 2 hours;
  - a reduction to zero by 31.3.22 of patients waiting over 52 weeks for elective treatment, and those waiting over 104 days for cancer treatment;
  - full risk stratification of those whose elective or out-patient care is delayed.

Trust Priority 2 – Workforce and Leadership

- We will strengthen **Recruitment and Retention** of key groups of clinical staff, specifically focussing on filling vacancies for health care support workers and registered nursing and taking account of Workforce Safeguards (2018) standards

- We will **Improve Culture** by developing overall plans to further implement and embed our values, improve working practices, and support new ways of working

- We will design and implement a **Health and Wellbeing plan** which sets out our offer for all staff the next two years.

- We will scope our **Leadership Development** Framework to enahnce the capabilities of clinical and non-clinical leaders at all levels.

- We will enhance and invest in the **People Directorate capability** to support the Trust to deliver the NHS People Plan and Trust People Strategy

Trust Priority 3 – Quality and Safety

- We will redesign the **Quality Improvement (QI)** offer, programme and culture across the Trust; investing in our QI team and empowering our staff to contribute to and champion our emerging QI community.

- We will continue to learn and improve following external agency reports, with clear action to resolve or mitigate risk, particularly related to patient safety, including the **response to the 2020 CQC report** and other major national reviews e.g. Ockenden

- We will focus on the following five **quality priorities:**
  - End of Life care and related mortality indicators
  - The Deteriorating Patient and sepsis
  - Reduction of medication errors
  - Safety of discharge
  - Diabetes Mellitus management

Trust Priority 4 – Strategic Service Development and Improvement

- With Hull University Teaching Hospitals, we will complete the **Interim Clinical Plan**, including:
  - the delivery of a revised leadership and clinical delivery approach for oncology, haematology and dermatology by May 2021;
  - the joining together of the clinical services of ENT, ophthalmology, cardiology and urology under a single service leadership by March 2o22;
  - improved access and treatment pathways, including a redesigned community approach by March 2022.

- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development by the end of 2021 of a **Pre-Consultation Business Case (PCBC) for the delivery of new models of care** for Urgent & Emergency Care, Maternity

Trust Priority 5 – Estates, Equipment and Capital Investment

- We will invest **c£130 million (subject to approvals) in estates and equipment**, including:
  - back-to-back MRI suite at DPOW:
  - new MRI at SGH;
  - new Emergency Departments, Same Day Emergency Care and Acute Assessment Units at both DPOW and SGH;
  - £40.3 million on major **energy schemes** across all three hospital sites including a new energy centre at Goole & District Hospital.

- We will continue to work with North and North East Lincolnshire Councils and NHSE/I on the long term development of a **new hospital for Scunthorpe and redevelopment of DPOW**.

Trust Priority 6 – Digital

We will deliver the **first phase of the Trust's Digital Strategy**, including investment of £2.5 million Digital Aspirant capital plus £2.5 million Trust 'matched' capital on:

- Improved access to patient information by linking WebV and HUTH Lorenzo EPR, & Yorkshire and Humber Care record and other sources;
- Upgrading the Trust data warehouse to improve business intelligence and data management;
- Upgrading versions of current inhouse systems to support paper-lite/paperless working;
- Investing in solutions & devices to enable real time clinical data entry and single sign on;
- Piloting a scalable automation platform (Robotic Processing Automation – RPA) to reduce the burdens of repetitive data entry.

Trust Priority 7 - Finance

- We will achieve the **Trust's 21/22 Financial Plan**.
- We will achieve the 21/22 Humber Coast and Vale HCP **system financial control total**.
- We will leave **Financial Special Measures**.

Trust Priority 8 – The NHS Green Agenda

- We will promote, develop and embed the **NHS Green agenda** into the Trust, specifically, procurement policies, staff energy champions, travel, waste and energy reduction.

- We will invest £40.3 million from the **Public Sector Decarbonisation Fund** (joint DHSC and BEIS) in Green schemes across all three hospitals, including replacing the coal fired boiler at Goole.

Trust Priority 9 – Partnership and System Working

- We will play a full part in the **development of the Humber Coast and Vale (HCV) Health & Care Partnership**, including the Humber Partnership Board, the Acute Collaborative, the Community Collaborative, the ICPs (Integrated Care Partnerships) of North and North East Lincolnshire, the HCV 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.

NLG(21)086

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Revised Trust Management Board – Membership and Terms of Reference
BACKGROUND DOCUMENT (if any)	Trust Management Board – Membership and Terms of Reference
PURPOSE OF REPORT	The report provides the updated Terms of Reference to be ratified
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Trust Management Board
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Trust Board is asked to ratify the updated membership and terms of reference for Trust Management Board. The TMB TOR has been significantly amended with key changes to the purpose (section 1) and the responsibilities (section 4): - The purpose of TMB is to be the senior operational decision making body of the Trust, determining or overseeing the determination of key operational policies, business cases, and decisions which need to be made at Trust level, but which fall below the remit of the Trust's Board of Directors. - TMB has the key responsibility to develop and agree objectives for submission to the Trust Board, in the form of the annual business plan, to deliver the agreed strategy and agree detailed capital and revenue business plans to deliver the objectives.

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

LINK TO STRATEGIC OBJECTIVES				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to approve the updated Terms of Reference

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

TRUST MANAGEMENT BOARD

Membership and Terms of Reference

Reference:	
Version:	2.0
This version issued:	
Result of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	April, 2022
Owner:	Peter Reading, Chief Executive
Document type:	Terms of Reference
Number of pages:	7 (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 Purpose

1.1 To be the senior operational decision making body of the Trust, determining or overseeing the determination of key operational policies, business cases, and decisions which need to be made at Trust level, but which are not matters reserved for decision by the Trust's Board of Directors.

1.2 To manage the clinical, operational and financial performance of the Trust on behalf of the Trust's Board of Directors, so that the Trust achieves the objectives set for it by the Board of Directors, by its regulators and by its commissioners, and meets (so far as is possible) the expectations of its other stakeholders.

1.3 To manage on behalf of the Trust's Board of Directors the development and delivery of the Trust's overall strategy and all its supporting and enabling strategies. This will include ensuring that there is appropriate integration, co-ordination and cooperation - between individual clinical services; between clinical and corporate functions; and with the Trust's key stakeholders and partners.

1.4 To support individual Executive and Divisional Clinical Directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues, and achievement of agreement between Trust Management Board members.

1.5 To assure the Trust's Board of Directors that, where there are issues and risks that may jeopardise the Trust's ability to deliver its objectives, these are being managed in a controlled way with the interests of patients and tax-payers are the heart of decision-making.

1.6 To be the senior formal committee of the Trust through which all other committees (except committees and sub-committees of the Trust's Board of Directors) report (directly or indirectly). The groups reporting into TMB are:

- Quality Governance Group
- Risk Register Confirm and Challenge
- Digital Strategy Board
- Business Case Review Group
- Capital Investment Board
- Nursing and Midwifery Board
- Operational Management Group
- Emergency Planning and Business Continuity
- Divisional Board Meetings
- Medical Education Committee
- Health and Safety Committee
- JNCC
- JLNC

The Chairs' of the above groups will be required to submit a highlight report to TMB. TMB reserves the right to request the Chair(s) of a group(s) to attend on an ad hoc basis.

2.0 Authority

2.1 TMB is authorised by the Trust's Board of Directors to manage the clinical, operational and financial activities and performance of the Trust within the overall Scheme of Delegation and subject to adequate reporting to the Board and its assurance committees.

2.2 TMB is authorised by the Trust's Board of Directors to develop and deliver the Trust's strategy and supporting enabling strategies, subject to those strategies being approved by the Board and subject to adequate reporting to the Board on their delivery.

3.0 Accountability & Reporting Arrangements

3.1 TMB is accountable through the Chief Executive to the Trust Board. Where required, reporting from the TMB will be to the Trust Board.

3.2 The Chair of TMB (the Chief Executive) has the overall responsibility for the performance of TMB and also has the final decision on actions required in order to comply with the Terms of Reference, or where a potential conflict may arise with the Trust's Board, or with their responsibilities as Accountable Officer.

3.3 Full members of the TMB may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie, but any such vote is advisory to the Chief Executive and not binding. Votes will be recorded in the minutes, including the votes of individual TMB members.

3.4 The Chair of TMB shall prepare a summary report to the Trust Board detailing items discussed, actions agreed and issues to be referred to the Trust Board.

3.5 The minutes of the meetings shall be formally recorded and presented to the Trust Board.

3.6 TMB shall refer to the Trust Board any issues of concern it has with regard to any lack of assurance in respect of any aspect of the running of the TMB.

3.7 Where the Chair of the TMB considers appropriate, they will escalate immediately any significant issue to the Trust Board.

4.0 Responsibilities

4.1 To develop and agree objectives for submission to the Trust Board, in the form of the Trust's Priorities and Annual Business Plan.

4.2 To deliver the agreed strategy and agree detailed capital and revenue business plans to deliver the objectives.

4.3 To ensure, where appropriate, the alignment of the Trust's strategy with the strategy of key stakeholders and other key partners.

4.4 To develop the Trust's clinical and non-clinical service strategies, ensuring co-ordination and alignment across the clinical divisions and corporate directorates.

4.5 To develop, agree and monitor implementation of plans to improve the efficiency, effectiveness and quality of the Trust's services.

4.6 To monitor and manage standards of care, quality and safety, ensuring appropriate actions are taken where necessary to maintain and improve these.

4.7 To identify and mitigate risk by monitoring the corporate risk register and board assurance framework, agree resourced action plans, and ensure their delivery, compliance and appropriate escalation in accordance with the Trust's risk management systems and processes.

4.8 To monitor the delivery of the Trust's service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Trust's objectives or other obligations.

4.9 To monitor and ensure the delivery of all specific actions agreed by the Trust Board, the TMB and by committees of both.

4.10 To devise the Trust's annual and longer term capital programme, submit to Trust Board for approval and monitor its delivery.

4.11 To oversee the agreement of all relevant policies (principally through sub-groups) – other than those retained by the Trust Board - to ensure the delivery of external and internal governance, compliance and best practice requirements.

4.12 To commit resources, subject to approved business case(s), as detailed in the Trust's Scheme of Delegation.

4.13 To approve the Terms of Reference for all the sub-committees and groups of the Committee, delegate work as appropriate and hold the respective Chairs to account.

5.0 Membership

5.1 Core Membership

TMB will include the following members:

- Chief Executive (Chair)
- All Executive Directors (voting and non-voting Trust Board members):
  - Chief Nurse
  - Chief Operating Officer
  - Medical Director
  - Chief Financial Officer
  - Chief Information Officer
  - Director of Estates & Facilities
  - Director of People
  - Director of Strategic Development
- All Divisional Clinical Directors

6.0 Responsibility of Members

6.1 Members of the TMB have a responsibility to:

6.1.1 attend at least 80% of meetings, having read any papers in advance

6.1.2 identify agenda items for consideration to the chair/administrator at least five working days before the meeting. The Chair of TMB will have discretion whether to accept items submitted later than this;

6.1.3 prepare and submit papers for the meeting, using the Trust's agreed template, at least three working days before the meeting.

7.0 Attendees (non-voting)

7.1 Chairs of HCC and MAC, Director of PGME, Chief Pharmacist, Director of Corporate Governance, Associate Director of Communications and Engagement.

7.2 In exceptional circumstances, deputies may be nominated to attend prior to the meeting, with the chair's approval.

7.3 The Chair of the TMB may also extend invitations to other staff (or representatives of outside organisations) with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such staff will be in attendance and will have no voting rights, and should only attend for the item for which they have been invited.

7.4 The Chair of the TMB may also invite other individuals to attend as observers from time to time (e.g. as part of their induction or development, or as part of external review or scrutiny).

8.0 Procedural Issues

8.1 Frequency of Meetings

8.1.1 Meetings will be held as a minimum on a monthly basis. Two meetings will normally take place per month (in the first and third weeks).

8.1.2 The business of each meeting will normally be transacted within a maximum of two hours.

8.2 Chairperson

8.2.1 The Chair of the TMB is the Chief Executive. .

8.2.2 If the Chair is not present, then the Chair will nominate an Executive Director to chair the meeting in their place.

8.3 Secretary

8.3.1 The PA to the Chief Executive (or if she is on leave, another Executive Director's PA) will act as secretary to the meeting and will be responsible for:

a) ensuring correct and formal minutes are taken, and distributing minutes;
b) keeping a record of matters arising and issues to be carried forward;
c) providing appropriate administrative support to the chair and TMB members;
d) agreeing the agenda with the Chief Executive prior to sending the agenda and papers to members no later than three working days before the meeting.

8.4 Quorum

8.4.1 A quorum will normally be seven members in attendance. Of these members:

a) at least three should be Executive Directors and;

b) at least three should be Divisional Clinical Directors.

8.4.2 When considering if the meeting is quorate, only those individuals who are members (or their deputies) can be counted, attendees cannot be considered as contributing to the quorum.

9.0 Decision Making

9.1 Wherever possible members of the TMB will seek to make decisions and recommendations based on consensus.

9.2 Full members of the TMB may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie, but any such vote is advisory to the Chief Executive and not binding. Votes will be recorded in the minutes, including the votes of individual TMB members.

9.3 In the event of a formal vote, the Chair will clarify what members are being asked to vote on – the 'motion'. Subject to the meeting being quorate, a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

9.4 Only the members of the TMB (or their deputies) present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

10.0 Review

Terms of Reference will normally be reviewed annually, with recommendations on changes submitted to the Trust's Board of Directors for approval.

11.0 Equality Act (2010)

11.1 The Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity and difference.

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

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

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

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NLG(21)087

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021				
REPORT FOR	Trust Board of Directors – Public				
REPORT FROM	Dr Peter Reading, Chief Executive				
CONTACT OFFICER	Helen Harris, Director of Corporate Governance				
SUBJECT	Revised Executive Team Meeting – Membership and Terms of Reference				
BACKGROUND DOCUMENT (if any)	Executive Team Meeting – Membership and Terms of Reference				
PURPOSE OF REPORT	The report provides the updated Terms of Reference to be ratified				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Trust Board is asked to ratify the terms of reference for the Executive Team Meeting.				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES -					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to approve the updated Terms of Reference				

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

EXECUTIVE TEAM MEETINGS

Membership and Terms of Reference

Reference:	DCT179
Version:	2.0
This version issued:	
Result of last review:	N/A
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Executive Team
Date for review:	March, 2022
Owner:	Peter Reading, Chief Executive
Document type:	Terms of Reference
Number of pages:	5 (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 Purpose

1.1 The Executive Team meeting:

- brings together the Trust's Executive Directors as well as the other direct reports to the Chief Executive;
- has responsibility for problem solving/'operational' decision making affecting the day to day running of the Trust but which do not require review and approval of the Trust Management Board***** and/or Trust Board (see also section 4.0 below).

*****The Trust Management Board is the organisation's management decision making forum and brings together the clinical and senior executive leadership of the Trust.

2.0 Authority

2.1 The Executive Team meeting is an informal consultative and advisory meeting, whose decision making authority is based solely on the individual accountabilities and authority of the Executive Directors themselves, rather than any formal collective authority.

2.2 Decisions which require authority which goes beyond that of any individual accountability as an Executive Director or grouping of Executive Directors, must be taken to the Trust Management Board for discussion and agreement.

3.0 Accountability and Reporting Arrangements

The Executive Team meeting is accountable to the Chief Executive. Where required, reporting from the Executive Team will be to the Trust Management Board and/or Trust Board.

4.0 Functions

4.1 Provides a forum for problem solving and for discussing and agreeing actions affecting the day to day smooth operation of the Trust. Where appropriate, issues requiring a formal decision e.g. commitment of resources, will be escalated to the Trust Management Board and/or Trust Board, as required.

4.2 Provides a forum for early discussion on strategy and other key issues and prior to formal decision making through the Trust Management Board (TMB) and/or Trust Board.

4.3 Provides a forum for forward planning in relation to key activities and events e.g. regulator or MP visits, OSC attendance, ICS or ICP meetings.

4.4 Provides a forum for briefing colleagues on system intelligence/engagement.

4.5 Monitors actions and pace in respect of key agreed mitigations in response to specific issues.

4.6 Provides 'safe space' peer support for colleagues.

4.7 Provides information and advice.

5.0 Responsibility of Members and Attendees

5.1 Members of the Executive Team meeting have a responsibility to:

- attend at least 80% of meetings, having read any papers in advance
- act as 'champions' and lead by example (reflecting the Trust's values), disseminating information, agreements and good practice as appropriate
- identify agenda items for consideration to the chair (either in advance of or at the start of the meeting). [**Note:** Where matters need to be deferred due to other priorities or the overrunning of the meeting, this will be recorded in the action notes for bringing forward at the next meeting.]
- adhere to the principles of collective decision making. [**Note:** Where concerns regarding decisions may exist, members of the Executive Team Meetings have a responsibility to ensure these concerns are aired at the time of the decision so that they can be discussed and resolved and/or recorded.]
- ensure that when matters are discussed in confidence at the meeting, such confidences are maintained
- declare any conflicts of interest/potential conflicts of interest in any of the agenda items in accordance with Trust's policies and procedures.

6.0 Membership

6.1 Core Membership

6.1.1 The Executive Team meeting will include the following members:

- Chief Executive (Chair)
- All Other Executive Directors:
  - Chief Financial Officer
  - Chief Nurse
  - Chief Operating Officer
  - Medical Director
  - Chief Information Officer
  - Director of Estates & Facilities
  - Director of People
  - Director of Strategic Development
- Director of Corporate Governance

- Associate Director of Communications

6.1.2 The Chair of the Executive Team meetings is the Chief Executive. In the absence of the Chief Executive, one of the Executive Directors will be asked to chair the meeting.

6.1.3 Where members of the Executive Team meeting are unable to attend, a suitable deputy can be nominated to attend and act in their absence, as appropriate, and at the discretion of the Chair. [**Note:** In respect of the latter point, there may be occasions where matters are discussed that it would not be appropriate to discuss outside of the Executive Team membership. Such instances will be communicated in advance of the meeting and the matter to be discussed.]

6.2 Other Persons Attending Meetings

Other attendees will be invited as the agenda dictates.

7.0 Procedural Issues

7.1 Frequency of Meetings

7.1.1 Meetings will normally take place weekly.

7.1.2 The business of each meeting will be transacted within a maximum of 3 hours.

7.2 Secretary

The PA to the Chief Executive who will act as secretary to the meeting including making arrangements for the meeting and for the provision of action notes after the meeting.

7.3 Quorum

7.3.1 A quorum will normally be five members in attendance; one of whom should be the Medical Director or Chief Nurse or their designated deputy(ies) ensuring appropriate clinical input into the meeting.

7.3.2 When considering if the meeting is quorate, only those individuals who are members can be counted, deputies and attendees cannot be considered as contributing to the quorum.

7.4 Recording of Actions Agreed at Meetings

Actions agreed at each meeting will be circulated to members by the end of that working day.

7.5 Review

Terms of Reference will normally be reviewed annually.

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 and difference.

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).

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NLG(21)088

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021				
REPORT FOR	Trust Board of Directors – Public				
REPORT FROM	Terry Moran, Chair				
CONTACT OFFICER	As above				
SUBJECT	Board Feedback – February 2021 Meeting				
BACKGROUND DOCUMENT (if any)	None				
PURPOSE OF REPORT	To provide feedback to Trust Board members of the meeting held on the 2 February 2021				
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None				
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Report provides overall feedback from the meeting held on the 2 February 2021				
ACTION REQUIRED					
Approval	**Information**	**Discussion**	**Assurance**	**Review**	
LINK TO STRATEGIC OBJECTIVES					
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**	
TRUST PRIORITIES					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	To provide strong leadership (Strategic Objective 5)				
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report				

TRUST BOARD – REVIEW OF MEETING

(ratings 1 to 4: 1 = low/poor, 4 high/good)

Date of Meeting: Tuesday, 2 February 2021

Business Conduct		Rating (1-4)				Comments
		1	2	3	4	
1	Did the Board focus on the appropriate agenda items?		2	2	5	• Difficult to have in depth focus as the agenda was so massive. • In view of the size of the agenda wonder if some of these could have been delegated to Committees.
2	Where appropriate, were relevant items debated at the relevant Board Assurance Sub-Committee prior to being submitted to the Trust Board?	1		4	4	• Items were on the trust board agenda that had not previously been seen at sub-committees which made it difficult. • I have marked this a 4 relating to Q&SC as other committees not stood up at the time of the meeting. • Some certainly were but not all.
3	How effective was the BAF item at the Board meeting? Please comment / suggest how this could be improved.	1	2	4	2	• The BAF now needs substantial revision along with the Risk Management Framework. • I felt the focused Board Development created rich conversation and allowed sufficient Board time to focus on this important subject. • We really need a new BAF, as discussed at the afternoon session. • I thought the deep dive was not clear enough and would prefer to see a separate paper on the specific area to

						gain the assurance intended. • Still work in progress at present but moving in the right direction. • No real challenge on the BAF items but lots on other BAF sections. • This was in fact superseded by the subsequent meeting. Appreciate it does need formal inclusion in the agenda.
4	Were you satisfied with the quality of papers: a) Is the purpose and content clear? b) Are papers clear on the Board action required? c) Did the papers meet your expectations to provide the necessary assurance? Please provide any additional comments.	a)		**7**	**1**	• There seemed to be issues with the IPR. • Greater focus on brevity, clarity, actions and deadlines required. Residual risks post management actions need to be more clearly highlighted. • Varying quality. • Some of the papers are still far too long and this needs focus if we are to reduce the timing of meetings and be more focussed…it was a marathon read this month! The lateness of papers are a problem we need to address. • Some of the papers were very detailed and wordy. More use made of executive summaries which should be a maximum of 2 pages**.**
		b)		**7**	**1**	
		c)	**1**	**6**	**1**	
5	Did any one item / paper stand out for you as a model to adopt for all items? Provide rating of paper and then be specific about why by providing a comment.					• The Ockenden paper and the CQC paper – both very good, but very detailed. • Estates Strategy was a high quality production.
Meeting conduct & timing		**1**	**2**	**3**	**4**	**Comments**
6	Did the tone and conduct of the meeting feel that you were able to contribute constructively?			**2**	**7**	• Chaired in a fashion that enabled this. Increasing familiarity with use of visual intervention, use of hand etc facilitates

						this.
7	How effective was the chairing of the meeting? Please include a comment if required.			**2**	**7**	• Chaired in a fashion that enabled this. Increasing familiarity with use of visual intervention, use of hand etc facilitates this.
8	Was the length of the meeting appropriate?		**1**	**3**	**4**	• Was quite lengthy day in total. • The meeting was not long enough for the agenda – but the agenda was too packed. But the meeting length should be appropriate! • Very long day on screen. • This question isn't the length of the meeting, but the complexity and number of papers expected to be dealt with in this time period.
9	Any Other Comments: • I would welcome further focused Board Development sessions to allow Board member to have adequate time to focus on key issues. • The lack of clarity of the accuracy of data in the IPR was a concern. • The late provision of papers is an area that gives me concern. A paper of some depth and time to assimilate was provided at 4.00pm the day before the meeting. My experiences in other meetings outside the NHS is that papers that were submitted within 24 hours of the meeting would either not be considered or marked as for information only and not discussed. I fully appreciate the pressures on staff at present but the comments still stand in light of this.					

NLG(21)089

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021
REPORT FOR	**Trust Board of Directors (Public)**
REPORT FROM	Neil Gammon, Non-Executive Director / Chair of Finance & Performance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Finance & Performance Committee – Minutes of meetings held on 28 October 2020 & 27 January 2021**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF REPORT	For Information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee 27 January & 24 February 2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Minutes of the Finance & Performance Committee held on 28 October 2020 & 27 January 2021.

ACTION REQUIRED

Approval	Information	Discussion	Assurance	Review

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to? Highlight the box this refers to

1. To give great care	2. To be a good employer	3. To live within our means	4. To work more collaboratively	5. To provide strong leadership

TRUST PRIORITIES - which Trust Priority does this link to? Highlight the box this refers to

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Risk 6
TRUST BOARD ACTION REQUIRED	The Board is asked to note the report.

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **28 October 2020 – via GoToMeeting**

PRESENT:	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Tony Bramley	Non-Executive Director
	Andrew Smith	Associate Non-Executive Director
	Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
	Lee Bond	Interim Director of Finance
	Ivan McConnell	Director of Strategic Development
IN ATTENDANCE:	Claire Hansen	Acting Chief Operating Officer
	Simon Tighe	Deputy Director of Estates & Facilities (For items 11.1; 11.2; & 11.3)
	Lucy Kent	Improvement Delivery Manager (For Item 5.1)
	Mike Smith	Finance Manager (For item 8)
	Abdi Abolfazl	General Manager, Medicine (For item 5.2)
	Darren Marshall	Divisional Finance Manager, Medicine (For item 5.2)
	Chris Evans	Associate Director of Information Systems (For items 5.4 & 5.5)
	Brian Page	Lead Governor
	Ian Reekie	Lead Governor Elect
	Becky Southall	Quality Governance Lead & Freedom to Speak Up Guardian, NHSE/I
	Maria Wingham	Improvement Programme Manager (Observer)
	Anne Barker	Finance Admin Manager (Minutes)

Item 1 10/20 **Apologies for Absence**

Apologies for absence were received from: Linda Jackson; Jug Johal (rep Simon Tighe); Shaun Stacey (rep Claire Hansen); and Kathryn Helley (rep Mike Smith)

Neil Gammon welcomed the following attendees to the meeting:

- Becky Southall from NHSE/I;
- Brian Page, current Lead Governor attending his final meeting;
- Ian Reekie Lead Governor Elect who will be attending future meetings;
- Simon Tighe, Estates & Facilities;
- Chris Evans, Information Services;
- Maria Wingham as an observer.

Neil Gammon advised that given current operational pressures due to OPEL 4 a number of attendees would be attending for their item only and as such the agenda would be flexed to accommodate.

Neil Gammon advised that all papers presented at the meeting today would be taken as read and only changes and/or updates would need to be highlighted.

Item 2 10/20 **Declarations of Interest**

Neil Gammon sought any declarations of interest and Lee Bond advised that as he was a member of both HUTH and NLAG Finance & Performance Committees he should declare an interest, which was noted.

The following item was taken out of sequence.

Item 11 10/20 Estates & Facilities

11.1 BAF Risk – Deep Dive – LV/HV

Simon Tighe presented the report and highlighted a concern with the HV grading study linking back to 2017, funding and staff changes had caused this medium risk to slip however funding was now confirmed and the study would be completed this year. The remainder of the risks were from the 2019 audit and were medium or low risk items.

Tony Bramley queried the item on the action plan referring to the replacement of the temperature gauge and Simon Tighe explained that the gauge was faulty and required replacing, which is an outstanding action. Centrica, who installed and serviced the Transformer, need to replace the gauge. There had been an issue with the heat gain in the transformer room but it had been confirmed by Centrica that the room was fit for purpose.

Neil Gammon referred to the monthly meetings to improve relations with the authorised engineer (AE) and asked how appointments of AEs were made in the first place. Simon Tighe advised that the process was based on quality and cost and the appointment of the LV/HV was done through that process 2½ years ago. As reported last year, performance was not as high as expected but with regular monitoring meetings the situation had now improved.

Stuart Hall referred to the combined heating and power plant and asked what happened to surplus energy. Simon Tighe explained that the waste heat is sent to the waste heat boiler and confirmed that the Trust does not sell back to the grid as the infrastructure is not placed to do so and that the CHP is matched to the site baseload.

Following the discussion the Committee received and noted the report.

11.2 Car Park Charges Update

Simon Tighe advised that from 1 November 2020 patient car parking charges would be reinstated; staff parking remains free following national guidance.

11.3 BAF Risk Review – Risk 7

Simon Tighe advised that risks were reviewed monthly and no changes to the gradings had been made.

In terms of risk 7c, Digital, Chris Evans reported that the new Chief Information Officer, Shauna McMahon, would commence in post in November and the Digital Strategy would then be completed and brought to the Committee for review. There were investments expected over the next 12 months on the back of the national programme. No changes to the risk rating had been made at this time.

Lee Bond referred to his comments made at the previous meeting and his concern over risk ratings of 20, specifically if building structures are not safe, referring to the closing and removal of patients from the Coronation Block at SGH and if NLAG was still running that risk now with no action plans in place to reduce the risk then that was a concern.

Neil Gammon highlighted that he did not clarify at the last meeting that the strategic risk, under discussion then, was specifically the non-delivery of constitutional targets which is evidenced. Neil Gammon added however, that, in his opinion, as a Trust we tend to exaggerate risk levels in some areas for a variety of reasons. He explained that he had

spoken with Helen Harris, Trust Secretary, after the last meeting and reported that she was looking at the risks in the BAF. He asked if Lee Bond would be expecting a more fundamental overhaul of the BAF. Lee Bond explained that he was particularly interested in risk appetite and how NLAG deals with risk appetite in terms of consistency across the Trust.

Simon Tighe added that risk ratings were reviewed and confirmed at departmental monthly meetings; however he acknowledged that the rating feels, and was high. He explained the logic behind it by citing an example of a roof collapse in the Trust. Simon Tighe added that as an engineer he undertakes risk assessments every day and he would be nervous if those ratings are determined elsewhere as that would result in a loss of ownership of those risks and could mean a reduction in the risk rating without agreement of specialty teams.

Andrew Smith acknowledged Simon Tighe's comments but also agreed that the BAF needs a wider review and it would be good to set timescales for this to be undertaken.

Neil Gammon agreed to discuss further with Helen Harris but also to add to the highlight report the strong feelings of the committee for evolutionary growth of the BAF and perhaps time to undertake a fundamental review.

Action: Neil Gammon

9.30am Simon Tighe left and Lucy Kent joined the meeting.

Item 3 10/20 **Minutes of the previous meeting held on 3 September 2020 – Public**

Tony Bramley noted a sentence in Section 5.3 (page 5) which appeared to have some words missing. It was agreed that Neil Gammon and Anne Barker would review and amend accordingly.

Action: Neil Gammon / Anne Barker

Post Meeting Note: The sentence should read "…. Jim Hayburn added that he was happy to support but slightly concerned that removing core capital ….."

Following review of the minutes from the meeting on 26 September 2020 and subject to the above amendment, the minutes were agreed as an accurate record.

Item 4 10/20 **Matters Arising**

All actions were noted as included within the Agenda and there were no matters arising.

4.1 Action Log

The Action Log was reviewed as follows:
4.2 – Additional KPIs to be added to the IPR – it was agreed that as the IPR is currently being reviewed and potentially changed then this item should be closed. Neil Gammon advised that an IPR scoping meeting was being arranged with Bev Haywood and it was agreed that Stuart Hall and Tony Bramley would join that meeting.

4 – Pathology Sexual Health Tender – Lee Bond advised that he understood that the Trust had been unsuccessful in retaining the service. He had asked for a report on the decision and whether there were sufficient grounds to challenge it. Moreover, he wanted to understand the likely impact on NLAG. Ivan McConnell explained that it was necessary to score 3 across all criteria, which the Trust had done apart from one, that being IT interoperability; Lee Bond wanted to understand the Trust's risk exposure to similar pieces of work and what mitigation was in place. He agreed to report back to the Committee on this work.

5 – CQC Progress Report – Committee assurance. The reports were now being presented to Trust Board and therefore the action could be closed.
7 – Finance Report - Agency and locum costs now included within the report. Item closed.
7 – Finance Report – review of finance risk against strategic objective 3 – Lee Bond commented that the only issue for further consideration was the financial plan and risk of delivery which were predicated with no Covid pandemic in place. The risk of living within financial envelope is subject to current pressures over the next 6 months. Item to be closed on the action log and will automatically be considered with each month's finance report.
9 – Strategic Development – There is a risk of substantial increases in capital spend from initial tender stage to commencement of project and the dependence of this risk on the governance and management arrangements for capital expenditure. Lee Bond explained that the organisation would be looking to follow P22 approach where the planning phase should manage those risks at the start of the tender stage. Ivan McConnell noted that in agreement with NLAG Chair a review of governance of capital programmes would be undertaken. He highlighted specifically that a programme director would be appointed for the ED/AAU projects which would cover slippage and financial management, with the phasing of GMP correctly aligned to reducing risk. He agreed that a report would be brought back to the F&P Committee in January 2021.

Following review and updates the Action Log was noted.

Item 5 10/20 Presentations for Assurance / Transformation Project Briefing

5.1 CQC Progress Report

Lucy Kent presented the report and was invited to update on any additional information and how the planned Trust Board session with Triumvirates was being reshaped.

Lucy Kent advised that given current, pandemic, operational challenges and to avoid additional pressures on the Divisions, the Trust Board CQC session was not going ahead the following week but the preparatory work that the Divisions had completed would still be circulated to Board members.

Lucy Kent highlighted the ongoing work on performance, ITT, cancer and the use of Power BI, noting that the latter is a daily report therefore difficult to use for assurance purposes.

Maria Wingham added that the proposed, redesigned IPR would be shared with Trust Board at their 5 November 20 meeting, followed by individual work with Trust Board assurance sub-committees to ensure the right information was included for all levels.

Andrew Smith noted that some areas rated red on the CQC paper did not feature on the risk register and suggested a revisit particularly in terms of competency, control items and data.

Lucy Kent explained that the IPR was now mapped to the risk register and discussions were being held with the Divisions on the rationale of including or not including such areas on the risk register.

Tony Bramley was pleased to note the changes, including tracking, made thus far but highlighted specifically some areas for further clarity, including the "Areas of general concern" on page 4. He noted these concerns were the same as the last report and suggested that it would be helpful to indicate if they were the same, newly added or removed.

Tony Bramley asked for the current position on CQC requirements and separate funding for these.

Tony Bramley asked for clarification on the areas included within the table (section 7) where the likelihood of compliance is stated as "likely but late", noting the overdue date for completion was 3 months ago so wanted to understand what "late" meant.

Lucy Kent addressed the issues raised and advised that in terms of the last point the work was predominately completed but comprehensive evidence was not available and this was currently being worked through with Divisions to obtain that information.

The first point and the suggestion by Tony Bramley for the areas of general concern were noted and would be addressed.

Lucy Kent addressed Andrew Smith's concern on the data issue and explained that it was hoped that a graph would be included in the next reporting cycle. Maria Wingham added that not all the issues were down to performance and the information team were heavily burdened with this work but anticipated having more detail for the following month.

Lee Bond considered the funding of the CQC requirements and explained the discussions ongoing with the CCGs, facilitated by NHSE/I, which resulted in four business cases being taken forward; each of these have seven figure sums against them. These will be developed in conjunction with the CCGs regarding investment support. The remaining business cases, of which there were 12, would need to be considered in terms of risk given the lack of additional funding.

It was agreed that this would be added to the highlight report to the Trust Board and Tony Bramley suggested the need to monitor those areas where no additional investment was available.

10.02am Following review the report was noted and Lucy Kent left the meeting.

5.2 Medicine Division – CIP Savings Plan

Ab Abdi and Darren Marshall attended the meeting to present the paper. Ab Abdi briefly ran through the paper previously circulated and highlighted that the Division had a shortfall of £3.7m due to the Division's allocation not funded at recurrent outturn position and with additional pressures including CQC "must do actions" resulting in a gap of circa £9.3m.

Neil Gammon emphasised that the purpose of inviting Medicine Division to the Committee was not only to support the Division and understand the areas of concerns but also to celebrate successes, noting the reduction in LOS and the substantive recruitment of seven consultants referred to in the report.

Questions from the Committee were sought and Tony Bramley stated that the paper had been helpful but asked for clarification on the use of the phrase "dis-economies of scale" referred to by Ab Abdi.

Ab Abdi explained that in dealing with two emergency departments and two sites there are areas where a tariff based payment is insufficient. Lee Bond stated that one of the difficulties is the perception by clinicians, of how the system is working but agreed the tariff system was flawed, however this year was not based on tariff. An early piece of work needed to be undertaken in order to explain to clinical leads how the financial

system operates this year and potentially in future years. Ab Abdi understood the explanation but was still concerned about the base line. Lee Bond explained that funding was based on historic costs in months 8, 9 and 10, of FY 2019/20 therefore the same level of activity needs to be undertaken this year but there will be additional Covid-19 funding on top of that.

Ivan McConnell added that the Division also need to think about moving forward and what the model of care would look like including the impact of NHS 111, AAU and ED and the ability to demonstrate within the system that efficient pathways are in place. Ab Abdi highlighted that a significant amount of work is being undertaken on efficiency and effectiveness; which was acknowledged.

Andrew Smith asked what the unidentified CIP was and Darren Marshall explained that this referred to the target for savings where no schemes had yet been identified. Ab Abdi explained that non-recurrent savings had been achieved and Neil Gammon noted that one of the reasons for the high CIP savings required in year was due to a significant proportion of savings being non-recurrent in previous years and asked for thoughts on recurrent savings.

Ab Abdi explained that the previous year the Division had achieved 83% which included both recurrent and non-recurrent.

Stuart Hall noted the 95% predicted achievement of the target and asked how confident the Division were at achieving this.

Darren Marshall explained, by way of assurance for the Committee, that the Division held fortnightly CIP forums with good attendance from finance, PMO, and procurement to ensure good governance and continuous working on the savings gap. He noted that 70% costs are pay related with pressure on retention of staff, increases in sickness, absence and isolation. These have resulted in the need for premium costs to manage that staff absence pressure.

Neil Gammon asked if there was anything that the Division required from the Committee noting the work that Lee Bond referred to in providing clinical staff with a better understanding of financial processes. Ab Abdi acknowledged that work but would also like clarity around specialist commissioning. This was agreed.

Neil Gammon undertook to highlight Medicine Division's participation to the Trust Board and thanked Ab Abdi and Darren Marshall for attending given current operational pressures.

10.45am Ab Abdi and Darren Marshall left the meeting.

10.50am Claire Hansen joined the meeting

5.4 Clinical Data Improvement Programme

Chris Evans attended the meeting to present the report which was taken as read and questions were sought.

Stuart Hall referred to the key risks, specifically the detailed work required on information flows, noting that the report refers to a requirement for more resource and asked where that resource would be coming from. Chris Evans explained that an in-depth piece of work on data flows throughout the organisation is required and a process is in place, with the costing team, looking at identifying key flows and risks and also working with clinical coding. Internal resource will be used for this, building on the audit work that Grant Thornton (GT) had completed.

Stuart Hall also referred to the experience of coders and asked how that can be improved. Chris Evans explained that knowledge from GT had been transferred to internal staff to be able to pick up once the GT contract ends at the end of the year.

Neil Gammon asked how that transfer of knowledge can be measured. Chris Evans explained that part of the work is through the audit process around Covid-19 and the assurance of capability is an ongoing process; a significant focus has been on supervision layers within the team structure and robust staff development plans are now in place.

Tony Bramley referred to the presentation and the 8 key headline risks but was not clear what the mitigating actions were or where the focus should be. He felt that it would help to have a prospective statement, a professional opinion, on whether this would work or not and what the level of assurance might be.

Lee Bond asked if there were any dashboards containing metrics that could be monitored to provide assurance to the committee that all processes are embedded and continue to be so. He wished to see some detail on co-morbidity scoring and the level of clinical involvement in coding. Chris Evans highlighted Appendix 2 of the document containing the current KPI report and explained that the audit processes are the mechanism for this with a monthly assurance report to the CDIP board, with escalation to TMB before being brought to the F & P Committee.

Chris Evans explained that additional improvement facilitator posts would be appointed, which were part of the original business case. They will work closely with Divisions which will add capacity.

Lee Bond asked if the data could be compared with HUTH and Chris Evans stated that they have similar processes so the team could help. Lee Bond agreed to bring a brief paper back to the Committee.

Action: Lee Bond

5.5 Data Quality Report

Chris Evans presented the report following the completion of the system and data validation programme. It provides assurance that appropriate actions had been taken to resolve any issues that had arisen and that risk mitigation plans were in place.

Andrew Smith asked for more detail concerning the ICO and the committee agreed that the Chair of F&P Committee should refer to the ARG Committee for oversight.

Action: Neil Gammon

Tony Bramley referred to the clinical harm review which was regularly examined in detail at the Q&S Committee and noted that any outstanding actions would be monitored by that Committee.

Following review and discussion the contents of the report were noted and Chris Evans left the meeting.

Item 6 10/20 **Integrated Performance Report**

Claire Hansen presented the report for discussion.

Claire Hansen noted that overall referrals are increasing as well as outpatients and elective numbers; cancer continues improving. The current situation is making it difficult

to continue with elective work and in order to address the elective cancellation plans, internal plans are in place to be authorised by the regional director. The current OPEL 4 situation has caused elective work to be reviewed in line with surge plans with a worst case scenario resulting in the need for 38 critical care beds. This work is currently being validated.

Claire Hansen also explained that similar procedures are being undertaken relating to O/P work but this does not need reporting to the regional team but the Exec Team are sighted on it. She noted that development of GDH HOBs facilities had paid dividends.

Stuart Hall referred to the key risks within the report and the possible loss of contract with St Hughs Hospital and asked if that happened what that risk would be. Maria Wingham explained that a national Independent Sector tender process was currently being undertaken by NHSI and confirmed that the contract was likely to continue.

Ivan McConnell noted however that the new contracts would be different with the potential of being able to use regional organisations rather than just local.

Claire Hansen presented the IPR and advised that the performance reported in the IPR is consistent with STP and ICS with O/P and noted that elective was better than our peers.

Tony Bramley referred to the peer to peer comparison, in particular Cancer 62 day and asked why the Trust's profile looked different. Claire Hansen agreed that there had been a dip but explained that this was due to a couple of specialities making a significant difference in the overall percentage performance. She noted an improvement was being made with 104 days performance.

Claire Hansen highlighted specifically the colorectal team and the challenges they had encountered which would continue through the winter; although plans they had in place would help with that performance. Having independent sector availability for colorectal work would also enable more focus to get improvement in cancer performance.

Tony Bramley referred to a change in guidance for colorectal which would allow more procedures to be undertaken and he noted proposals discussed at Q&S for change in pathways, which if successful, would enable delivery of performance which had not been the case in the past.

Claire Hansen acknowledged the challenge given the track record but stated that because of the Covid-19 situation a change in clinical leadership and overall behaviour and attitude had been noted and she was confident that this would continue to enable progress in performance.

Lee Bond asked Claire Hansen about scoping capacity given the difficulties for a number of organisations. Claire Hansen agreed and advised that there are plans to look at that but these were not expected yet. The speciality had worked hard to streamline processes and was working with GPs on appropriate referrals. It was anticipated that any pathway changes resulting would reduce overall demand for the service.

Stuart Hall queried the ED progress and which issues there were a concern. Claire Hansen advised that the zoning in A&E and wards, as well as wait time to be seen, were having an impact on flow as well as discharges. Limited capacity was a factor, not just due to Covid-19 but also to D&V, which is normal during winter but was slightly earlier in the year than would have been expected.

Stuart Hall also queried the capacity at Goole and asked how more use of the site could help drive 7-day working. Claire Hansen repeated that the implementation of HOBs at Goole had been successful and would help with the capacity for procedures. It had enabled an opportunity to work more closely with HUTH which was currently being considered.

Neil Gammon queried the progress with the O/P risk stratification and Claire Hansen explained that the national initiative was focusing on elective, day patient case work but suspected this would be rolled out to other areas. She advised that the Trust was further developed in this regard than others in the region given the processes that are in place and whilst there was still work to do the regional team were confident in what was in place; it is hoped that more information would be included in the next report.

Following review and discussion the report was noted.

6.3 BAF Risk Review

The BAF Risk 1 was reviewed and agreed that the rating was still appropriate. Claire Hansen asked for the committee to be aware of a risk from a staffing point of view as the increase in staff isolating or with positive Covid-19 results which could have a potential financial risk due to the need for use of agency staff.

11.45am Mike Smith was welcomed to the meeting for item 8.

Item 7 10/20 Finance Report – M06

Lee Bond presented the report and noted the highlights from the Executive Summary.

- Additional Covid-19 expenditure of £1.4m (£9.5m year to date) with funding limited to the value to achieve breakeven position.
- Cash balances - decrease in month of £2.2m.
- Better payment performance continues to improve and Lee Bond advised that he was encouraging finance teams to work with managers across the Trust to improve further.
- Potential issue with E&F as currently reporting £700k overspend but need further work to understand the drivers for this.
- Elective incentive scheme could mean financial loss to the Trust but the penalty incurred in September of £209k was not reflected in the YTD financial position as per NHSI guidance.
- Detailed individual divisional information included within the report - Lee Bond asked the Committee if they were content to receive this amount of detail each month. It was explained that this information is seen on a quarterly basis and Lee Bond asked if half yearly would be sufficient.

Tony Bramley stated that whilst the Committee need to see and understand the Covid-19 expenditure he would support a regular summary being brought to the Committee which would diminish the need for the detail so would support Lee Bond's suggestion of half yearly.

7.1.1 Budgets 2020/21

Lee Bond presented the report which outlined the 2020/21 financial planning framework including the Trust's budget setting principles. He noted that retrospective top-up funding ended on 30 September and was replaced with a centrally calculated deficit top up which for the Trust would be £29.4m as block income for the second half of the year.

A system wide allocation for Covid-19 expenditure would be received with this Trust receiving £6.4m. Therefore it had been proposed that for the second half of the financial year the Covid-19 budgets would be devolved to the divisions to manage with a caveat that if the R rate increased then would potentially have to revisit some assumptions.

The delivery of the financial plan requires delivery of the CIP plan; the original CIP plan was for £13m with £10.3m already identified and whilst the plan was not significantly back-end loaded for delivery there needs to be pressure to achieve.

The Committee agreed with the proposal for the Covid-19 budgets to be devolved to the divisions. Lee Bond explained that this would be taken to TMB the following week for final sign-off.

Tony Bramley queried whether control totals still exist and Lee Bond explained that the break-even control total still leaves a gap of £5m but as long as the Trust can demonstrate that every effort was being made to achieve the control total he would not expect to get any push back from NHSI. Lee Bond added that he has ongoing discussions with the Regional Finance Director, also noting that as an ICS with £9m still to be resolved, a balanced plan had not been submitted.

The national requirement was for each system to achieve a break-even position and therefore the system needs to work together to deliver that position.

Following review and discussion the report was noted.

7.2 BAF Risk 6

Lee Bond explained that as this was work in progress he anticipated that the risk rating for this will be discussed at a future F&P meeting once that work is complete.

Item 8 10/20 **Savings Programme 2020/21**

Mike Smith presented the report and highlighted that the current forecast of the CIP position was £9.9m against a plan of £10.4m and with some adjustments to be made would be £10.2m equating to £300k adrift of plan, although he added this may be a conservative estimate. Recruitment is affecting savings; £2m non-recurrent savings in the programme so this would impact planning for the following financial year.

Stuart Hall asked if focus had been taken off the CIP savings programme and Mike Smith explained that the teams were still operating and the monitoring meetings had still been taking place with divisions. Engagement with the divisions, it was suggested, was not as strong in some areas as it had been in the past. However, the focus had been on Covid-19 and latterly on the recovery plan so he acknowledged that the process of CIP had not been effective as in previous years.

Stuart Hall suggested that the recurrent CIP delivery, currently 70%, should be the focus.

Mike Smith acknowledged that the report presented was a big document but this was due to special measures and also how CIP was monitored and explained that the first part of the report is the essence of CIP with the remaining pages giving the detail and asked if the Committee would like this to be similar to the Finance Report previously discussed where the detail is only brought periodically. It was explained that Mike Smith and his team would be moving into the Finance Directorate so the approach could be decided through discussions with Lee Bond, Neil Gammon and Andrew Smith.

Claire Hansen referred to the comment from Mike Smith on the engagement with divisions and suggested picking this up through the divisional meetings.

Item 9 10/20 **Strategic Development**

There was nothing new to update this month.

BAF Risk Review – Risks 8 & 9

Ivan McConnell advised that a review is underway on the major risks across the Humber Acute Services so the risk level currently remains the same.

Ivan McConnell advised the Committee that funding had been confirmed for the A&E business case which was good news.

Item 10 10/20 **Business Planning & Performance**

10.1 Business Planning Timetable

Claire Hansen gave a brief update, provided by Kathryn Helley, on planning for 2021/22. A workshop would take place in November for the divisions to present their initial thoughts including capacity work and taking account of what that would mean against the recovery plans. It was understood that HUTH and York trusts were looking at multi-year business plans and this is being considered by NLAG.

Initial conversations had taken place with ICS colleagues for plans for system wide planning.

It was noted that all this was in the absence of national planning guidance. It was not known when this would be issued.

The Committee expressed concern on the timing of the workshop given the current climate and Claire Hansen explained that would take place as part of weekly meetings with the divisions to ensure it continues.

Item 12 10/20 **Items for Information**

12.1 F&P Workplan 2020/21

The workplan was noted.

Item 13 10/20 **Matters to Highlight to other Trust Board Assurance Committees**

Other than the agreed need to refer the Data Quality Report (Item 5.5) to the Quality Risk and Governance subcommittee, there were no further issues to highlight to other Trust Board Assurance Committees.

Item 14 10/20 **Matters for Escalation to the Trust Board**

The following items were noted to be highlighted to the Trust Board:

- Briefing from Medicine Division.
- BAF review to include a wider examination of NLAG's Risk Management systems.
- CQC Business Cases – risk of their not being taken forward due to lack of funding.

Item 15 10/20 **Any Other Urgent Business**

There was no other urgent business raised.

Neil Gammon advised the Committee that this would be Brian Page's last meeting as he was stepping down as Lead Governor and he thanked Brian for his attendance and input to the Committee meetings. Neil Gammon advised that Ian Reekie would be taking over as lead governor from 1 November 2020 and looked forward to seeing him at future meetings.

Item 15 10/20 **Date, Time and Venue of next meeting**

Thursday, 26 November – 9.00am-12.30pm – Virtual Meeting

Due to the current Covid19 situation this meeting was cancelled.

Attendance Record 2020/21

Name	*Apr 20	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	*Nov 20	Dec 20	Jan 21	Feb 21	March 21
Neil Gammon		✓	✓	✓	✓	✓	✓					
Linda Jackson		✓	Apols	✓	✓	Apols	Apols					
Tony Bramley		✓	✓	✓	✓	✓	✓					
Stuart Hall		✓	✓	✓	✓	Apols	✓					
Jim Hayburn		✓	✓	✓	✓	✓						
Lee Bond						✓	✓					
Peter Reading		-	-	-	Apols	-	-					
Shaun Stacey		✓	✓	✓	✓	Apols	Apols					
Jug Johal		Apols	✓	✓	✓	✓	Apols					
Ivan McConnell		✓	✓	Apols	✓	✓	✓					
Marcus Hassall		-	-	-	-	-	-					
Kathryn Helley		✓	✓	✓	✓	✓	Apols					
Helen Harris			✓	-	-	-	-					
Brian Page		Apols	Apols	✓	Apols	Apols	✓					
Ian Reekie							✓					
TOTAL ATTENDEES		**8**	**9**	**9**	**9**	**7**	**7**					

* Meeting Cancelled

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **27 January 2021 – via GoToMeeting**

PRESENT:

Neil Gammon	Non-Executive Director / Chair of F&P Committee
Tony Bramley	Non-Executive Director
Andrew Smith	Associate Non-Executive Director
Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
Lee Bond	Chief Financial Officer
Ivan McConnell	Director of Strategic Development
Shaun Stacey	Chief Operating Officer
Brian Shipley	Deputy Director of Finance
Shauna McMahon	Chief Information Officer
Anne Barker	Finance Admin Manager (Minutes)

Item 1 01/21 **Apologies for Absence**

Apologies for absence were noted from Linda Jackson; Helen Harris; Ian Reekie

Item 2 01/21 **Declarations of Interest**

Lee Bond's declarations of interest noted from previous meetings regarding member of Finance Committee at both NLAG and HUTH.

Item 3 01/21 **To approve the minutes from the previous meeting held on 28th October 2020.**

The minutes were approved as an accurate record.

Item 4 01/21 **Matters Arising**

Tony Bramley referred to Item 4 (Page 3) – Pathology Sexual Health Tender and previous discussions at F&P Committee that NLAG had not been successful in its bid and that following NLAG questioning the tender was re-advertised with NLAG once again bidding. Tony Bramley suggested that an update should be brought to a future F&P committee to either advise of a successful bid or the impact on Path Links if not.

Lee Bond confirmed the retender exercise was being undertaken and he had been in discussion with Mick Chomyn on financial exposure should NLAG be unsuccessful; noting that this is highly likely. Internal discussions have been held on how far we can reduce the financial margins and this would be considered over the next couple of months and he confirmed that an update would be brought back to the Committee.

Action: Lee Bond

Shauna McMahon joined the meeting.

5.1 - Clinical Data Improvement Programme – To be included as part of an operational update.

Action: Shaun Stacey

Item 5 01/21 **Review of NLAG Monthly Performance and Activity Delivery**

5.1 Performance Report

Shaun Stacey gave a brief update on the four key issues of concern including:

52 Weeks Waits – These continue to significantly increase despite actions in place. Most of the patients are not in priority 2 or 1A i.e. treated in 72 hrs or 4 weeks therefore having to accommodate where possible which is causing growth in 52 weeks. Breaches increased in September/October 20 which impacted on the already difficult position. Shaun Stacey noted that pre-Covid both 52 and 40 week waits were well below standard apart from four specialities.

Follow-ups – An agreement was in place with CQC that the reduction in the 'follow-up lists would be implemented by March 2021. In March 2020 the trajectory was on target. Ophthalmology, with no community service, are seeing the biggest increase in their backlog. This was addressed in Wave 1 by reviewing those patients with a timescale of 6-9months who are now becoming live on the system and therefore showing significant growth. We are using independent sector thanks to finance agreeing funding for additional activity, but demand has exceeded capacity.

Diagnostics – Issues with sufficient access to specialist diagnostics due to increased activity, including long waiting times to PET and complex scanning, which has a direct correlation with demand from HUTH. Due to Covid, enhanced cleaning requirements have played a significant part in diagnostic wait increases at NLAG.

Shaun Stacey highlighted that there are three recovery trajectories in the report with 92% delivered but unfortunately not enough to impact on the waiting list figures. Access to independent contract was restricted with only 6 sessions available and their criteria for treating patients e.g. 70 patients referred with only 10-11 accepted in some weeks.

A&E – Deteriorating picture due to challenges on discharges. The latter part of 2020 was managed sufficiently but then struggled despite having additional 80 beds agreed. Poor A&E performance and worsening Ambulance handover was noted.

Shaun Stacey advised on an agreement of mutual aid with York to provide up to 50 beds for step down rehab.

Ivan McConnell joined the meeting.

Members of the Committee were invited to ask questions.

Tony Bramley commented on the gravity of the situation presented by the update and given the compressed time of the meeting, suggested that the F&P Committee should be reinstated in full.

Tony Bramley referred to section 2.5 – Outpatients (page 7/12) and the charts showing O/P attendances and the narrative below which he did not feel gave a sense of what the outcome was going to be.

Section 2.6.2 – Cancer – December headlines (page 9/12) (5th bullet) in terms of screening forecasts, noting the national standard of 90% for 62 day screening and achieving only 20% which Tony Bramley suggested this stands out given all others are close to the standards.

Shaun Stacey explained that diagnostic performance was a challenge in ensuring the right level of access is provided to cancer patients. Given the number of patients there was not enough access with PET and HUTH affecting that performance, but assured the Committee that everything is being done. Shaun Stacey explained that improvement would be seen once the new scanning unit at Grimsby is in place with more patients going through as the facilities will be much faster, but noting that HUTH are also struggling with capacity and demand in their services.

Stuart Hall acknowledged the valiant efforts are taking place but suggested there were a number of areas where no assurance can be given and felt that it would be remiss of this Committee not to escalate the issues and asked Shaun Stacey how this was going to be dealt with, and also asked what the current position on risk stratification was.

Shaun Stacey referred to the O/P risk stratification and explained that the challenge is reporting an accurate position in-month which is why it was not included within the report as trying to correlate the data. Shaun Stacey advised that currently this stands between 20% and 85% with, for example, gynaecology at 85% and colorectal at 20%. He noting that next month the Trust will report to Regulators with a robust report, speciality by speciality, identifying the current position and trajectory for improvement. He acknowledged that the report had gaps this month partly attributable to restricted production timescales. Shaun Stacey apologised for this and offered to send the data after the meeting via email; the Committee did not require this and fully appreciated the pressures being faced.

Neil Gammon proposed that the highlight to the Trust Board would make it clear that the Committee did not feel assured citing the four main areas raised by Shaun Stacey and also noting risk stratification difficulties.

Action: Neil Gammon

Ivan McConnell queried if there was a future risk that needed to be highlighted regarding the opening of the new MRI and the loss of mobile units. Shaun Stacey advised that this is currently being reviewed to see if can sustain mobiles but in different locations and working at ICS level on that. It was agreed to also add this to the highlight report.

Action: Neil Gammon

Andrew Smith advised that whilst supportive of Tony Bramley and Stuart Hall's comments, suggested that the issues are not just about this paper but are much broader, noting that as a Trust we seem to be extremely good at analysing data but lack clarity of what actions are required and by when.

Lee Bond questioned the difficulties with the PET scanning at Hull, as highlighted by Shaun Stacey, and agreed to look into the issues but suggested that because of the small number of patients this is disproportionately affecting performance.

Action: Lee Bond

Shaun Stacey confirmed, to Lee Bond, the arrangements for the mutual aid at Goole with York that the ownership of the management of the patients would remain with York, explaining that York discharge the patient to Goole with no medical intervention required by Goole; if that changes and the patient becomes unwell they would be transferred back to York or Scarborough therefore not entering our emergency system.

Shaun Stacey also highlighted there were still five step down beds in Goole for NLAG and there is no current impact on the elective activity but would review if required.

5.2 Ophthalmology New Medica CCG Contract

Shaun Stacey advised that New Medica are now being utilised although there is gap which the team are working to rectify.

Tony Bramley referred to the action required on page 3 of the report and how assured could the Committee be that this will work when it did not work before and asked if capacity is being increased or changing methods to give that increase when it was clearly a challenge in the past.

Shaun Stacey explained that there had been an increase in the amount of triaged patients by comparison to what was available previously, although he was not confident that this would be achieved given Covid restrictions so do not think that the 3000 trajectory would be met.

Stuart Hall was concerned about the impact on patients from a quality perspective and asked if this had been referred to Q&S Committee; Neil Gammon agreed to refer across.

Action: Neil Gammon

Shaun Stacey added that it is a CCG contract which is used, not an NLAG one. This is on the back of arrangements with CCG as this was the only way funding could be released to run this programme. He noted that under NHS contract rules referrals can be rejected by the independent provider which is not something the Trust can do.

Recently agreed discussions take place on a fortnightly basis specifically about increased capacity for referrals.

Shaun Stacey also referred to the Ophthalmology business case and a requirement for new equipment which will have a major impact in 2021/22 if not signed off. It was disappointing that not able to provide in this financial year but acknowledged the nature of the capital funding regime, noting the previous requests have been turned down which compromises their productivity.

Item 6 01/21 **Finance Report – M09**

Brian Shipley gave a brief overview of the report and highlighted key issues to note including:

- Trust ahead of financial plan at Month 09
- Planned deficit with non-clinical income better than plan
- Over delivery with main drop-off in clinical supply spend due to reduced activity levels
- Slightly off-set by pay bank incentives running into February 2021 and additional cover for out of hours in medicine and additional maternity anaesthetic cover in Surgery off-set with slippage in the planned midwifery expansion and additional capacity costs
- Potential penalties of £0.6m is not expected to be enacted due to % of Covid patients and staff sickness against the base line
- Primary year end forecast is £1.17 ahead of plan with £1.6m aside for additional capacity for final quarter of year; £0.6m for AAU for demolition at both SGH and DPOW; £1m annual leave provision as staff struggle to take leave this financial year.
- Savings delivery is on plan with almost a third non-recurrent which is of concern
- Balance sheet and cash look healthy and should even itself out once adjustments made
- Capital is behind plan.

Neil Gammon noted that it was generally good news but slightly dissipated by the non-recurrent element which was a concern for 2021/22 and suggested that CIP is taking a back seat and asked what could be done to improve the situation. Lee Bond suggested that it was not the right time and as much as it would be good to get that back on track the clinical teams are not in the right space mentally to do that. The finance team can though continue to look at benchmarking to identify any fertile ground to increase our cost base, but have to be cognisant of Shaun Stacey's earlier comments about difficulties in increasing performance. It was agreed that this should be added to the highlight report.

Lee Bond advised that the first quarter of the new financial year will be a continuation of the block contract currently in place and suspected that a planning process will be undertaken in the first quarter for the following three quarters of the year but will obviously depend on the Covid situation.

Item 7 01/21 **Estates Strategy**

There were three papers provided for the Committee i.e. Estates Strategy; Supporting document to the Estates Strategy; and the Green Plan.

Jug Johal presented the documents and took the Committee through the slides of the supporting document. Jug Johal referred to the Green Plan which replaces the sustainable management plan and covers 2020/22 and is aligned to the Trust Travel plan to reduce carbon impact in line with government guidance.

Andrew Smith stated that whilst this a good piece of work and gives a clear picture of where we currently are, he was not quite sure about the document's contents if publically presented or precisely what the Committee is approving. He went on to say that more clarity is required against the actions, for example, how many of the actions are locked in as approved schemes and when completed how many of the issues will it address. How many of the options are aspirational such as another hospital - what is the likelihood of achieving that and what are the probabilities of the options being fulfilled.

Lee Bond added that the information is helpful to highlight were we are and describes a particular path but struggled linking the Strategy with the clinical strategy and asked if something is needed at the beginning to say the report is written at a point of time with the current services in place; he also questioned having a 10year strategic document where the clinical model in place now may not be the one in the future.

Jug Johal explained that the detail of the short to medium term is in the full document and does not give the real detail and action plan that underpin the backlog maintenance and explained that reference should be made to the individual documents brought regularly to the F&P Committee in terms of the deep dives. In answer to Andrew Smith's question of how realistic the options are, Jug Johal did not know the answer to that but the document provides evidence for any future bids that may be applied for.

In terms of the clinical strategy this is covered in the full document and the team worked with Ivan McConnell's Trust Strategy team on that but acknowledged that as soon as completed it becomes out of date.

Ivan McConnell stated that it was inevitably a document at a point of time and suggested that when it is submitted to the Trust Board for approval it should have the caveat that it is subject to review in October 2021. The clinical strategy has been respected as best it can and will not be all hospital based care but horizontal care. He also noted that the Trust has been encouraged to seek further funding away from the Treasury as the size of the problem has been recognised nationally. It was suggested therefore that within the highlight report it states that a review of the strategies will be undertaken in September/October 2021.

Neil Gammon noted in the report reference to the internal consultees and asked if POE had been consulted, which Jug Johal confirmed but acknowledged they had been missed off the list and he would rectify.

Action: Jug Johal

Tony Bramley referred to the failing infrastructure and the need to put things in place to rectify. He noted that lack of investment could lead to potential risk to community or total failure. Jug Johal agreed to revise the Strategy to highlight those points and agreed to share the revised report the following month.

Action: Jug Johal

Ivan McConnell made the observation that any long term investment, even if using private equity, will take two years to go through the Treasury and four years for build scheme, whatever is done could be looking at seven years so need to be realistic about timescales.

Following review and discussion the Committee approved the Estates Strategy subject to the concerns raised and Jug Johal agreed to revise the introduction and conclusions to strengthen the Strategy.

Stuart Hall also noted that the introduction also needs alignment to the Finance Strategy.

7.2 NLAG Green Plan

Jug Johal advised that the Green Plan has already been to TMB and was going to Trust Board for final approval. The Committee decided to defer receipt of the NLAG Green Plan until the next meeting due to lack of time and the need to give adequate scrutiny. It accepted that this would place another document out of currency but for sound reasons and for a short period. Jug Johal agreed to review the Green Plan in light of the discussions on the Trust Estates Strategy and re-present to F & P in February.

Action: Jug Johal

Item 8 01/21 **Matters to Highlight to other Trust Board Assurance Committees**

Ophthalmology Issue to be referred to Quality & Safety Committee – Neil Gammon

Item 9 01/21 **Matters for Escalation to the Trust Board**

The following issues were agreed as requiring escalation to the Trust Board:

- Performance Report including:
  - RTT
  - Follow Up Appointments and risk stratification
  - Diagnostics
  - A&E

- Lack of clarity around actions to address performance shortfalls
- Ophthalmology New Medica CCG Contract
- Finance Report
- Estates Strategy and NLAG Green Plan

Item 15 01/21 **Any Other Urgent Business**

Neil Gammon wished to place on record his thanks to Tony Bramley for his invaluable contribution to the Committee which had been much appreciated particularly when he returned as NED in November 2019. He wished him good luck for his future ventures.

Item 11 01/21 **Date, Time of next meeting**

Wednesday, 24 February 2021 – 9.00-12.30pm via Teams Meeting

Attendance Record 2020/21

	*Apr	May 20	June 20	July 20	Aug 20	Sept 20	Oct 20	*Nov	*Dec	Jan 21	Feb 21	March 21
		✓	✓	✓	✓	✓	✓			✓		
Linda Jackson		✓	Apols	✓	✓	Apols	Apols			Apols		
Tony Bramley		✓	✓	✓	✓	✓	✓			✓		
Stuart Hall		✓	✓	✓	✓	Apols	✓			✓		
Jim Hayburn		✓	✓	✓	✓	✓						
Lee Bond						✓	✓			✓		
Peter Reading		-	-	-	Apols	-	-			-		
Shaun Stacey		✓	✓	✓	✓	Apols	Apols			✓		
Jug Johal		Apols	✓	✓	✓	✓	Apols			✓		
Ivan McConnell		✓	✓	Apols	✓	✓	✓			✓		
Shauna McMahon										✓		
		-	-	-	-	-	-					
		✓	✓	✓	✓	✓	Apols					
			✓	-	-	-	-			Apols		
		Apols	Apols	✓	Apols	Apols	✓					
							✓			Apols		
TOTAL ATTENDEES		**8**	**9**	**9**	**9**	**7**	**7**			**7**		

* Meeting Cancelled

NLG(21)091

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	Tuesday 6 April 2021
REPORT FOR	Trust Board of Directors (Public or Private)
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Dawn Harper, Deputy Chief Nurse Jenny Hinchliffe, Deputy Chief Nurse
SUBJECT	Nursing Assurance Report
BACKGROUND DOCUMENT (if any)	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).
PURPOSE OF REPORT	This report provides assurance to the Trust Board that processes are in place to record and manage nursing and midwifery staffing levels on a shift by shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.
OTHER GROUPS WHOHAVE CONSIDERED PAPER (where applicable) ANDOUTCOME	N/A
EXECUTIVE SUMMARY (including key issues ofnote or, where relevant,concerns that the committee need to be made aware of)	This paper is prepared in a new format for some indicators to enable a visual oversight of trends and all indicators will be aligned to this style over the coming months. Due to the ongoing pandemic, data required by the Chief Nurse team has not been consistent, complete or provided in some instances due to resource. The presentation of data is, however, improving as the data analyst develops the nursing dashboard. The changes to ward reconfigurations and zoning make it challenging to make comparisons and benchmark data, and it is worth noting that this will affect any Model Hospital metric comparisons in the future and may affect our staffing returns.

	. The monthly Nursing metrics panel review the information provided by the nursing dashboard and commission any work required to investigate and support any areas of concern. The significant challenges the nursing workforce have experienced throughout the pandemic has led to some shifts being staffed only on minimum staffing levels, impacting on experience of staff, patients and their families and this has been reflected in complaints and PaLs. Staff report that communication with families has been challenging at times due to the reduced staffing numbers requiring bedside care to be prioritised. It is important to acknowledge that not being able to provide high standards of care to patients and their families has led to low morale of staff in some areas, therefore, staff welfare is paramount. The patient contact helpline and family liaison assistants are supporting this communication with families which is supporting frontline staff to prioritise bedside care.

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

LINK TO STRATEGIC OBJECTIVES - which strategic objective does this link to? Shade the box this refers to				
1. To givegreat care	**2. To be a good employer**	**3. To live withinour means**	**4. To work more collaboratively**	**5. To providestrong leadership**

TRUST PRIORITIES - which Trust Priority does this link to? Shade the box this refers to					
Leadershipand Culture	**Workforce**	**Quality and Safety**	**Access andFlow**	**Finance**	**Service andCapital Investment Strategy**

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	Staffing: Inability to secure sufficient numbers/skilled staff. Quality: Risk of non-delivery of agreed quality/clinical improvements;
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: Note the report.

Assurance Report March 2021 (February 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 meetsthe needs of our patients. It is recognised that decisions in relation to safe clinical staffing require atriangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical oversight. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels on a shift by shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Due to the ongoing pandemic, data required by the Chief Nurse team has not been consistent, complete or provided in some instances due to resource. A data analyst has now joined the Chief Nurse Team which means work is underway to develop the nursing dashboard and data collectionrequired by the Chief Nurse team.

Oversight has continued to be provided to the Quality and Safety Committee on nursing and safestaffing. There continues to be ongoing changes to ward reconfigurations and zoning which makeit challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons in the future and may affect our staffing returns.
As we continue to work outside of the pre-Covid ward configurations, any data should be viewedwith caution, for this reason we continue to review individual metrics and apply professional judgement.

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. A matrix has been developed to identify and record risk ratings for all ward areas in orderthat progress can be tracked against actions and the risk re-assessed monthly.

2.0 Safe Staffing

2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

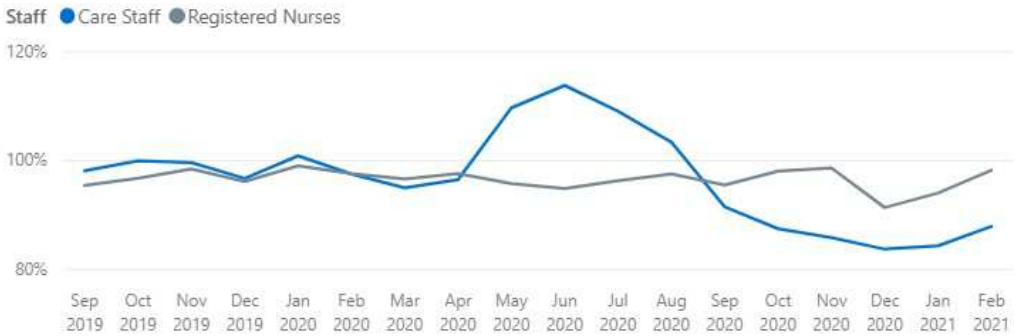
The information presented shows data on inpatient wards only.

Shift Fill Rates Summary Feb 2021

Overall	Registered Nurses	Care Staff	Nursing Associates
93.7% ▲ 3.6%	98.2% ▲ 4.2%	87.9% ▲ 3.6%	55.6% ▲ 8.3%

Overall Fill Rate

Fill Rate by Staff Group



Fill Rate by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPoW	94.3%	2.0%	92.3%	
Feb 2021	GDH	100.7%	9.6%	91.2%	
Feb 2021	SGH	92.3%	5.0%	87.3%	

Fill Rate by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	Medicine	95.9%	5.9%	90.1%	
Feb 2021	Surgery & Critical Care	95.0%	2.8%	92.2%	
Feb 2021	Women & Children's	83.8%	-3.3%	87.1%	

Shift fill rate data is used to populate the monthly Hard Truths return, previously referred to as the Unify return, which is submitted to NHS Digital. The data is taken from the Allocate Eroster systemand is used to calculate the Care Hours per Patient Day. The fill rate submission currently requiresinformation on in-patient areas only. Ambulatory Care, Short Stay and Emergency Departments are excluded. There was a short pause in the monthly submission to NHS digital during the first Covid surge, with data now submitted monthly again.

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 speciality as well as demographic and bed base. Establishments have been reviewed consistentlyduring 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 therobust process that would normally be undertaken. A recent document, Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency, released on Feb 17th 2021, identifies that the above principles remain key for ensuring safe staffing and skill mix, and also identify that any staffing reconfigurations going forward should be subject to a Quality Impact Assessment with final sign-off from the Chief Nurse and Medical Director.

For the reasons outlined above, ward establishments have not been formally amended, however the Chief Nurse has plans in place to re-set baseline establishments now that we are starting to stabilise and move at pace to reestablish elective work. Collection of the Safer Nursing Care Tooldata will commence at the end of April once the revised bed base is in place.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard. A downward trend can be seen from the overfill position from June 2020 which has been a result of increased sickness and absence due to Covid, and reduced ability to fill bank and agency requests. The combined fill rate has been below 95% for the last 6 months. A significant decrease can be seen inHCSW fill rate on some days which is a concern, however, should be addressed through the accelerated recruitment activity which is underway. During January and February an increased fill rate is seen both for RN and HCA. This will be monitored to ensure this increase is sustained.

RN Ratio Summary Feb 2021

RN Ratio

62.2% ▼ -1.5%

RN Ratio %

RN Ratio by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPoW	60.9%	-1.2 %	62.1%	
Feb 2021	GDH	59.8%	+0.5 %	59.3%	
Feb 2021	SGH	64.1%	-2.2 %	66.3%	

RN Ratio by Division

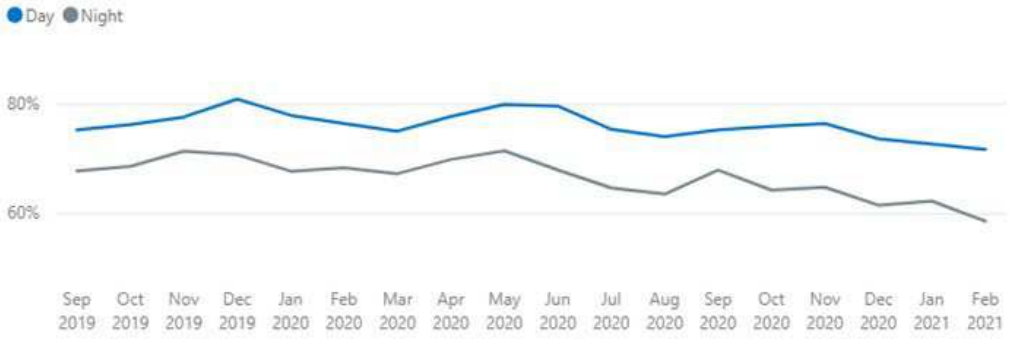
Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	Medicine	56.7%	-0.0 %	56.7%	
Feb 2021	Surgery & Critical Care	73.3%	-0.7 %	74.0%	
Feb 2021	Women & Children's	67.1%	-2.0 %	69.1%	

Registered Nurse to HCSW ratio for the Trust is 60% in line with ward establishments. Medicine has the lowest RN ratio in February at 56.7%.

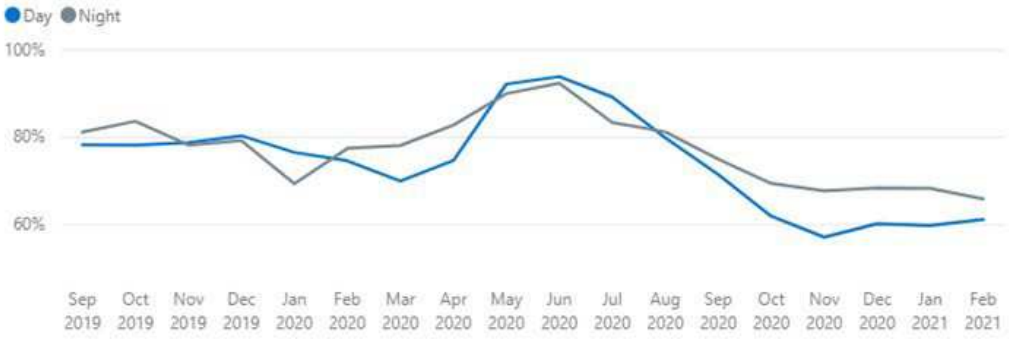
Substantive Fill Rates Summary Feb 2021

Day - Registered Nurses	Night - Registered Nurses	Day - Care Staff	Night - Care Staff
71.8% ▼ -1.0%	58.7% ▼ -3.7%	61.2% ▲ 1.4%	65.9% ▼ -2.4%

Registered Nurses Substantive Fill Rate %



Care Staff Substantive Fill Rate %



Wards with Substantive Fill Rate Below 50% **Feb 2021**

Staff	Registered Nurses	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
WARD 24 SGH	46.9%	▲ 46.9%
WARD 28 SGH	34.9%	▼ -21.8%
WARD 22 SGH	30.5%	▲ 7.9%

Staff	Registered Nurses	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD B3 DPoW	49.5%	▲ 5.6%
WARD B7 DPoW	49.2%	▲ 7.5%
Rainforest DPoW	48.2%	▲ 2.7%
Ward 19/Gynaecology Outpatients SGH	48.2%	▲ 48.2%
Ward C1 Glover	42.7%	▲ 6.9%
Stroke Unit SGH	41.4%	▼ -7.7%
WARD C6 DPoW	39.9%	▲ 1.9%
WARD 3 GDH	39.3%	▲ 5.4%
WARD 17 SGH	37.3%	▼ -7.3%
Ward A1	28.7%	▼ -6.5%
WARD 24 SGH	26.4%	▲ 26.4%
WARD 16 SGH	20.7%	▲ 0.2%
WARD 22 SGH	19.6%	▲ 3.4%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Amethyst	49.5%	▼ -20.2%
29 SGH	49.5%	▼ -1.3%
WARD 3 GDH	44.9%	▲ 5.6%
WARD 16 SGH	44.7%	▼ -1.0%
WARD C5 DPoW	40.6%	▲ 2.2%
Ward 19/Gynaecology Outpatients SGH	35.8%	▲ 35.8%
WARD 28 SGH	24.0%	▼ -17.2%
ICU SGH	0.0%	0.0%
ITU DPoW	0.0%	0.0%

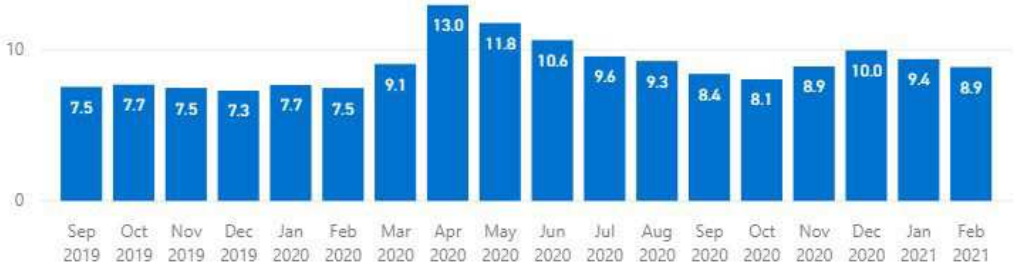
Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD B3 DPoW	48.4%	▼ -32.3%
Ward 26 SGH	45.0%	▼ -3.6%
WARD 28 SGH	42.2%	▼ -6.7%
WARD 24 SGH	41.7%	▲ 41.7%
Ward 19/Gynaecology Outpatients SGH	14.3%	▲ 14.3%

Substantive versus temporary staff fill rate is monitored and indicates that the substantive fill rate for both RN and HCA is lower on nights than days with 13 wards with substantive fill rates below 50% on nights. This is a reduction from 15 wards in January. Ward 22 for the 2nd month hasa substantive RN night fill rate below 20%. This risk is in part mitigated by the block booking of regular agency nurses who are familiar with the ward.

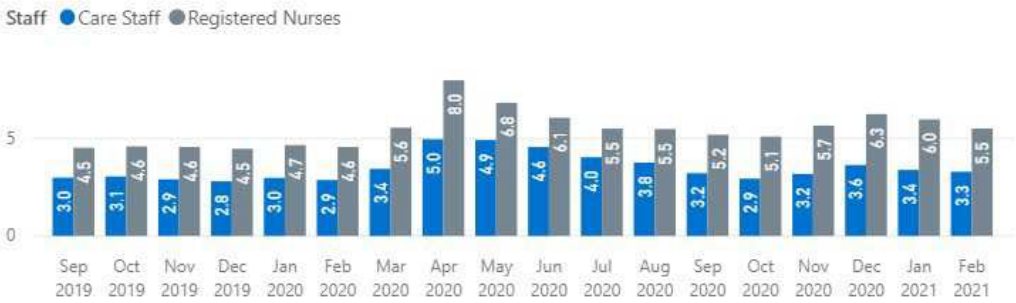
CHPPD Summary Feb 2021

Overall	Registered Nurses	Care Staff	Nursing Associates
8.9 ▼ -0.53	5.5 ▼ -0.47	3.3 ▼ -0.09	0.1 ▲ 0.03

Overall CHPPD



CHPPD by Staff Group



CHPPD by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPoW	9.1	! -0.6	9.7	
Feb 2021	GDH	11.7	✓ 0.8	10.9	
Feb 2021	SGH	8.3	! -0.5	8.8	

CHPPD by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	Medicine	7.6	! -0.2	7.8	
Feb 2021	Surgery & Critical Care	10.8	! 0.0	10.8	
Feb 2021	Women & Children's	14.6	! -1.8	16.5	

Wards with CHPPD Below 6.0 **Feb 2021**

Staff	Care Staff		Nursing Associates		Registered Nurses		Total	
Ward name	CHPPD	Change	CHPPD	Change	CHPPD	Change	CHPPD	Change
WARD 25 SGH	2.5	▲ 2.52			3.4	▲ 3.38	5.9	▲ 5.90
WARD C2	2.9	▼ -1.15			2.9	▼ -2.08	5.9	▼ -3.23
WARD 22 SGH	2.6	▼ -0.62			3.0	▼ -0.15	5.6	▼ -0.77
WARD B7 DPoW	2.6	▼ -0.12			2.8	▼ -0.03	5.4	▼ -0.17
WARD 28 SGH	1.8	▼ -0.58			3.1	▼ -0.20	4.8	▼ -0.78
Amethyst	2.2	▼ -0.54			2.6	▼ -0.28	4.8	▼ -0.82

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, however 6 wards had CHPPD below 6.0 in February; this is an increase from the 4 wards in January. Wards B7, 28 and Amethyst had CHPPD below 6.0 for the second consecutive month.

The graphs above shows the trend for the CHPPD which was on a slight downward trend followingthe initial 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. A reduction was then seen due to increased sickness and absence; however, an increase can be seen again over the last 4 months.

Maternity Staffing

2.1.1 Midwife: Birth Ratio

The midwife: Birth ratio was 1:22 in January, 1:25 in February and has been maintained between 1:22 - 1:26 over the last 6 months which is below 1:28 and in line with national guidance. This calculation is derived from the Birthrate Plus tool and is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus methodologies are consistent with the recommendations in the National Institute for Health and Care Excellence (NICE) safe staffing guideline for midwives in maternity settings which have beenendorsed by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Maternity staffing and Red Flag incidents continue to be monitored on a daily basis.

The Chief Nurse is undertaking a desktop maternity staffing establishment review in early March2021.

2.1.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD Feb 2021

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**93.9%**	**-4.36%**	**77.2%**	**-5.5%**	**18.7**	**-8.80**
Registered Nurses	97.6%	-7.03%	86.4%	-2.6%	12.1	-6.20
Care Staff	87.8%	0.16%	61.9%	-10.1%	6.6	-2.60
Jasmine & Honeysuckle	**98.2%**	**-0.23%**			**17.4**	**-6.64**
Registered Nurses	98.0%	-1.07%			11.6	-4.57
Care Staff	98.7%	1.47%			5.8	-2.07
Ward 26 SGH	**92.9%**	**1.18%**	**67.7%**	**-2.1%**	**7.6**	**-2.72**
Registered Nurses	94.0%	-0.07%	73.4%	-3.0%	5.6	-2.12
Care Staff	89.9%	4.58%	52.2%	0.3%	2.0	-0.60
Total	**95.1%**	**-1.33%**	**73.1%**	**-3.8%**	**13.1**	**-5.26**

Maternity Wards RN Ratio

Ward name	RN Ratio %	RN Ratio Change
Blueberry/Holly DPoW	64.8%	-1.8%
Jasmine & Honeysuckle	66.7%	-0.6%
Ward 26 SGH	74.0%	-1.0%
Total	**68.0%**	**-1.1%**

Ward 26 reported a fill rate of 94% for Registered Midwife in February. All wards have seen a reduction in the CHPPD. A further reduction in the CHPPD will be seen next month due to changein the calculation; currently babies are not part of the report but these will be included along with the women to give a more accurate CHPPD.

2.3 Staffing Indicators

2.3.1 Vacancies

The information presented below shows data on inpatient wards only.

Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPOW	24.3	6.1	18.2	
Feb 2021	GDH	9.2	0.6	8.6	
Feb 2021	SGH	40.4	3.7	36.8	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	C&T	2.5	0.0	2.5	
Feb 2021	Medicine	57.7	5.9	51.9	
Feb 2021	Surgery	9.8	5.1	4.7	
Feb 2021	WC	3.8	-0.6	4.4	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPOW	34.5	-2.9	37.4	
Feb 2021	GDH	-1.1	-1.4	0.3	
Feb 2021	SGH	27.3	-3.6	30.9	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	C&T	0.4	0.0	0.4	
Feb 2021	Medicine	44.7	-2.4	47.1	
Feb 2021	Surgery	11.8	-4.6	16.4	
Feb 2021	WC	3.8	-0.9	4.7	

The inpatient ward nursing vacancy position has increased for RNs and decreased HCSWs. The information in the graphs above shows in-patient ward vacancies only. In February the overall trustRN vacancy 10.32% which equates to 173.05 WTE, this compares 9.95% (166.81 WTE) in January. The highest area of RN vacancies remains in the Medicine Division with 87.64 WTE in February compared to 85.97 WTE vacancies in January. Surgery and Critical Care Division has anincreased vacancy of 35.40 WTE in February compared to 29.53 WTE in January.

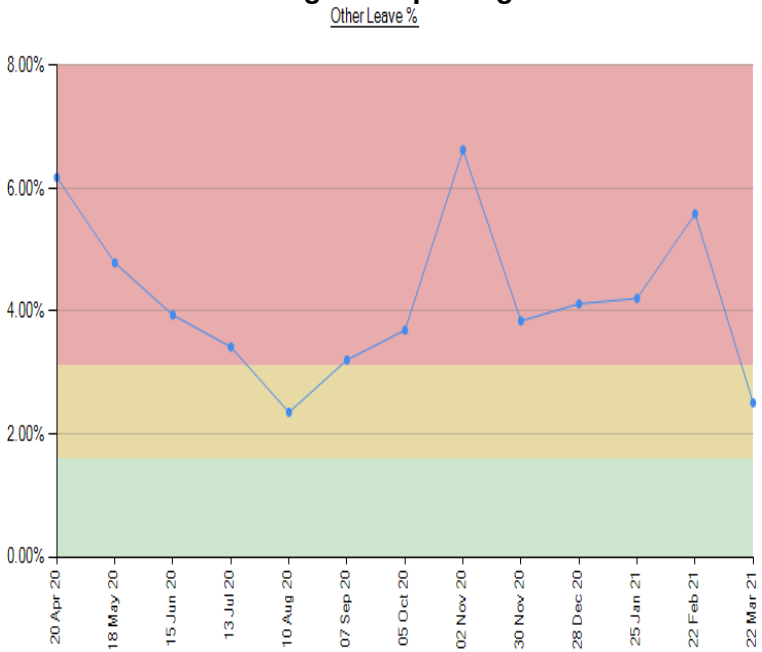
19 overseas nurses joined the Trust at the end of October and a further 20 joined in December. They sat their OSCE exams in January and February 2021 and, having all now passed, NMC registrations are coming through. Not all of these new registrants are reflected in the February RNvacancy figures and many remain supernumerary due to the increased support and training requirements. A review of the OSCE preparation programme has been undertaken given the shortpreparation time overseas nurses have had, and recommendations for future cohorts approved bythe Nursing, Midwifery and AHP Board. Feedback is being sought from the overseas nurses abouttheir experience to date and a review of cultural differences and the implications for induction and training needs is underway. A further 10 overseas nurses joined the Trust in February, 30 will join in March/April 2021, 60 between April and October and 20 in December. Accelerated recruitment and onboarding is being supported through successful bids for funding to NHSE/I and a task project group has been established by the Deputy Chief Nurse to manage this.

The Trust vacancy position for HCAs decreased slightly in February to 102.32 WTE (10.32%) compared to 111.86 WTE (13.22%) in January. The Medicine Division has the highest HCA vacancy rate at 16.99% (64.73wte) compared to 18.53% (70.60WTE) in January. Active recruitment continues to fill all vacancies with financial support received form NHSI/E to accelerateHCA recruitment. The Trust has been asked to aim for, and is predicting to achieve, zero or close to zero HCA vacancies by the end of March and weekly reporting to the national team is in place. A project group has been set up by the Deputy Chief Nurse, and as part of this programme an attraction event was undertaken with Indeed on 22nd January to support recruitment of HCAs without prior health or care experience. Interviews of 80 candidates took place on 11th February and successful candidates have been offered jobs and will commence in March or early April if notice period required. A central ‘pool’ for successful candidates is being developed so that future turnover can be managed in a timely way. The CPD team are working to increase care camp (induction for clinical staff) capacity and to deliver the accelerated Care Certificate programme.

Staff Availability

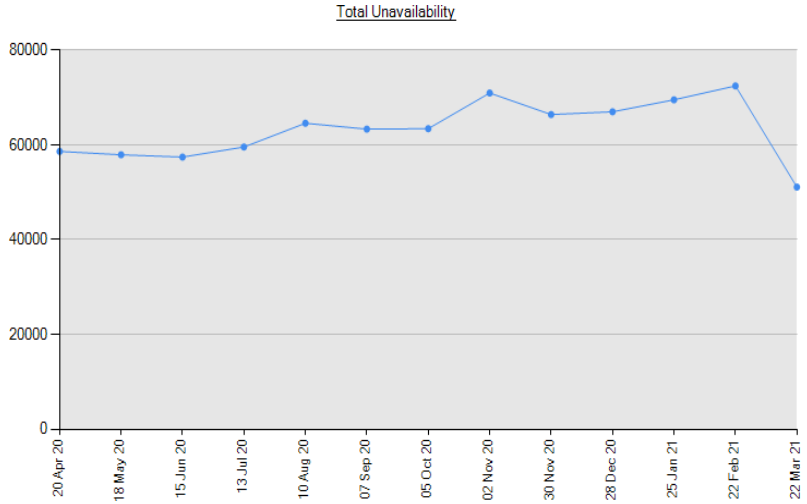
The availability of staff remains reduced as a result of the Covid pandemic. Absence due to Covid is reported under ‘Other Leave’. A spike can beseen in the beginning of November and has subsequently decreased as can be seen in the first graph below.

Other leave for Nursing for Reporting - %:



Graph 1

Total Unavailability for Nursing for Reporting – hours:



Graph 2

Total unavailable hours (includes sickness, parenting, annual leave, study leave & other leave) for the roster 25.01.2021 until 22 .02.2021 were72445 hours. This is an increase compared to 68878 in January and has remained high throughout the pandemic.

2.3.2 Staffing Incidents

The information presented below shows data on inpatient wards only.

Wards with Incidents **Feb 2021**

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - A1	2	↓ -1	1	0
DPOW - AMU	3	↑ 2	3	↑ 3
DPOW - B2	2	0	0	0
DPOW - C1 Glover	1	↑ 1	1	↑ 1
DPOW - C2	4	↑ 4	1	↑ 1
DPOW - Maternity	9	↑ 9	0	0
DPOW - NICU DPW	1	↑ 1	0	0
SGH - CDS	8	↑ 8	1	↑ 1
SGH - CDU	2	↓ -1	1	0
SGH - Ward 19	1	↓ -2	0	↓ -1
SGH - Ward 22	3	↑ 3	1	↑ 1
SGH - Ward 23	2	0	0	↓ -2
SGH - Ward 24	1	0	1	0
SGH - Ward 25	4	↑ 4	4	↑ 4
SGH - Ward 26	4	↑ 3	3	↑ 3
SGH - Ward 28	1	↓ -1	1	↑ 1

There were a significantly increased number of nurse staffing incidents reported in February compared to low number reported in January. February numbers are similar to the previous 5 months. Of the 48 inpatient staffing incidents reported in January, 18 were red flag incidents. Additionally, there were 27 community incidents reported.

Of the 14 inpatient red flag incidents, 8 were reported at SGH which is also the site with the lowest CHPPD and shift fill rates, and highest RNvacancies in February.

Of the 14 red flag incidents:

- 2 incidents related to a delay in medicine rounds by 1 hour on ward C2 and ward 25
- 1 incident related to a delay of more than 30 minutes to provide acute pain relief on ward C3 short stay
- 1 incident related to less than 2 trained nurses on a clinical area on IAAU yellow A SGH
- 2 incidents related to trained nurse less than 12 months qualified or still in preceptorship left in charge on C1 Glover and ward 22
- 8 related to less than 50% substantive staff on wards A1, IAAU Yellow B SGH, Short stay C3 (2), ward 25, ward 28 and ward 29 (2)

For the month of February 2021 there were 19 maternity red flag incidents. This was a significant increase on the data for January 2021 whichhad 2 red flags. All red flag incidents within maternity are discussed on a weekly basis and an overview is undertaken to understand if there have been other incidents that have not been captured via Datix.

Of the 19 maternity red flag incidents:

- 12 were around delays in women having induction of labour commenced. This was during an exceptionally busy period and has sincesettled
- 1 related to missed medication
- 6 incidents whereby community midwives were called into work in the maternity unit as part of the escalation process

5.0 Quality

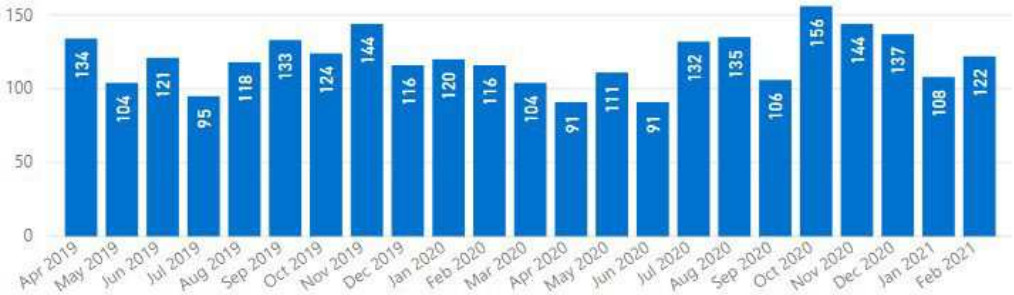
5.1 Falls incidence data

The information presented shows data on inpatient wards only.

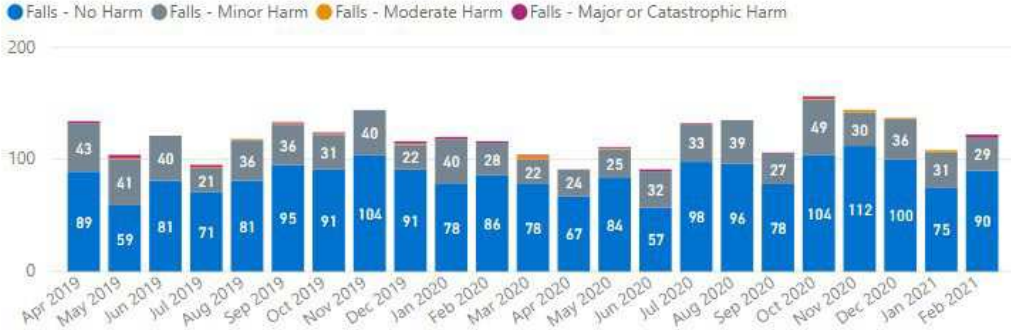
Falls Incidents Summary Feb 2021

Falls - Total	No Harm	Minor Harm	Moderate Harm	Major or Catestrophic
122 ▲ 14	90 ▲ 15	29 ▼ -2	0 ▼ -2	3 ▲ 3

Falls - Total



Falls by Category



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPOW	58	◆ 0	58	
Feb 2021	GDH	6	! 4	2	
Feb 2021	SGH	58	! 10	48	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2021	C&T	2	! 1	1	
Feb 2021	Medicine	84	✓ -4	88	
Feb 2021	Surgery	36	! 19	17	
Feb 2021	WC	2	! 1	1	

Following a peak in the number of falls reported during the second wave of the COVID-19 pandemic, the number of falls reported are now returning to usual levels. The trends by site showan increase in the total numbers of falls reported at the Scunthorpe site.

The Medicine Division continues to report a higher number of falls.

Three areas reported a fall with major harm during February 2021. These were Wards B6, B7 andC2 at Grimsby. No lapses in care were identified in two of the incidents following investigation at the falls huddles. Learning was identified in the third incident involving B7 and a full investigationis now being undertaken to understand the root cause and any learning.

5.1.1 Falls per 1,000 Bed Days

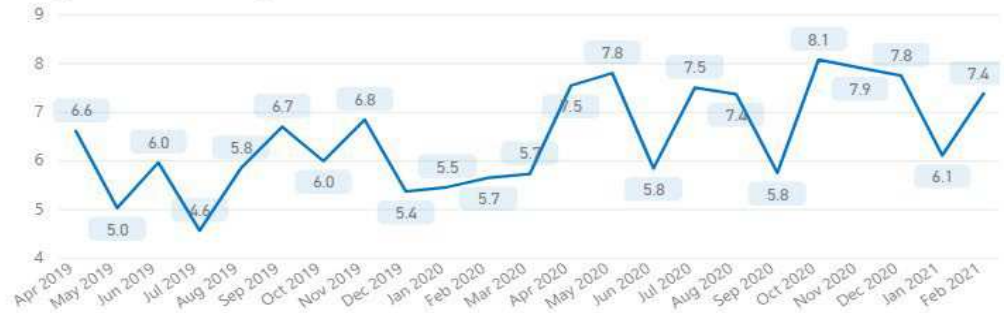
The information presented shows data on inpatient wards only.

Falls per 1,000 Bed Days Summary Feb 2021

Falls per 1,000 bed days

7.4 ▲ 1.3

Falls per 1,000 Bed Days



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Feb 2021	DPOW	6.8	0.3	6.5	
Feb 2021	GDH	9.6	6.6	3.0	
Feb 2021	SGH	7.9	1.9	5.9	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2021	C&T	5.6	2.2	3.3	
Feb 2021	Medicine	8.6	-0.1	8.7	
Feb 2021	Surgery	7.4	4.3	3.1	
Feb 2021	WC	1.2	0.7	0.5	

Whilst both main sites reported a similar number of falls, the number of falls per 1000 occupied bed days has increased at the Scunthorpe site.Caution should be used when comparing the Goole data, any slight increase in reported falls will significantly impact upon the data.

5.2 Areas of Concern

The information presented shows data on inpatient wards only.

Top 5 Wards with Falls Incidents **Feb 2021**

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
SGH - Ward 24	6	▲ 2	5	▲ 2	0	0	0	0	11	▲ 4
DPOW - A1	7	▲ 3	3	▲ 1	0	0	0	0	10	▲ 4
DPOW - C2	3	0	4	▲ 4	0	0	1	▲ 1	8	▲ 5
SGH - Ward 25	8	▲ 8	0	0	0	0	0	0	8	▲ 8
DPOW - Amethyst	7	▲ 2	0	▼ -1	0	▼ -1	0	0	7	0
DPOW - B2	7	▲ 5	0	▼ -1	0	0	0	0	7	▲ 4
DPOW - B7	2	▲ 2	4	▲ 2	0	0	1	▲ 1	7	▲ 5

Top 5 Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
GDH - Ward 3	45.8	▲ 45.8
DPOW - A1	22.9	▲ 10.8
SGH - Ward 24	15.5	▲ 6.1
SGH - Ward 25	13.1	▲ 13.1
SGH - Ward 16	12.8	▼ -1.0

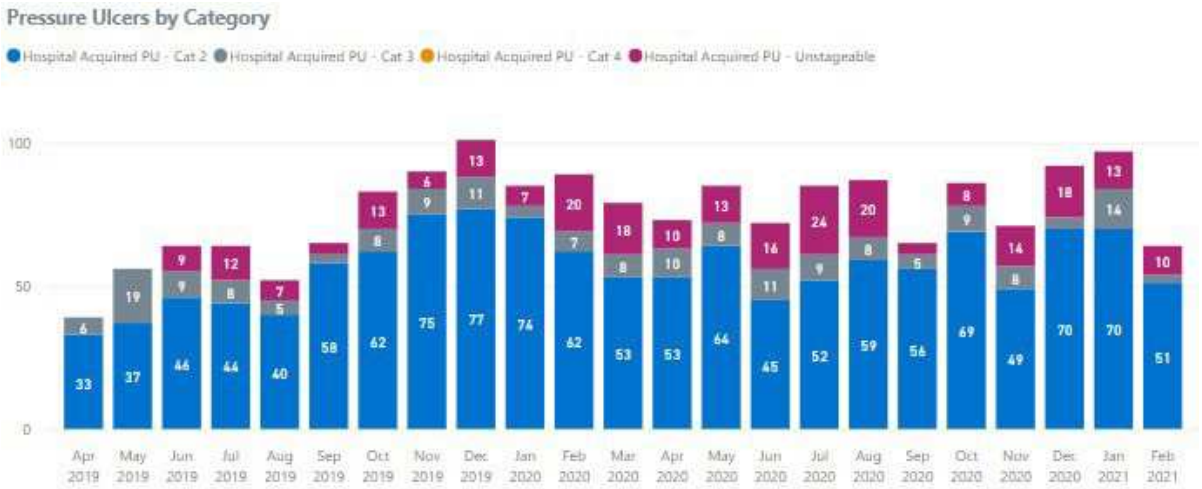
For the majority of falls reported by higher reporting wards in February, there was either no or low harm to the patient. The majority of fallsreported by these areas were single falls, indicating that appropriate risk reduction measures were in place to prevent further falls.

Ward C2 has flagged for a serious harm to a patient following a fall and increased falls overall in February. Following a nursing team changeoverto a new environment and new leadership, extra education has been arranged in partnership with the ward management team to deliver frequent bitesize training on the ward to support staff. Ward 25 had a significant increase in falls also in February.

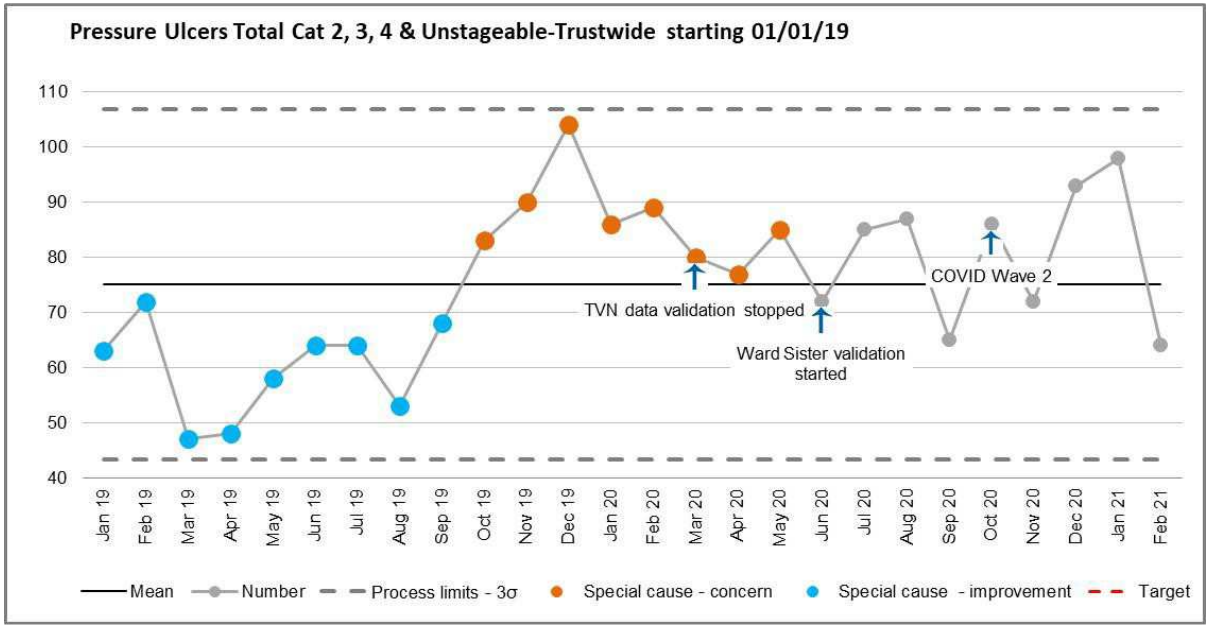
6.0 Pressure ulcers

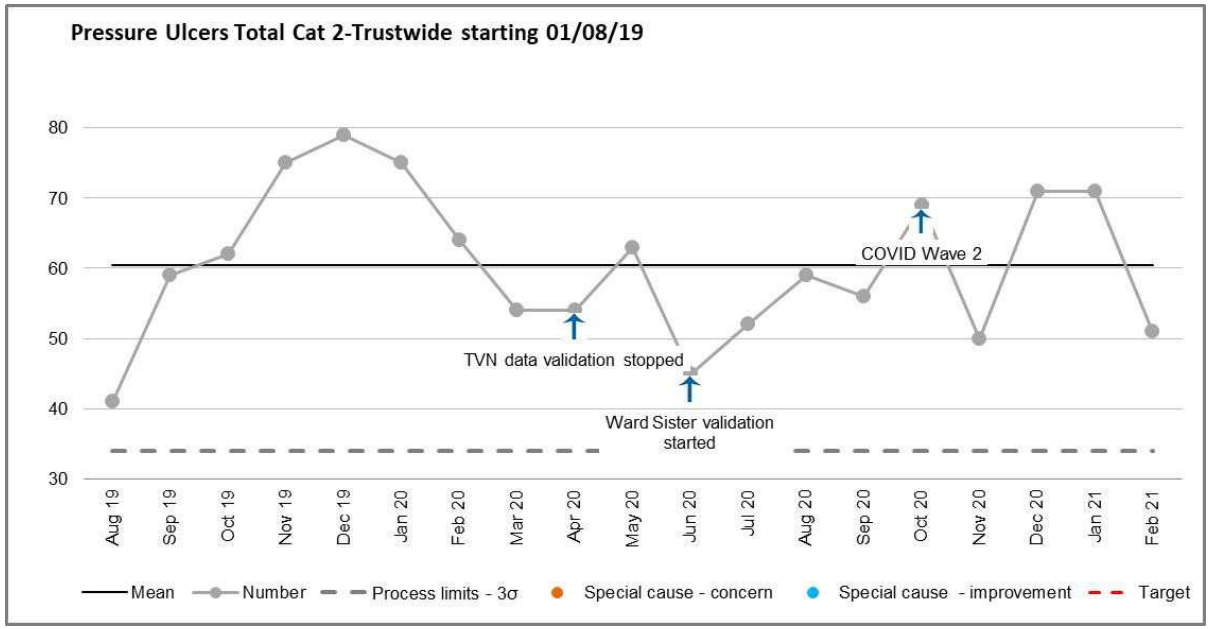
In February 2021, 64 hospital acquired pressure ulcers (Category 2,3,4 and unstageable, this is standard throughout this report) were reportedacross the 3 hospital sites. This is significant decrease from the previous month. The trend over time is demonstrated in Graph 1 below. From October 2020, the data is now reported by the ward responsible (where the pressure ulcer developed) rather than the reporting ward.

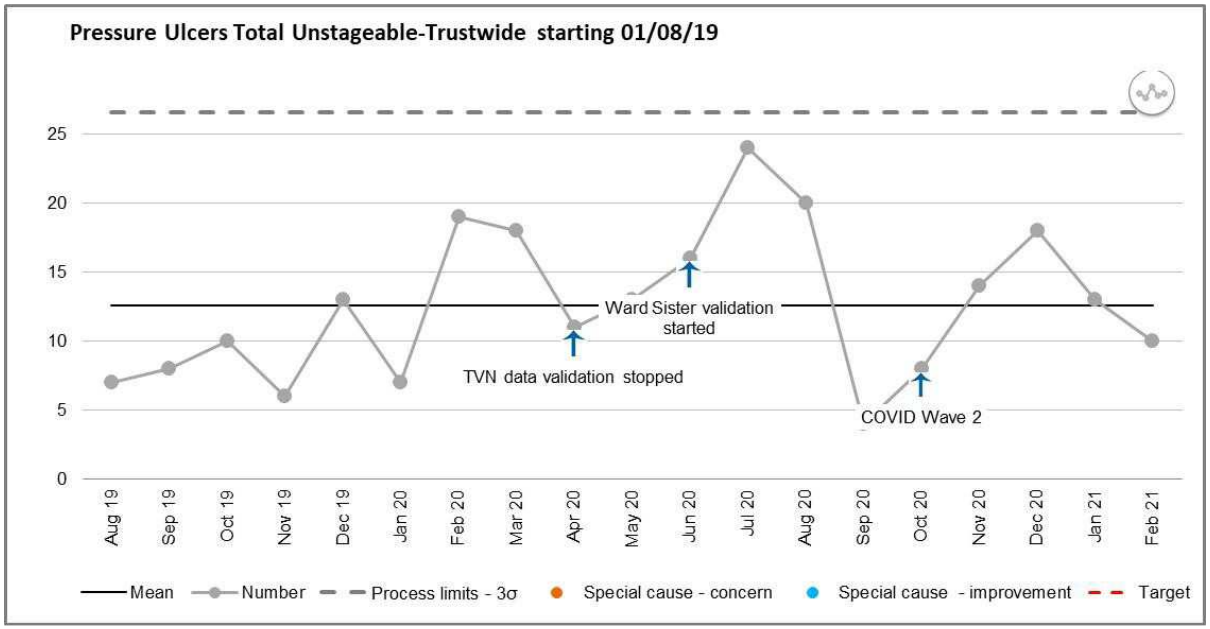
Graph 3 – Hospital acquired pressure ulcer incidents by month



The SPC charts below detail the trends in reported pressure ulcers Trustwide and by category over time. This remains an area of development and further analysis and triangulation will be supported by the Chief Nurse's data analyst over the coming months.


Pressure Ulcers Total Cat 2, 3, 4 & Unstageable-Trustwide starting 01/01/19
110
100
90
80
70
60
50
40
COVID Wave 2
TVN data validation stopped
Ward Sister validation started
Jan 19
Feb 19
Mar 19
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mean
Number
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Pressure Ulcers Total Cat 2-Trustwide starting 01/08/19
80
70
60
50
40
30
COVID Wave 2
TVN data validation stopped
Ward Sister validation started
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mean
Number
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Pressure Ulcers Total Unstageable-Trustwide starting 01/08/19
25
20
15
10
5
0
Ward Sister validation started
TVN data validation stopped
COVID Wave 2
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
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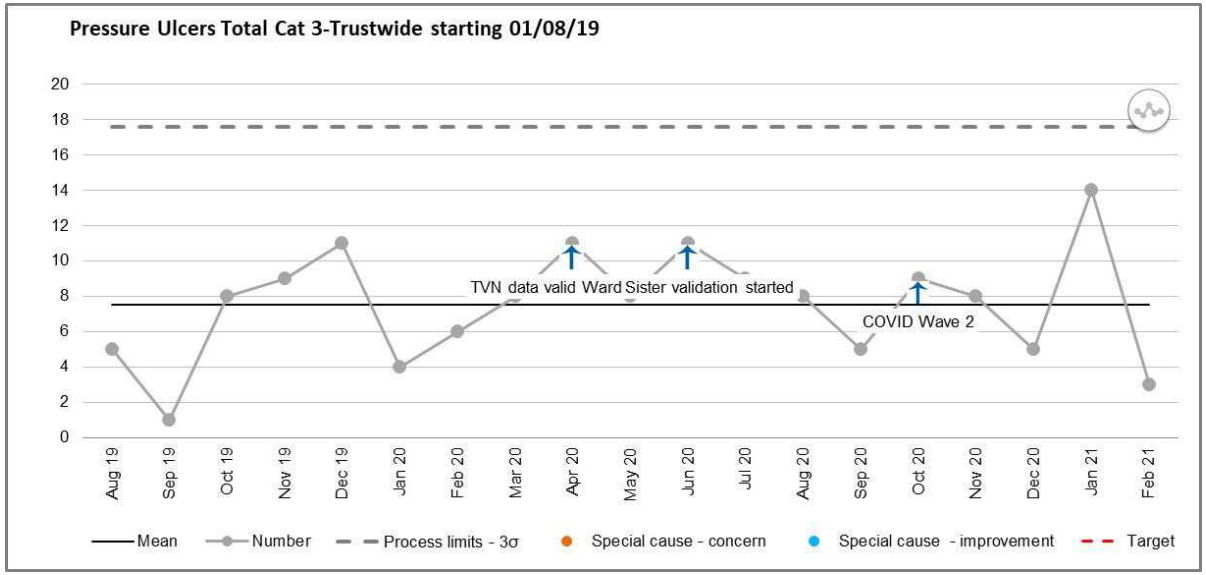
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mean
Number
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Pressure Ulcers Total Cat 3-Trustwide starting 01/08/19
20
18
16
14
12
10
8
6
4
2
0
TVN data valid Ward Sister validation started
COVID Wave 2
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mean
Number
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

6.1 Data per 1000 bed days

The data demonstrates an increase in the number of reported pressure ulcers per 1000 occupiedbed days over two months previously, however it should be noted that the number of pressure ulcers reported in February has decreased.

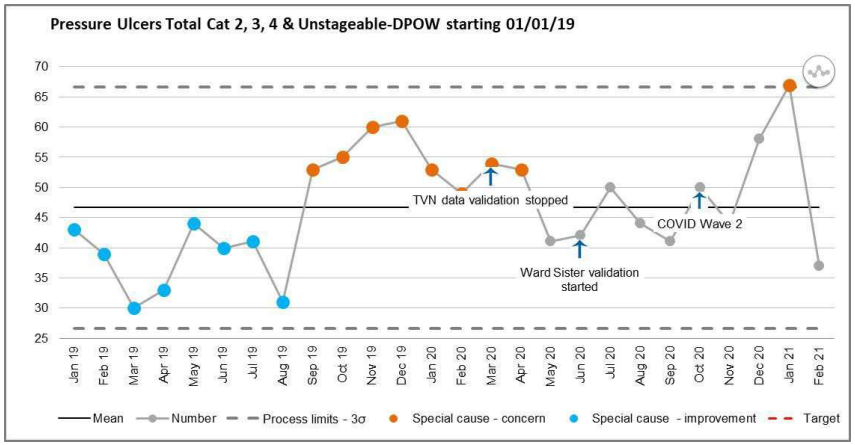
The data below demonstrates the reported incidence of pressure ulcers (hospital acquired category 2,3,4 and unstageable) per 1000 occupied bed days. Work is currently in progress toobtain data from local NHS Trusts to facilitate benchmarking of NLAG data.

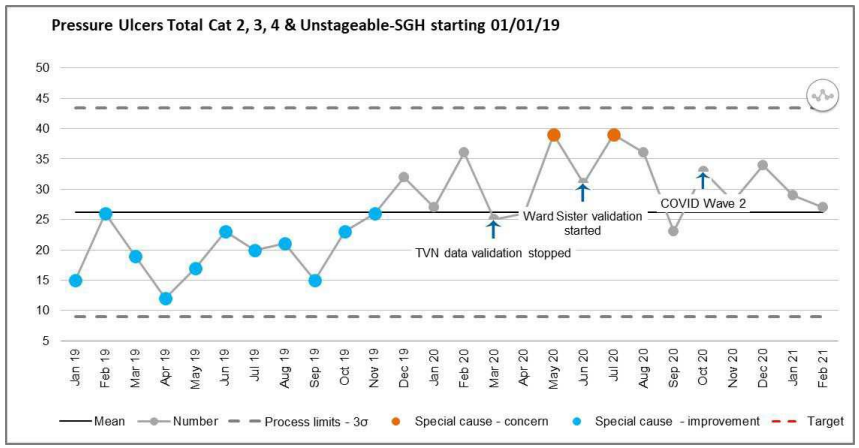
Graph 4 – Trustwide hospital acquired pressure ulcer incidents per 1000 occupied bed days

6.3 Site Comparison

The highest incidence continues to be reported by the Grimsby site which also reports the highestincidence per 1000 occupied bed days. There has been a significant decrease in the number of pressure ulcers reported at the Grimsby site in February 2021. The data per 1000 occupied bed days shows that both sites have reported a similar number of pressure ulcers per 1000 occupied bed days. Goole has been excluded from the site comparison due to the low numbers reported which will adversely affect the data

DPOW & SGH SPC

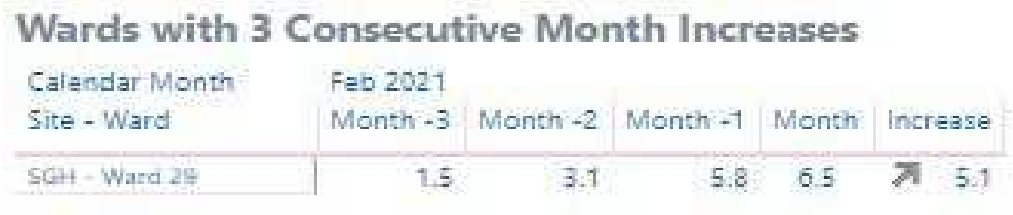




Areas of Concern

Recent developments to the Nursing Dashboard now allow areas of improvement and deterioration to be identified by the dashboard. In February 2021, no wards demonstrated animprovement in the number of pressure ulcers reported per 1000 occupied bed days over theprevious three months and Ward.

- Ward 29 at Scunthorpe demonstrated a deterioration over 3 consecutive months



Wards with 3 Consecutive Month Increases

Calendar Month	Feb 2021				
Site - Ward	Month -3	Month -2	Month -1	Month	Increase
SGH - Ward 29	1.5	3.1	5.8	6.5	5.1

The following wards reported higher numbers of Category 2, 3 or unstageable pressure ulcers inFebruary 2021;

- Ward 25 at Scunthorpe
- Ward C2 at DPoW
- Amethyst at DPoW
- C1 Glover at DPoW

It can be noted that the majority of pressure ulcers reported were category 2 pressure ulcers. Thisis suggestive that appropriate preventative measures were in place to prevent further deterioration.

Due to the continuing reconfiguration of wards as a result of the implementation of the COVIDsurge plan, it is not possible to provide representative comparison on all wards.

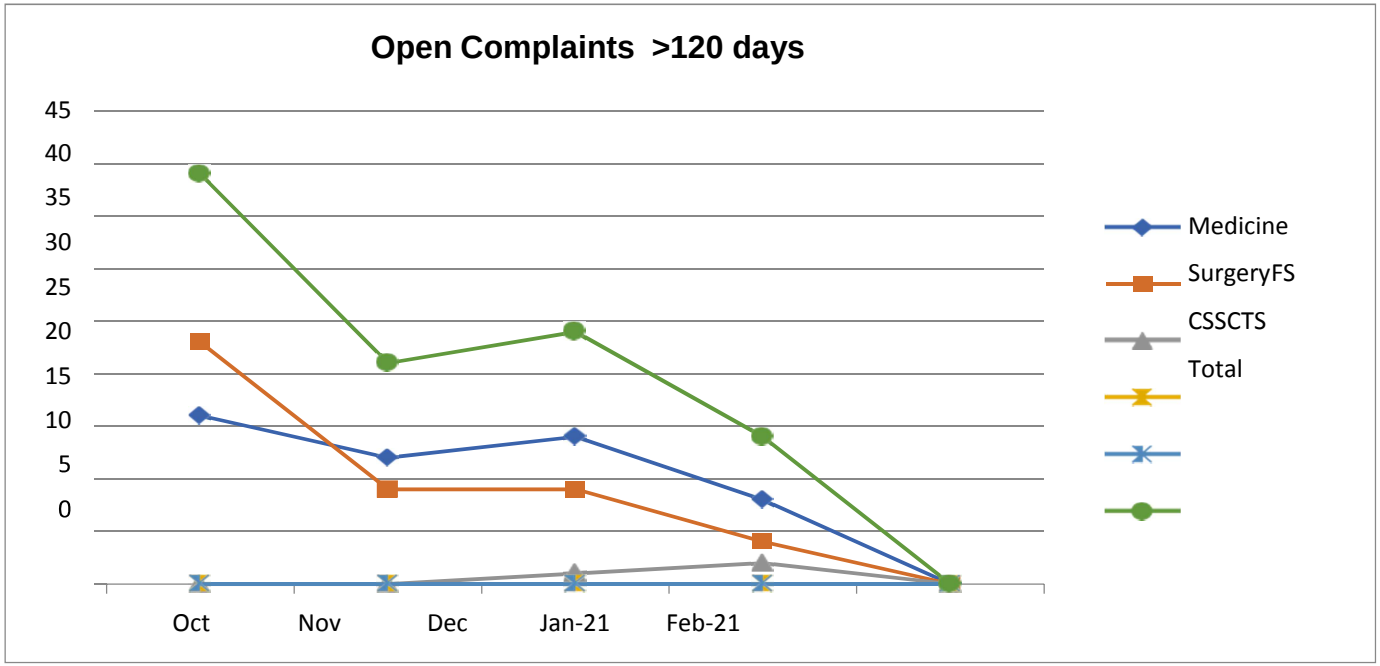
C2 at DPoW has triggered as a higher reporting area for three consecutive months The total number of pressure ulcers reported in February 2021 is lower than in January 2021 and December2020, with a marked reduction in the number of unstageable pressure ulcers. The impact of additional training from the TVN team will be monitored through the Nursing Metrics Panel.

7.0 Patient Experience

7.1 Complaints

Trust wide the total number of open complaints is 83, which is a continued reduction, this is excluding re opened complaints .The trajectory to achieve the KPI of closing all old process complaints by February 28th 2021 was successfully achieved and this progress can be seen in Graph 5 below.

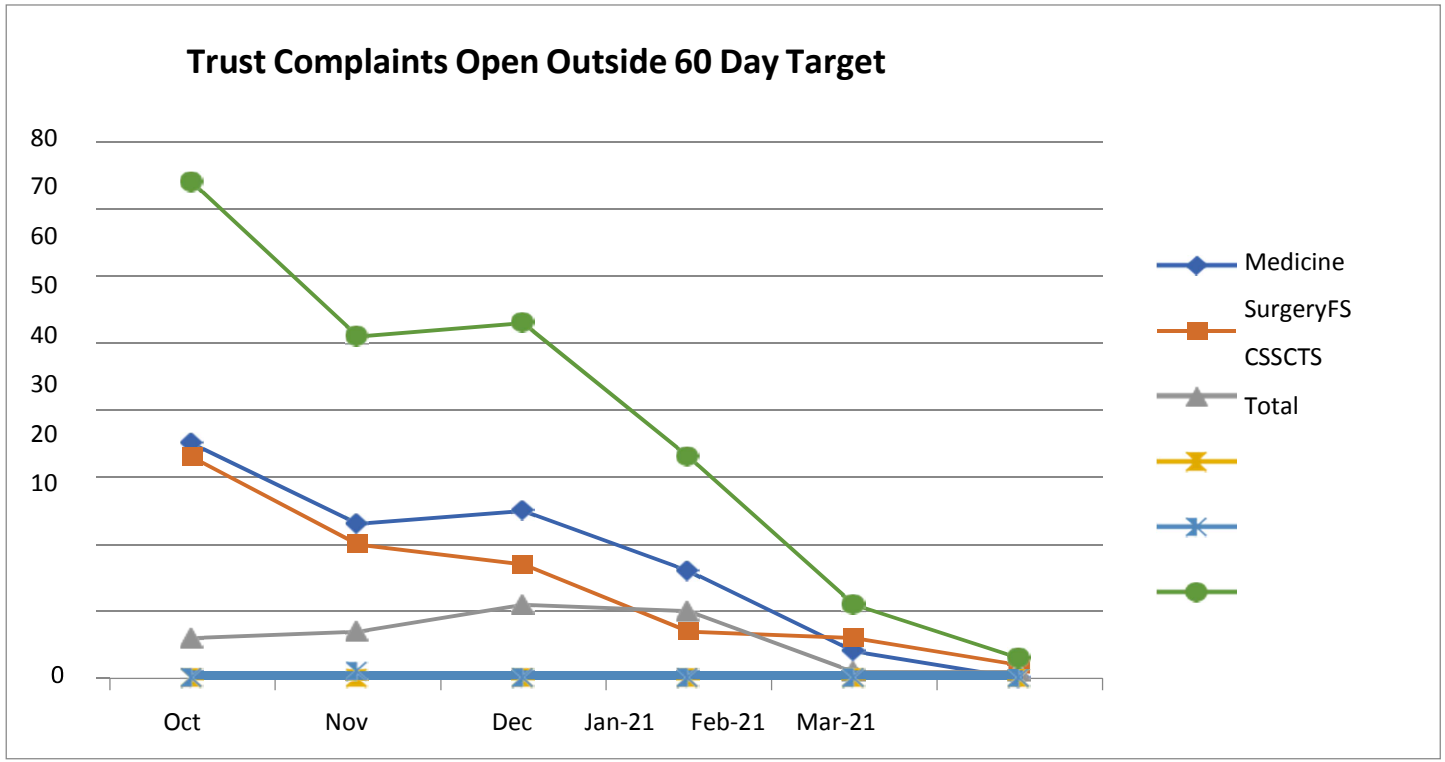
Graph 5



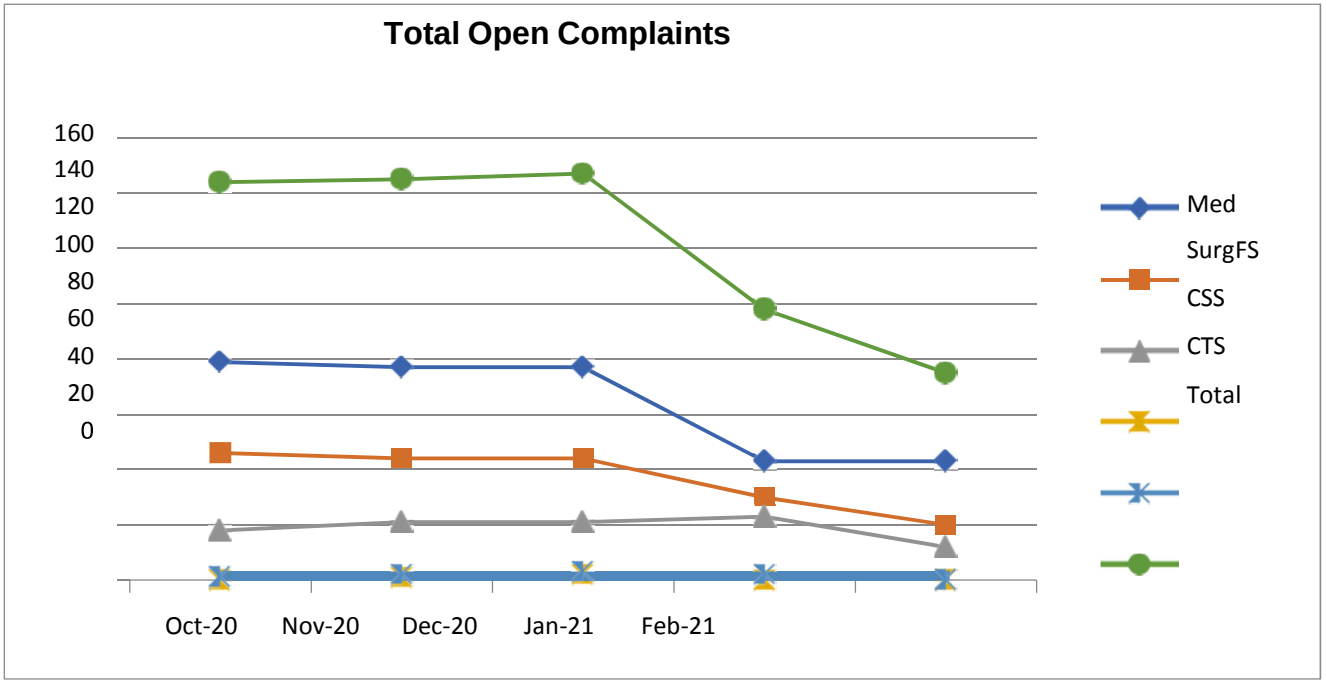
The graph below evidences the extent of the work undertaken to improve the trust wide management of complaints, where all divisions show a positive shift in their position, through collaborative working with the central complaints team and engaging in a significant change to process. This quality improvement project has been a great success and one which has had a direct impact on the way our Trust will be viewed by both our local communities and our regulators as we are able to evidence a positive shift in our responsiveness to feedback.

The next stages of this improvement project will be focusing on the quality of learning from complaints and PaLs in order to evidence that patient and family feedback is meaningful to the organisation.

Graph 6



Graph 7



Re opened complaints currently stands at 6. All paused complaints will reopen within the new process; this piece of work will commenced in April, in line with government changes to Covid 19restrictions.

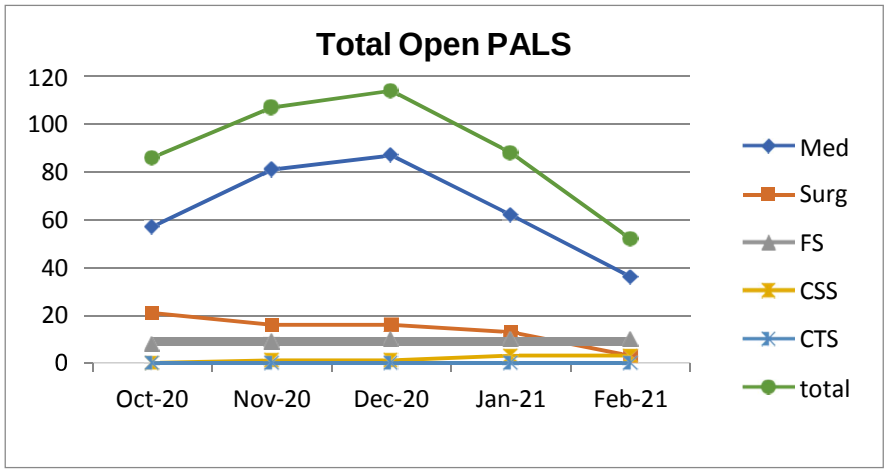
The complaints review will be working towards the July 2021 KPI to deliver 85% complaints beingmanaged within timescale. Further engagement with divisions will now see the initial transition to the new process evaluated and learning shared. Competent Lead Investigators, who have evidenced high levels of learning in their investigations along with the delivery of a meaningful response, will be asked to be divisional champions, sharing their skills. This will be a supportive addition to the roll out of complaint training trust wide.

There will be further improvements made in the coming month in the complaints governancereporting tool, ensuring divisions are sighted on current position, learning and themes.

7.2 Pals

Trust wide the total number of open Pals was reported at 45, which is a further decrease since lastmonth, due to a central team focus on following up and closing some older concerns, and working closely with divisions this can be seen below in Graph 8.

Graph 8



However, the Pals and Complaints Project Lead has identified that multiple divisional processes inmanaging Pals is contributing to delays in responding and is working with divisions to review this. The central team is exploring digital meeting platforms to meet the needs of the changing environment.

7.3 Patient Contact Helpline

The helpline continues to receive high volumes of calls, and there is ongoing work to ensure thatall related calls are recorded through the portal, this will evidence scale of usage.

The Family Liaison Assistant posts have all been recruited to and a support programme is being designed to maximise the role. An additional, but significant, aspect of this role will be to provide moral support to ward teams, not only in practical terms but by equipped to sign post staff to trust support. The Health Tree Foundation is supporting the posts by funding highly visible polo shirts, with recruits becoming equipped to be charity ambassadors in ward areas. This will be through theinitial bespoke induction training.

7.4 FFT

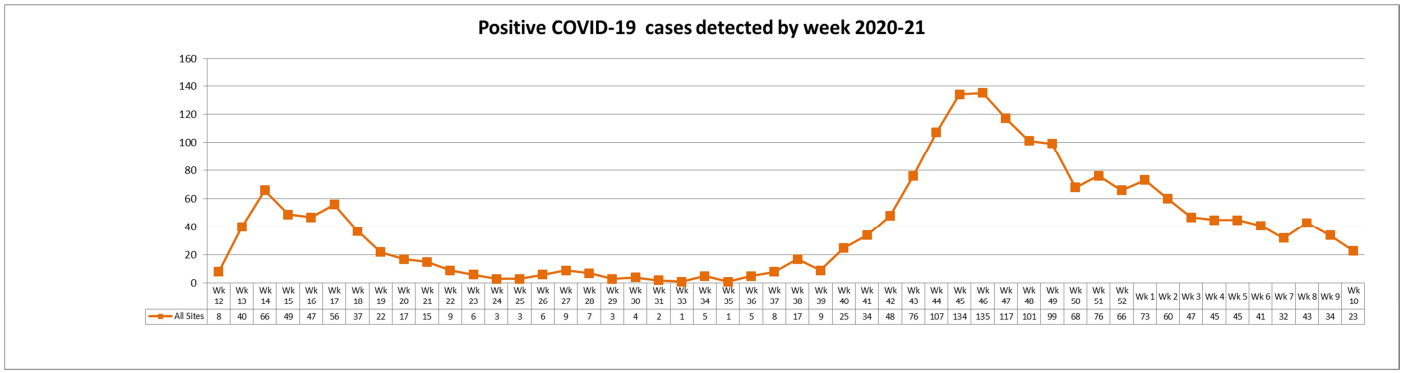
The delivery of the Family and Friends Test has resulted in further work to equip areas to providenon paper options for patients. This will take the form of areas specific QR posters and business cards. Further work will be undertaken to link patient feedback into virtual appointment platforms.

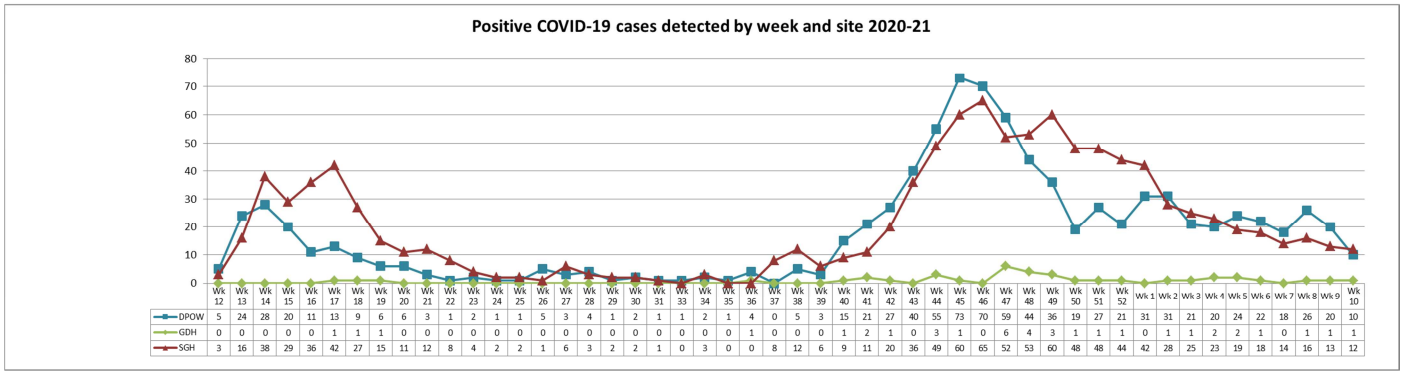
8.0 Infection Prevention and Control

February has seen an improving position across the Trust for Covid-19. See graph 9

Current COVID trend

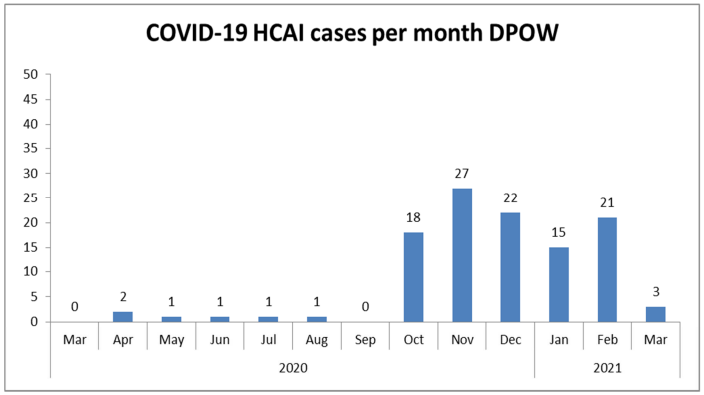
Graph 9

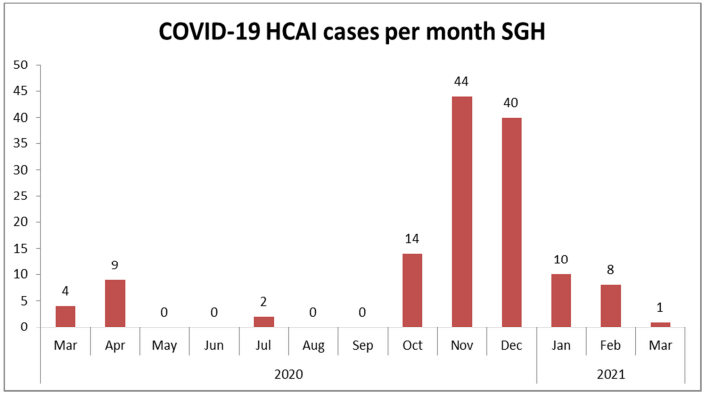




Hospital acquired Covid, despite a spike at the DPoW site, this is now reducing.

HOC numbers by month





A new IPC Board assurance framework was issued mid-February with 20 new or modifiedquestions. There is a greater emphasis on preventing nosocomial transmission; this re- assessment is underway.

9.0 15 Steps

The Trust introduced the 15 step challenge in April 2019 to all inpatient areas with the ultimateoutcome was to improve the quality of patient outcomes.

The schedule for April 2019-March 2020 was completed, however a decision was made by The Chief Nurse in conjunction with guidance and advice from Deputy Director of Infection Prevention and Control to suspend all 15 steps visits from March 2020 in order to be able prioritise workforce to support our wards and departments due to the start of COVID 19. This was also to preserve thesafety of all levels of staff, reduce footprint across areas and re-allocate staff to areas affected by COVID.

The 15 steps schedule was reviewed monthly throughout this time, to determine a suitable date torecommence the visits. The decision to pause the 15 steps visits remained until February 2021, however from March a "lighter version" of the traditional 15 steps visits was commenced with 2 consistent (maximum 3) members of staff present and the overall visit time is reduced from 2.5 hours to 1-1.5 hours. The 4 elements of the toolkits remain in place but the overall number of assessments will be reduced.

A series of visits has been compiled between March and May with 22 areas being scheduled to be reviewed and for support to be offered. From June onwards- we will recommence a full 15 steps schedule.

Themes identified from the early lighter visits include:-

- Notice boards require updating
- A drive for staff to adhere to the uniform policy
- Covid Risk assessments to be updated
- Environments to be improved

10.0 Triangulation of workforce and quality data has highlighted:

- Wards B7, 28 and Amethyst wards - all three wards had a CHPPD of below 6.0 for thesecond consecutive month and a fill rate of less than 50% substantive staff.
- Ward 28 also has a substantive RN day fill rate of 34.9%, RN night of 19.6%, Care Staffday of 24.0% and Care Staff night of 42.2% and is being kept under review.
- Amethyst ward has also seen an increase in the number of falls and pressure ulcers in February and is receiving intensive support from the Matron, Head of Nursing and the Deputy Chief Nurse. An interim Ward Sister has been brought into the ward to cover for unexpected absence of the ward leader. A Ward Quality Improvement action plan is now inprogress.
- Ward 29 at Scunthorpe demonstrated a deterioration in pressure ulcer incidence over 3 consecutive months and will be

scrutinised in more detail

- C2 at DPoW has triggered as a higher reporting area for pressure ulcers three consecutive months as well as an increase in Falls in February, A pro-active response by the Matron and Ward sister has led to scrutiny of these incidents and focused training and support is being provided for staff. The ward team have moved to a new environment as part of the ward reconfiguration and experienced significant challenges of re-zoning throughout the pandemic period. Quality indicators will be monitored, however, at this time further support is not required.
- Ward 25 at SGH has had a high number of falls and a CHPPD of below 6 and an increased number of pressure ulcer incidents in February and therefore will be closely monitored.

11.0 Conclusion

Due to the regular ward re-configuration over the last several months, data comparison will not be possible for some ward areas. The significant challenges the nursing workforce have experienced throughout the pandemic has led to some shifts being staffed only on minimum staffing levels, impacting on experience of both staff and patients and their families and this has been reflected in complaints and PaLs. Staff report that communication with families has been challenging at times due to the reduced staffing numbers requiring bedside care to be prioritised. It is important to acknowledge that not being able to provide high standards of care to patients and their families has led to low morale of staff in some areas, therefore, staff welfare is paramount. The Trust well-being offer is easy to access and available to all, however, this provision for support and talking therapies does not meet the needs of all staff and, therefore, practical professional development in the form of leadership training is also being offered to equip staff with skills to lead through this challenging period.

Recruitment initiatives continue, most successfully being the number of oversees nurses in the pipeline for this year, however, this initiative is not straight forward as many within this nursing group will require long periods of supervision, training and support due to the significant differences in healthcare in their country of origin. Proactive steps are now being taken to support these nurses going forward and international recruitment plans are being reviewed.

Assurance visits have continued throughout the pandemic period and enable further triangulation and monitoring and the Ward Assurance Tool is now also uploaded to Power BI to provide further data for triangulation. The nursing metrics panel has been continued throughout the pandemic period to ensure senior nursing oversight of key quality indicators. The triangulation of this data enables focused investigation and support to be instigated in specific areas and then further monitored as improvement plans progress.

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	Tuesday 6 April 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Jo Loughborough, Senior Nurse Patient Experience
SUBJECT	Patient Experience Update Quarter 3
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF REPORT	For information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality & Safety Committee Patient Experience Group
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	• Please note this is Q3 report only, data does not represent the current situation at the end of March. This is important in particular when reviewing the complaint performance which has improved significantly in Q4 Please refer to the Nursing Assurance paper for up to date information regarding complaints performance. • Streamlined reporting due to Covid Impact • Full transition of all divisions into new complaint process has been successfully completed, making significant difference to complaints management. • Successful launch of Patient Contact Helpline to further support family/carer communication during Covid 19

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

LINK TO STRATEGIC OBJECTIVES -				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	This links to the risk of not being responsive to patient feedback and delivering agreed timelines of complaint responses.
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: note the report for information

Northern Lincolnshire and Goole NHS Foundation Trust

PATIENT EXPERIENCE REPORT

Performance for Quarter 3 Period 2020-2021

*Note due to COVID-19 reporting and collection of some Patient Experience Data was suspended during March 2020, which may impact on the interpretation of the report.

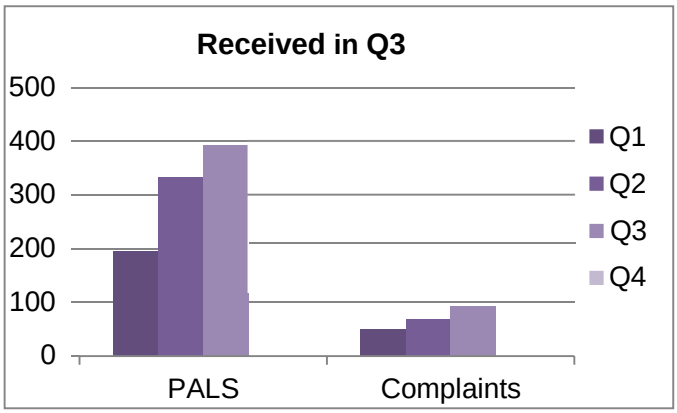
- This report has been streamlined due to Covid priorities

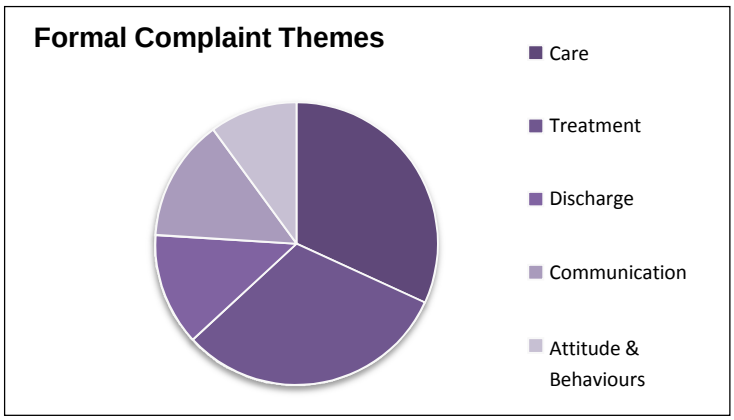
Contents –

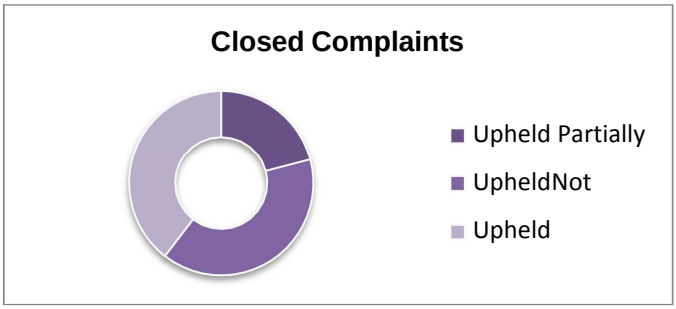
Headlines
- Complaints
- Pals
- Friends and Family Test
- Learning
- Patient Surveys
- Patient Experience During COVID-19
- Patient Experience News and Developments
- Patient Experience Risks
- Divisional Summary

Headlines (Patient Experience)

The Patient Experience report covers key information at Trust wide and divisional level:







12 Stories shared on Care Opinion – 100% positive

Ombudsman Referrals 3

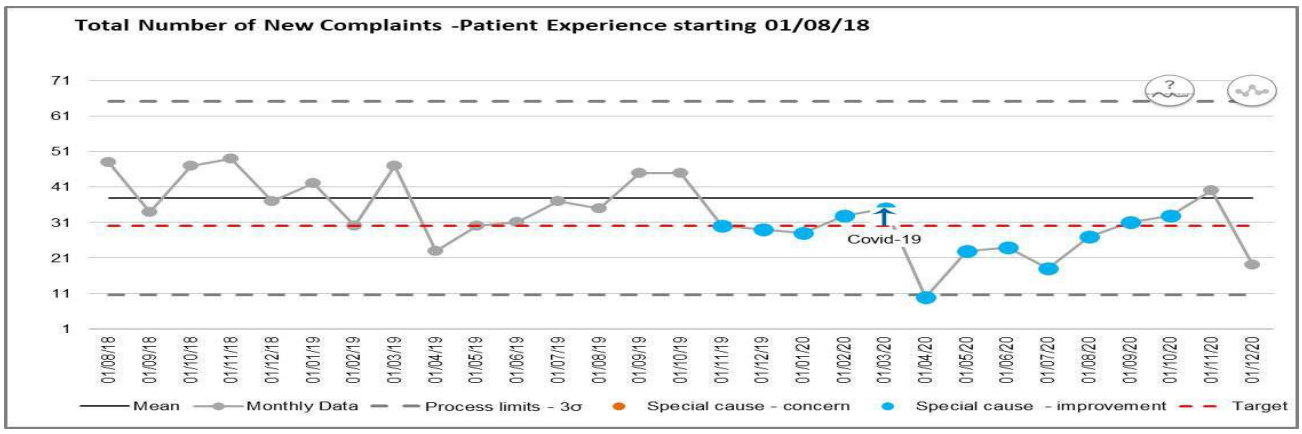
Actions

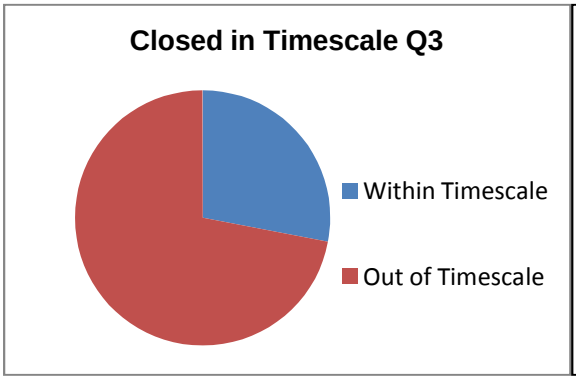
- PALs and Complaints Project Lead commenced in post
- Implementation of new complaints process commenced November 2nd
- Patient Contact Helpline launched
- Continued responsive approach to visiting
- Recruitment to Patient Experience Team to provide support with communication
- PALs review commenced to improve timeliness

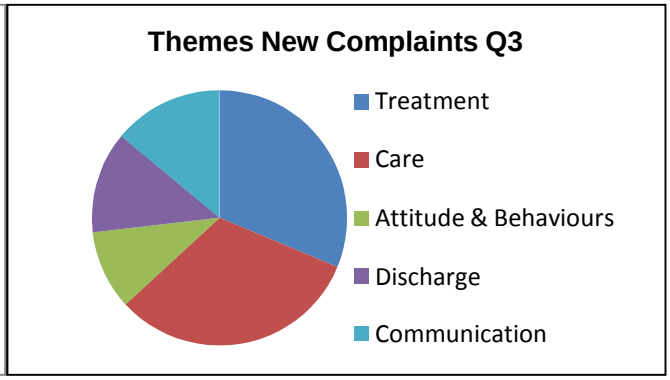
Risks/Issues

- Impact of Covid 19 second wave on new complaint process transition and closure of old process complaints
- Poor Communication emerging as key theme between wards and families

Q3: Formal Complaints (Patient Experience)

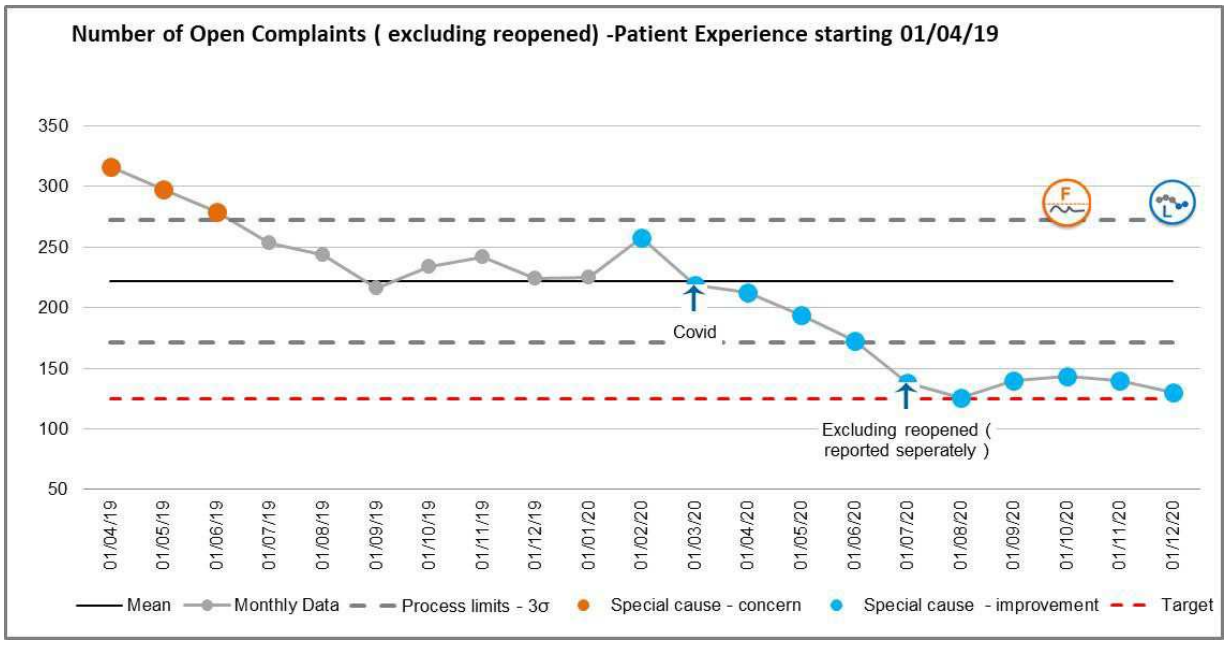






The number of open complaints continues to decrease. This continual improvement journey can be seen in graph 1 below

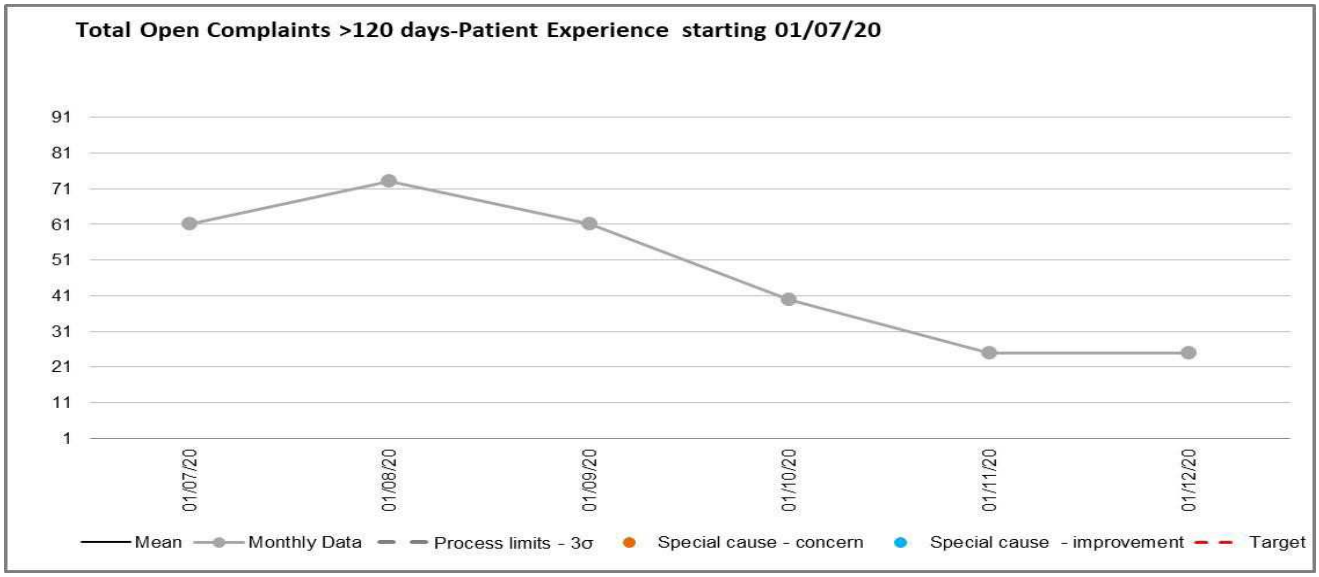
Graph 1



Q3: Formal Complaints (Patient Experience)

As Trust wide transition to new complaint process commences the central complaints team have focused on closing those complaints >120 days, with progress on this during Q3, show below in Graph 2

Graph 2



- 92 new formal complaints received – 48% rise from Q2
- 87 complaints closed
- 28 % complaints closed in Q3 within timescale
- Number of open complaints continue to decrease

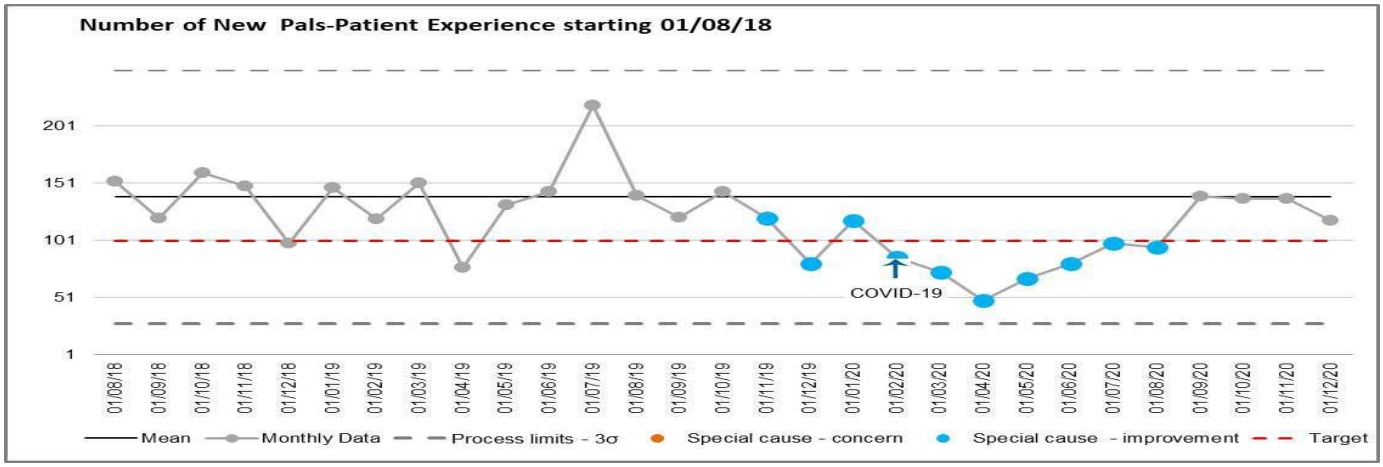
Actions

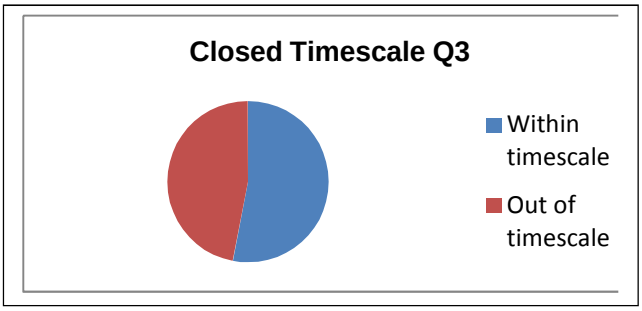
- Divisional engagement with changes to complaint process continues
- Training in good complaint handling being developed
- New Complaint process launched
- Supportive Complaints Action plan in place to ensure continued pace of complaints work
- Additional central complaint team member seconded to assist in transition period

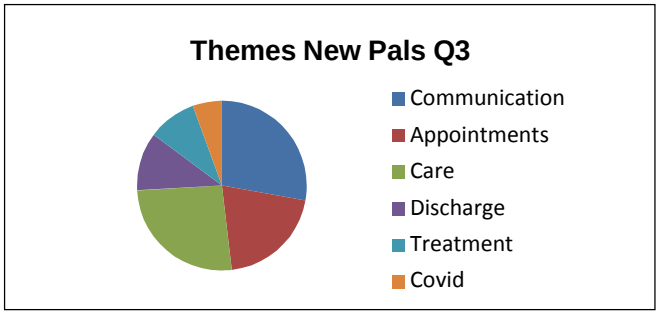
Issues/Risks

- Impact of second wave on clinical staffs ability to respond to complaints
- Training requirements for Lead Investigators needs further development

Q3: Pals Concerns (Patient Experience)







- 392 new Pals concerns received – 18% increase
- 515 Pals concerns closed
- 53% of Pals were closed within timescale - in line with previous quarter
- Pals numbers normalised to pre Covid levels

Actions

- Pals & Complaint Project Lead to undertake full service review and identify improvement pathway
- Communication continues to be main theme throughout divisions with patient bed base
- Possible relocation of Pals service at DPOW due to essential building works

Issues/Risks

- Multiple divisional processes impacting on timeliness of response pathway
- Unknown impact of lack of drop in option once Pals office moves – peer services being contacted for modelling

Q3 Friends and Family Test (Patient Experience)

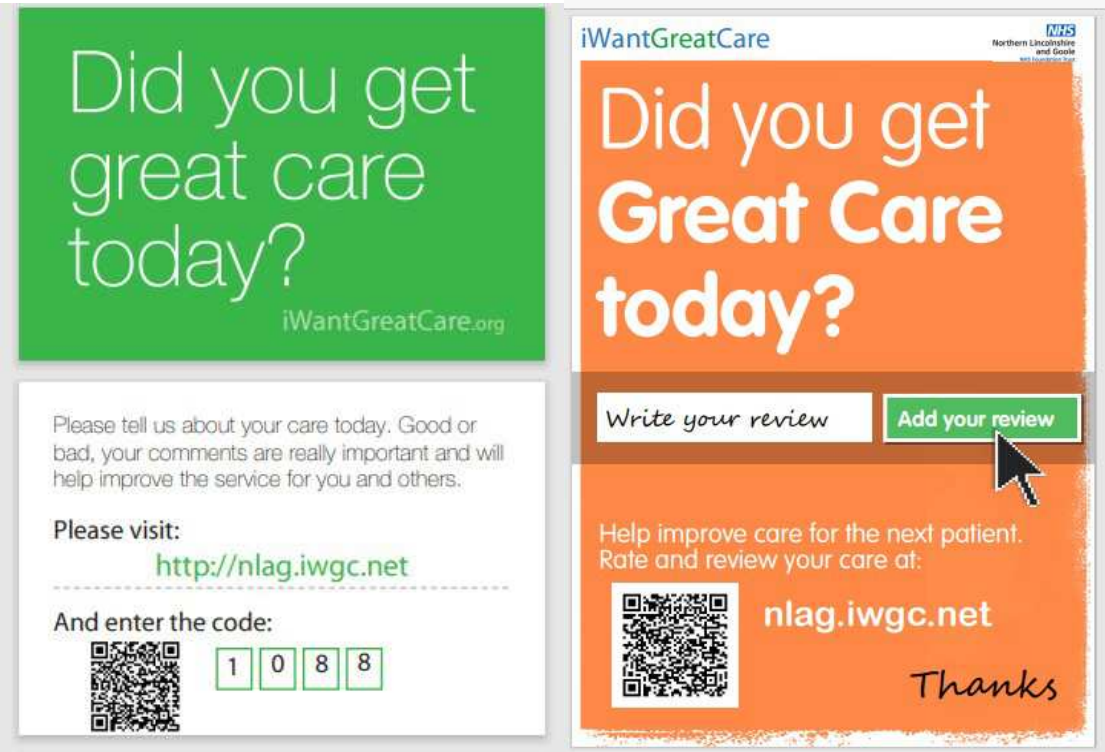
December 2020 saw the first collection of Friends and Family Test feedback since March 2020.

Following NHSEI guidance from the national Insights team, the focus is to enable patients to leave feedback if they desire, but trusts are to be asked not to prioritise response rates but move the focus of FFT to improvements arising from feedback.

It is expected that reporting in the coming months will be low in numbers.
Use of paper as a methodology requires built in quarantine time for data collection and entry, based on this further work is to be done with electronic access.

Business cards and area specific QR posters, as seen below, are being developed for dissemination trust wide in early 2021.

Reporting will be available from January 2021 onwards: this will be service level and organisational level.



Q3: Patient Surveys (Patient Experience)

The Trust INSIGHT survey has been paused whilst the Patient Experience Team prioritise working on ward areas to support effective communication between staff, patients, families and carers.

The National Survey programme continues with the National Inpatient Survey 2020 and the Children and Young People Survey 2020 commencing. The main methodology this year will be electronic with reduced paper surveying. Results will not arrive into Trust until mid-2021.

An interim National Inpatient Covid Survey was undertaken by Ipsos Mori on behalf of CQC has been produced; this includes anonymised data from a larger randomized sample of over 10,000 adults.

Themes arising from this mirror the Trust feedback, patients are generally happy with care but raise communication as an issue. There are no internal actions required from this report.

Q3: Learning (Patient Experience)

In Q3 the review of how learning from complaints and Pals is captured is being reviewed.
The current incident reporting system, and specifically the complaint module, used by the Trust needs further amendments to enable improved evidence of learning. Currently the Pals and Complaints Manager is developing a simple reporting system with the Datix team which will allow divisional reporting of learning outcomes and central team audit.

This piece of work will be an improvement journey, with the initial stage being central team training, which has already commenced.
Embedding of learning has been integrated into formal complaint responses, ensuring clear and simple outcomes for complainants to reflect on.
Divisional reporting of learning will commence in early 2021 once the new process is fully transitioned and the old process is closed.

Examples of learning from patient feedback, including complaints, concerns and other routes can be seen below.

Concern;
Families unable to get responses from ward telephones
Learning;
Families have shared their experiences directly .Through extensive discussions with staff and senior nursing teams it is clear that staff are prioritising bedside care when staffing is at minimum numbers and do not havethe time to respond to numerous telephone calls . The learning derived from this isthat additional resource is required during the current pandemic.
In response to this the Chief Nurse Directorate & Redeployment Hub have launched a Patient Contact Helpline to receive calls 9-5 and obtain answers for callers through "runners" at each main site. This is being supported by the central governance team giving their time

Concern:
Surgical pathway incorrectly closed by Data Quality
Learning:
Investigation identified individual learning and need for cross checking of all pathway data open.
1:1 refresher training delivered to Data Quality staff member by line manager.
All Data Quality Team reminded to be vigilant when closing pathways, if patient has more than one pathway open, process to check for multiple pathways.

Concern:
Recovery of patient was complex and communication poor at times
Learning:
Investigation identified that slow progress of patient was unusual and wider discussions may have identified additional causes
Weekly clinical meetings now held in general surgery to discuss complex patients & those whose admission is longer than planned

Actions

- Revised use of complaint module on incident reporting system to produce learning evidence from complaints
- Central complaints team staff training in collating and understanding learning
- Divisional learning reporting plan commenced
- Audit of learning from complaints embedded in new complaint policy

Issues/Risks

- Further Training requirements for central and divisional staff on extracting learning from investigations
- Creating central log with audit dates and feedback – this needs developing

Q3: COVID-19 Impact (Patient Experience)

The continued effects of the Covid pandemic felt across our own Trust are being felt in many acute Trusts, following feedback on the national platform for Patient Experience Leads. The difficulties in maintaining effective communication: being the national theme, with trusts implementing similar roles and systems to support this. Some of this work undertaken internally is detailed below.

Visiting

The Chief Nurse Directorate and Senior Nursing Teams across the Trust continue to work with wards to ensure that the Interim Visiting Policy is used well. Feedback indicates that experienced managers use the guidance successfully but those with less experience need support to apply it. The patient experience team continues to provide a conduit to identifying these areas for support, allowing senior nurses to go into wards and provide oversight.

The Interim Visiting Policy has always been a responsive document, and this was evident when for Christmas day risk assessed visiting was permitted across many wards. This was done with direct input from the senior nursing team, with a priority of ensuring those, whom this may have been their last Christmas, had opportunity for visiting, undertaken safely.

Whilst this was a complicated undertaking to ensure safety of patients, visitors and staff, the positive mental wellbeing this supported at this exceptionally difficult time was immense. This could be witnessed in the emotional responses from both families and patients.

Communication – patient updates

Families and carers are providing direct feedback through Pals and complaints, social media and the patient experience inbox that the inability to obtain an update on their loved one is distressing. A number of measures have been established:

- Patient Experience inbox – to receive messages/pictures
- Increase in Patient Experience Team – to dedicate time daily to allocated wards , providing updates/supporting patient communication
- Patient Contact Helpline – to receive telephone calls when there are difficulties accessing a ward. They will send a runner to the area to obtain a response.
- Patient /Family Liaison Assistants – through Redeployment Hub non clinical staff supporting wards with communication, answering of telephones, helping patients make video calls and working with ward staff to keep communication flows going.

Q3: Developments (Patient Experience)

Developments continue across the Patient Experience agenda:-

- November 1st saw commencement of new complaint process , with gradual full transition planned from old process by February 2021
- Introduction of new process complaint training
- Learning section embedded in complaint responses as standard
- Launch of IWANTGREATCARE FFT data collection trust wide
- Successful transition of new interpreting system trust wide
- Continued work with Patient Panel creating useful communication leaflet based on their experiences
- Commenced review of management of patient property following number of pieces patient feedback : including caring for property at end of life

Q3: Risks (Patient Experience)

- The risks to development of the patient experience agenda have been included in this report for clear oversight of the issues.
- There are currently 2 “live” moderate risks on the register, relating to:
  - Management of Complaints
  - Implementation of electronic systems to support FFT

These risks are reviewed in the Chief Nurse Performance Meeting on a monthly basis.

Q3 Divisional Overview (Patient Experience)

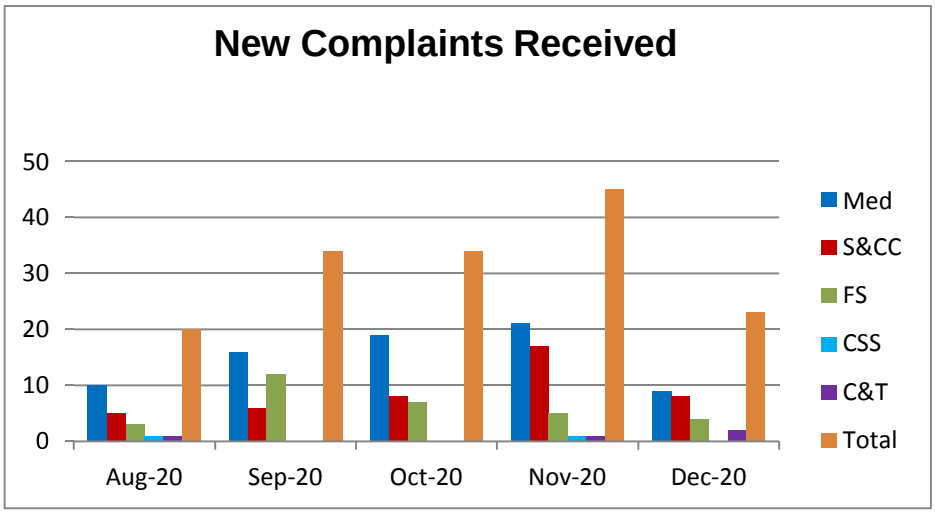
The following pages provide a highlight on divisional complaint data in a streamlined format.

The linear graph format, used in graphs A-G, show divisional data and Trust level data.

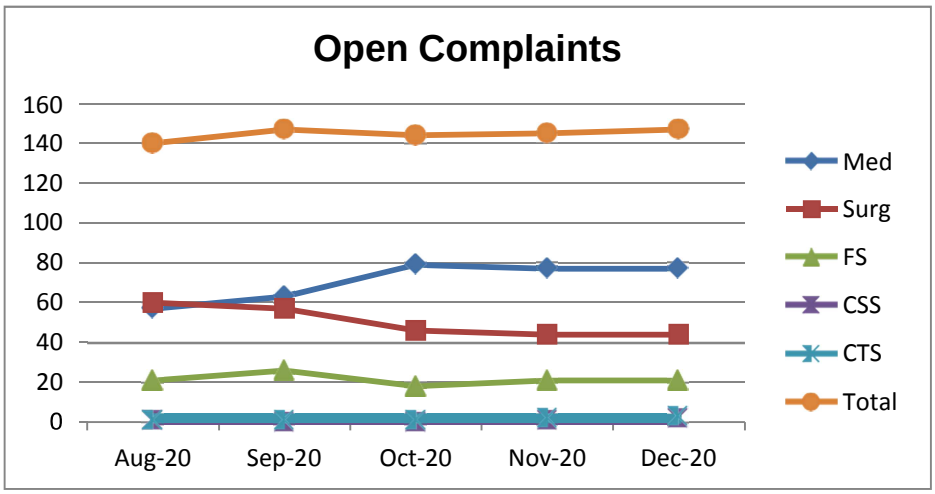
Main highlights from this data are:

- New complaint numbers are normalising to pre Covid levels – this is across all divisions
- Open complaint numbers are predicted to reduce in Q4 as the old process complaints are closed - this is notwithstanding a significant rise in new complaints, although this would be an anomaly
- A " seasonal dip " in December for closed complaints due to overall staff leave and impact of second wave staff absence - this is being monitored through weekly Complaints Support and Challenge Meeting
- Significant improvement in open complaints outside of timescale since Q2 : as old process complex complaints closed
- New Pals Concerns have returned to pre Covid levels – this is across all divisions
- Medicine continues to work collaboratively with Pals team to review larger numbers of open Pals – historically , as a division, they have a higher number of concerns in line with their activity levels
- Closure of Pals concerns has increased as the central Pals team vacancy position has been addressed – a process review will form part of Pals service review to develop an improved

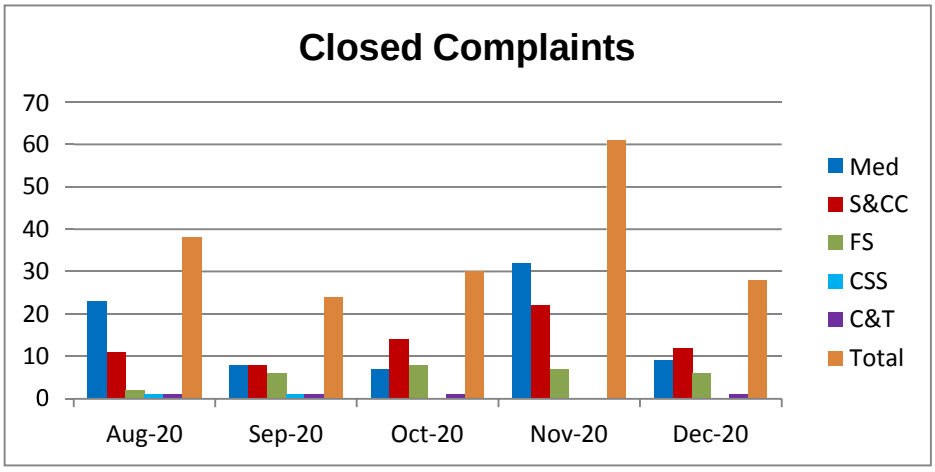
Graph A

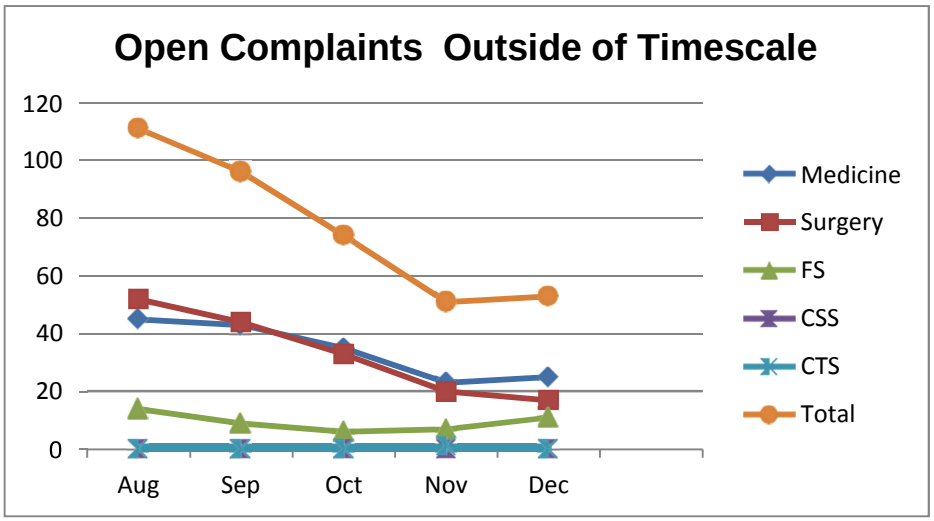


Graph B

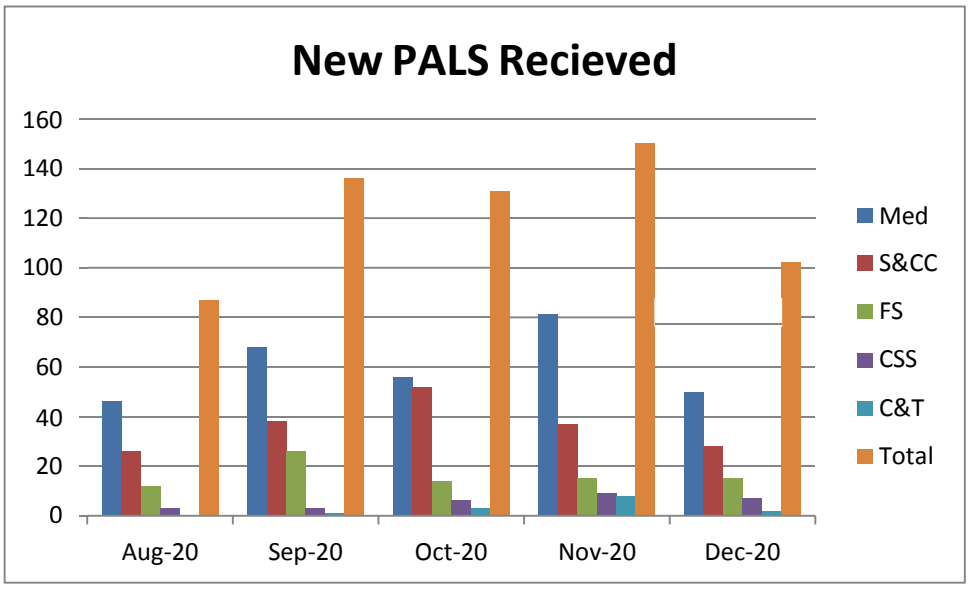


Graph C

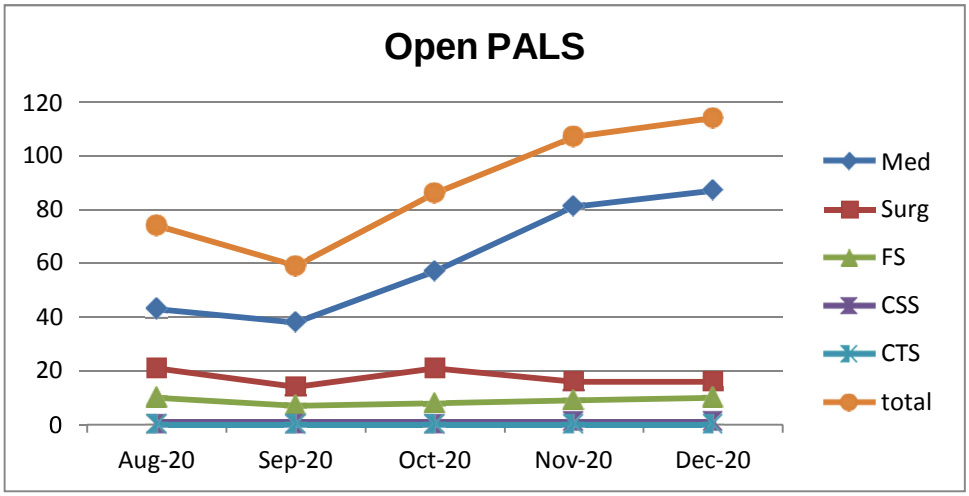




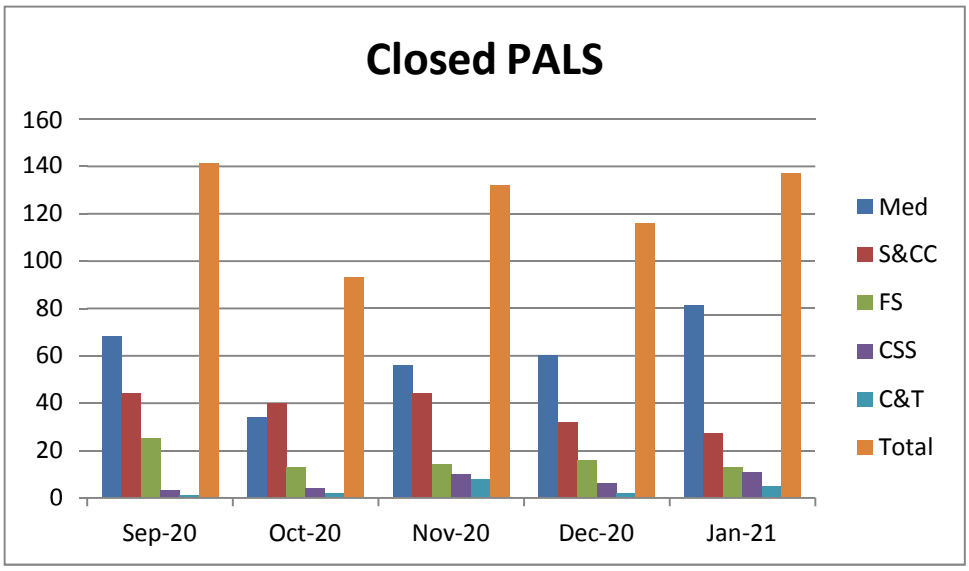
Graph D



Graph E



Graph F



Graph G

Actions

- Launch of new complaint process
- Focus on closure of all old process complaints by February 28th 2021
- Pals service review

Issues

- Capacity of clinical staff with Covid second wave impacting
- Development of complaint training programme
- Unknown progression of Covid pandemic

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG (21)093

DATE	06 April 2021
REPORT FOR	Trust Board
REPORT FROM	Guardian of Safe Working (GoSW)
CONTACT OFFICER	Jane Heaton
SUBJECT	Quarterly report
BACKGROUND DOCUMENT (if any)	N/A
PURPOSE OF THE REPORT	For information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The note the quarterly report – for information This report went to TMB on 15 February 2021. Exception report data from 1st October 2020 to 31st December 2020 in line with the Doctors in Training contractual obligations. There was a slight decrease in the number of exception reports this quarter down to 42 report from 49 the previous quarter. The majority of the reports were in connection with working hours, however there were 5 reports for missed educational opportunities.

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

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

TRUST PRIORITIES - which Trust Priority does this link to?					
Leadership and Culture	**Workforce**	**Quality and Safety**	**Access and Flow**	**Finance**	**Service and Capital Investment Strategy**
BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)		Strategic Objective 2: To be a good employer x Strategic Risk 4: Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term. Strategic Risk 5: Ineffective staff engagement and ownership of Trust agenda affects morale and failure to change and improve the culture			
BOARD / COMMITTEE ACTION REQUIRED		Trust Board is asked to note the report for information.			

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Jane Heaton
Interim Guardian of Safe Working
26th January 2021

Contents

1. Executive Summary.....5
2. Exception Reports.....3
3. Immediate Safety Concerns.....5
4. Work Schedule Reviews.....6
5. Trend in Exception Reporting.....6
6. Fines Levied against Departments during this Quarter.....6
7. Number of filled and Unfilled shifts.....6
8. Comminication / Engagement.....6
9. Support for the Guardian Role.....7
10. Key Issues and Summary.....7

1. Executive Summary

Exception reports for the quarter 1 October 2020 to 31 December 2020 saw a very small decrease in reporting at 42 this quarter, down from 49 in the last quarter.

The majority of the exception reports submitted were in connection with working hours, with a small number also submitted around educational opportunities for which the Director of Post Graduate Medical Education is overseeing and discussing within the relevant Divisions/Directorates.

There is still much work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared so that we see the exception reporting on a downward trend.

Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working monitoring and actioning outstanding exception reports should reduce.

2. Exception Reports

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	231
Number of Doctors/Dentists in Training (WTE)	197.5
Number of Less than full time (LTFT) Trainees (Headcount)	10
Number of Training post vacancies (WTE)	27.15
Number of Trainees by Site (Head Count)	
SGH	103
DPOW	101
Goole	0

During the period of this quarterly report (October 2020 to December 2020) there have been a total of 42 exception reports submitted through the allocate exception reporting system.

This showed a decrease of 7 exception reports from the last quarter (July 2020 to September 2020).

Of the 42 exception reports submitted, 34 of these were linked to hours. This showed a decreased of 12 reports from the previous quarter.

The exception reports for this quarter relating to hours had been agreed by the Guardian of Safe Working (GoSW) for payment due to time off in lieu (TOIL) not being an option within their services. These exception reports have now been closed on the system as they have been actioned appropriately.

The below table is a breakdown of the exception reports over the last quarter (October 2020 to December 2020)

Exception Reports Open (ER) between 1 October 2020 and 31 December 2020	
Total number of exception reports received	42
Number relating to hours of work	34
Number relating to pattern of work	1
Number relating to educational opportunities	5
Number relating to service support available to the Doctor	2
Number initially relating to immediate patient safety concerns	3*

*This number is not included in the total number of exception reports received – when completing an exception report there is an option to specify if the doctor feels there is an immediate safety concern and the system then flags this within the numbers.

Exception Report Outcomes (ER) between 1 October 2020 and 31 December 2020	
Total number of exception reports resolved as at 31.12.20*	31
Total number of exception reports unresolved as at 31.12.20*	11
Total number of exception reports where TOIL was granted	3
Total number of exception reports where overtime was paid	26
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	2
Total number of exception reports resulting in fines	0

*These numbers may include exception reports carried over from the previous quarter.

3. Immediate Safety Concerns

During this quarter a total of 3 exception reports were submitted were the Doctors raised an immediate safety concern in addition to either a concern around working hours or educational opportunities. Within the system, an exception report relating to hours of work, the work pattern, educational opportunities and service support has the option for the doctor of specifying if they feel it is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

When investigating those exception reports that had a potential safety concern also attributed to them the outcome was:

- A reduction in FY1 and FY2 on call presence due to COVID absences, however the out of hour's service was deemed safe with other grades of Medical Staff involved with the on call cover arrangements.

- Inability to take full annual leave entitlement by a doctor was exception reported and the doctor also flagged this as a safety concern, again following investigation it was not categorised as an immediate safety concern.

4. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

5. Trend in Exception Reporting

During this quarter the majority of the exception reports submitted have been from the Medicine Directorate and have been due to COVID related absence.

This quarter showed a marginal increase in exception reports relating to educational opportunities again due to a change in service delivery as a result of COVID, for example doctors have reported the inability to attend out-patient clinics either due to the clinic being converted to telephone consultations or the doctor required on the Ward due to service commitments.

Another trend identified was the inability to take all the annual leave before the end of a doctor's rotation and where this happened agreement was reached to remunerate the doctor for the untaken leave. Again this was due to absences primarily associated with COVID.

6. Fines Levied against Departments this quarter

During this quarter there were no fines levied against a Department.

As an update where previous fines had been levied work has been undertaken with the Doctors to identify how to spend the fine monies. Agreement was reached with the Doctors and orders have been placed for various items for their use within the Doctors mess.

7. Communication and Engagement

Work has been undertaken during this last quarter to look at the communication and engagement with our Doctors in Training.

A couple of discussion meetings have taken place with the local BMA junior doctor representatives to determine how meetings take place going forward.

There were 3 meetings that were held ad hoc with our Doctors in Training:

- Juniors Doctors Huddle
- Junior Doctors Forum
- Guardian of Safe Working Meeting

Following discussions and in partnership with our Junior Doctors we have now confirmed that the Junior Doctors Huddle will remain an informal meeting between the Junior Doctors and the Post Graduate Medical Education Centre (PGME) which gives the Junior Doctors the opportunities to raise any concerns/issues in an informal setting.

Agreement has been reached that the Guardian of Safe Working and the Junior Doctors Forum will combine into one meeting. This meeting will be formal with agreed Terms of Reference. These Terms of Reference are in the final draft stage awaiting ratification. Clear and defined lines of escalation are contained within the Terms of Reference to ensure concerns/issues are dealt with and escalated appropriately.

8. Support for the Guardian Role

There had been no dedicated administrative resources for the Guardian of Safe Working, however following a successful business case approval was granted for the administrative tasks associated with the Guardian of Safe Working to be carried out within the Medical Director's office. Therefore the Trust now has dedicated time for the administration of the work carried out in association with the Guardian of Safe Working.

The Trust's Guardian of Safe Working left the organisation on 30th November 2020 and despite initial recruitment processes we were unable to recruit. An interim Guardian of Safe Working was appointed following discussions with LNC, the BMA and local BMA representatives.

A further advert and recruitment process will be undertaken during January 2021 and the advert has been complied in partnership with LNC.

9. Key Issues and Summary

Exception reporting during this quarter remained relatively static in comparison with the previous quarter.

Recruitment to the Guardian of Safe Working is on-going.

Engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to agree a formal forum with agreed Terms of Reference and governance arrangements.

Further training requirements for the Educational Supervisors has been identified and it is planned this will take place during 2021.

In summary, it appears to be a positive position going forward, however there is still much work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned so that we see the exception reporting on a downward trend. Once the refresher training has been carried out and the Educational Supervisors reminded of their responsibilities the time of the Guardian of Safe Working should reduce as the Guardian of Safe Working should not be the main individual monitoring and progressing exception reports which is currently the case.

Compiled By:

Jane Heaton
Associate Director – Strategic Medical Workforce and Interim Guardian of Safe Working
Helen Fitzpatrick
Administrative Support to the Guardian of Safe Working

Date: 26 January 2021

NLG(21)094

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6 April 2021
REPORT FOR	**Trust Board of Directors (Public)**
REPORT FROM	Neil Gammon, Non-Executive Director / Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Health Tree Foundation Trustees' Committee – Minutes from 5 November 2020**
BACKGROUND DOCUMENT (if any)	-
PURPOSE OF REPORT	For Information
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	HTF Committee – 8 March 2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	Minutes of the Health Tree Foundation Trustees' Committee held on 5 November 2020 and approved at its meeting on 8 March 2021.

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

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

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	N/A
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to note the report.

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **5 November 2020 – Via GoToMeeting**

Present:	Neil Gammon	Non-Executive Director / Chair of HTF
	Tony Bramley	Non-Executive Director
	Andrew Smith	Associate Non-Executive Director
	Lee Bond	Interim Director of Finance
	Dr Kate Wood	Medical Director
	Jug Johal	Director of Facilities
	Dawn Harper	Deputy Chief Nurse (Rep Chief Nurse)
	Paul Marchant	Chief Financial Accountant
	Victoria Winterton	Head of Smile Health
	Clare Woodard	HTF Charity Manager
	Adrian Beddow	Associate Director of Communications
	Andy Barber	Chief Executive of Smile
In attendance:	Mark Surridge	Mazars (For item 6.2)
	Lauren Short	Finance Directorate Admin Assistant (For the Minutes)

Item 1 11/20 **Apologies for Absence**

Apologies for absence were received from Linda Jackson and Ellie Monkhouse.

Item 2 11/20 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Neil Gammon read from an e-mail received from Terry Moran which confirmed Neil Gammon's appointment as Independent Chair of the Health Tree Foundation Trustees' Committee until 31 March 2021, which was consistent with his original appointment and would be considered for renewal in the usual way at that time.

Item 3 11/20 **Minutes of last meeting held on 3 September 2020**

The minutes of the meeting held on 3 September 2020 were reviewed and were agreed as an accurate record.

Kate Wood referred to item 4 section 3 on page 2 (Clinical Scholarship) and informed the committee that her deputy, Dr Arusu Kuppuswamy, is leaving his position on 1st December 2020. Kate Wood will liaise with Clare Woodard to nominate a new person to take on this work.

Item 4 11/20 **Matters Arising**

No matters arising were discussed.

Item 5 11/20 **Review of Action Log**

The action log was reviewed and noted.

Item 6 11/20 **Items for Discussion/Approval**

6.1 HTF Terms of Reference Review

Approval of this item was deferred to the next meeting.

Neil Gammon advised that The Terms of Reference will be amended to include the ability of trustees to nominate deputies in their absence. Such deputies would not be voting members.

6.2 Auditors Update

Mark Surridge from Mazars Auditors confirmed that the audit of the 19/20 Accounts has been completed, subject to final check and review. Unfortunately, Jon Machej the audit manager, is currently off sick so there will be a slight delay. However, Mark Surridge reassured the committee that the accounts would be approved before the 31st January 2021 deadline. He commented that the audit had gone well and he wished to thank Paul Marchant and Rachael Hinkley for providing the information in a timely manner.

The Chair thanked Mark Surridge for his update.

10:55am Mark Surridge left the meeting.

Item 7 11/20 **Updates from Health Tree Foundation**

7.1 HTF Update Report

Clare confirmed that the Rear into Gear equipment has now been ordered and that a plan needs to be put in place around publicity to thank the donors. Kate Wood offered to help, nominated Mr Sasapu and suggested a non-executive director should be included.

Clare Woodard advised that a further £50k grant from NHS Charities Together had recently been approved as part of the Covid -19 Wave 2 funding. This is to be used for staff welfare and Clare asked for the committee's thoughts on how this could be spent. Clare put forward a proposal to give 'Hampers of Happiness' to those nominated for their hard work during these unprecedented times as a feel good gesture.

Dawn Harper thought this was lovely however, there could be up to 50-60 staff a day who would meet the criteria and with limited funding it would be difficult to choose one individual or group over another. The Chair agreed and thought it may be beneficial to nominate a whole ward, rather than an individual. It was agreed that further discussion would take place outside the meeting to agree the optimum way forward

7.2 Update of Development Tracker

This tracker was put in place after a strategic development meeting in October 2018 in order to track and progress agreed actions.

The Chair explained that a number of these actions had been completed, others had been overtaken by events and some were now incorporated as part of normal business. The intention was to no longer update the tracker but to put the outstanding items into a more conventional action plan.

Lee Bond referred to the Annual Review item regarding a return of investment and the financial reserves policy. Andy Barber explained that HTF benchmarks themselves against the NHS Charities Together report. Paul Marchant advised that under the reserves policy the charity would expect to hold reserves approximately equal to 12 months running costs (£196k) and general expenditure costs for 6 months (£360k), making a minimum reserve of £556k.

The Chair and Lee Bond agreed to discuss these figures and the way of working during their 1:1 meeting.

Tony Bramley felt that forthcoming plans and the ability to raise funds in the future could be affected by the Covid -19 pandemic. He felt we needed to re-visit these, to which Andrew Smith agreed. The Chair agreed to consider what post Covid -19 plans might look like.

Action: Neil Gammon

Kate Wood suggested we may need to reconsider the criteria for approving requests for some core items of equipment as additional items of core equipment do benefit and make it easier for staff and patients. Victoria Winterton explained that requests for replacement equipment are not all rejected but reviewed to see if they can be appropriately funded or referred to the staff lottery for their funding.

The Chair explained that HTF's response to funding requests is never clear cut in that there is invariably room for interpretation. By example, he referred to the £300k agreed by the Trustees in July 2019 for the Trust to purchase 'CQC must haves' equipment. Paul Marchant confirmed that the final cost was £166k due to VAT savings and changes to the original request

Kate Wood and Jug Johal commented that they were not aware that not all the funding had been spent. The Chair emphasised that this did not mean that there was additional money now available that had to be spent. Each funding request must be considered on its merits. In the case cited, the original estimates plus the changing requirements had led to a smaller sum being required.

7.3 Updated HTF Charitable Funds Procedures

There was no discussion on this item. The Chair asked Trustees to forward any concerns or comments within one week. The procedures would be agreed subject to any such issues being raised.

7.4 Updated Fund Guardians List

There was no discussion on this item; the new list was noted.

Item 8 11/20 **Sparkle Programme**

8.1 Sparkle Update Report

There was no discussion on this item; the details of which were noted.

Item 9 11/20 **Finance Update**

9.1 Finance Report

There was no discussion on this item; the details of which were noted.

9.2 CCLA Investment report for April to June 2020

There was no discussion on this item; the details of which were noted.

Item 11 11/20 **Any Other Business**

Tony Bramley asked for an update on fund raising. He expressed his gratitude for the NHS Charities Together grants however, moving forward, he questioned whether the committee may have to adjust its budget due to non-grant funding shortfalls.

The Chair agreed and asked for a revised forecast paper to come to the next meeting to reflect the current pandemic pressures.

Clare Woodard informed the committee that more funds from NHS Charities Together had been released for wave 2 of Covid-19 and as noted above her recent application for a £50k share of that had been approved.

The Chair advised that the revised Covid-19 spending approvals governance rules, as used during the first wave of the pandemic, would be used again. This meant that he would respond to requests for timely approvals of Covid-19 funds, ensuring that any such approvals would be brought back to the committee for their retrospective consideration.

Action: Clare Woodard/Neil Gammon

Item 10 11/20 **Matters for Escalation to the Trust Board**

The following items had been highlighted during the meeting for inclusion on the public highlight report to the Trust Board:

- Application of £50k funding from NHS Charities Together approved.
- HTF to consider how fund raising in a Covid-19 pandemic and post pandemic climate might best be managed.

The meeting finished at 11:05 am

Item 12 11/20 **Date and Time of the next meeting**

Thursday, 14 January 2020 – 10.00am-1.00pm – via GoToMeeting

Attendance Record:

Name	May 2020	July 2020	Sept 2020	Nov 2020	Jan 2021	March 2021
Neil Gammon	✓	✓	✓	✓		
Peter Reading	✓	✓	✓	-		
Terry Moran	Apols	✓	Apols	-		
Linda Jackson	✓	Apols	Apols	Apols		
Tony Bramley	✓	✓	✓	✓		
Sandra Hills	Apols	Apols	Apols	-		
Lee Bond				✓		
Andrew Smith				✓		
Jim Hayburn	✓	✓	✓			
Marcus Hassall	-	-	-	-		
Jug Johal	✓	✓	Apols	✓		
Kate Wood	✓	Apols	✓	✓		
Ellie Monkhouse	✓	✓	✓	Apols Sent a rep		
Paul Marchant	✓	✓	✓	✓		
Andy Barber	-	✓	✓	✓		
Victoria Winterton	✓	✓	✓	✓		
Clare Woodard	✓	✓	✓	✓		
Adrian Beddow	✓	✓	✓	✓		
Total	12	12	11	10		

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Northern Lincolnshire and Goole NHS Foundation Trust

DATE	6/04/2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Adrian Beddow, Associate Director of Communications
CONTACT OFFICER	Charlie Grinhaff, Communications Manager
SUBJECT	Communications Team Update – Q4 2020/21
BACKGROUND DOCUMENT (if any)	
PURPOSE OF REPORT	To highlight key priorities and developments in relation to internal and external communications activitiy between Jan and March 2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	New Communications Officer dedicated to Capital works has secured positive media coverage including the front page of the Goole Times. The team are working to align workstreams and objectives to the Trust priorities. The Trust has reached 10,000 likes on its corporate Facebook page

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

LINK TO STRATEGIC OBJECTIVES -				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide strong leadership**

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

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF)	
TRUST BOARD ACTION REQUIRED	The Trust Board is asked to: To note the report

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

March 2021

Kindness • Courage • Respect

Q4 update 2020/21

Key developments and projects

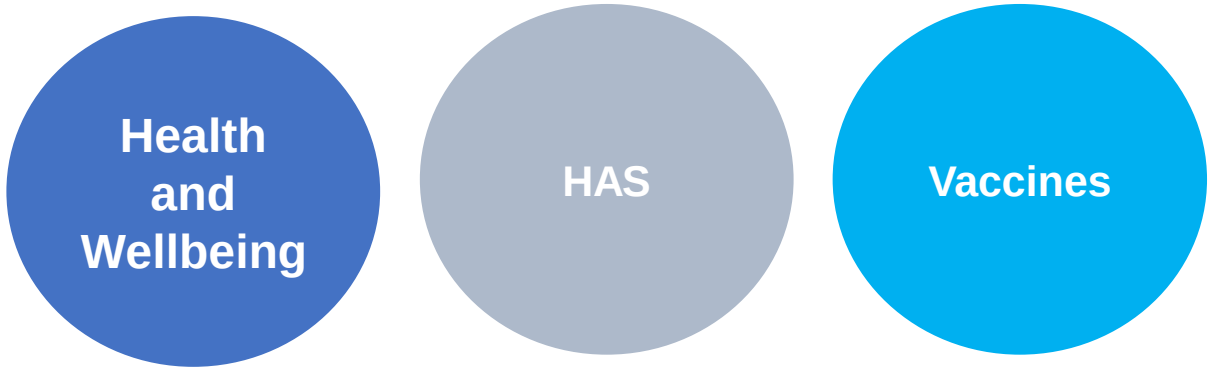
The team have been working from home for a year now. They have recently relocated from Scunthorpe General Hospital to new office accommodation at New Beacon House, but continue to work remotely. Planning is currently underway for 2021/22 with the team's objectives being aligned to the Trust's priorities.

The new **Communications Officer for Capital projects** has settled in well and has created a new dedicated Hub site to keep staff informed of programme updates and created a weekly all staff email called 'Building Our Future' to keep staff apprised of key development from a practical point of view- eg parking changes, workers on site etc

The Associate Director is still dedicating two days per week to **Humber Acute Services** – the internal communications campaign will begin in April ahead of public awareness raising in May.

Projects we are supporting include:

Health and Wellbeing initiatives
Vaccine rollout
Health Tree Foundation
End of life – 24/7 pilot for palliative care support
Outpatient Transformation programme



Internal Communications

We have implemented a new schedule for all staff emails:

Monday - Peter's Monday Message *Tuesday* - COVID-19 update *Wednesday* – Wednesday Weekly News
Thursday - Building Our Future update *Friday* - COVID-19 update

Senior Leadership Community Briefings have resumed and have moved to MS Teams

Ask Peter – COVID-19 continues to be the most popular topic for questions

Top posts on the staff Facebook Group:

One year of COVID nursing – memory window created on ward C1
Staff member expressing thanks for the care given to them as a patient at DPOW
What do porters do? They do a fab job

80+
Staff attended the last SLC briefing

344
Ask Peter responses between Jan and March

3,200
Staff use our closed Facebook group

External Communications - media

Media activity, including radio and TV interviews, remains limited due to the Level 4 incident and we are now in the pre-election period so are restricted on what we can do proactively.

Recent media interviews:

Jug Johal on the £40m decarbonisation funding – That's TV
Dr Stuart Baugh on World TB day– That's TV
Sue Snelson on one year on from lockdown – BBC Look North (Top story)
Gail Meadows on staff health and wellbeing – Lincs FM

Top media releases views on website (Jan to March)

Updated visiting (issued November)
Local NHS staff receive the vaccine
Centre of Excellence accolade for Endometriosis

Notable coverage:

Front page story in Goole Times – Major cash boost for hospital (energy improvement schemes)
Arrival of MRI scanner at Grimsby hospital
Planning permission granted for Scunthorpe A&E

123
Media enquiries dealt with (85% within deadline)

13
Media releases issued

94%
Of media coverage was positive or neutral

Social Media and Website

Social media campaign – we featured 20 staff members from a variety of professions to highlight the efforts of staff throughout the pandemic to mark one year on from our first COVID-19 positive inpatient

Top social media stories in March:

Our emergency departments are very busy
One year on from NLaG's first COVID-19 inpatient
#ThumbsUpFriday to the vaccination team
Planning permission granted for Scunthorpe ED
NLaG is a centre of excellence for Endometriosis
New ultrasound machine for Scunthorpe

10,000
Likes on our corporate Facebook page

4,600
Followers on Twitter

Most popular website pages

Lateral flow testing
Vaccination booking
Rollout of digital appointment letters

500,000
Page views on our website