Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 3 August 2021, via MS Teams, Time 10.00 am – 12.45 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** Linda Jackson, Acting Chair	Note	10:10 hrs	Verbal
2.2	**Apologies for Absence** Linda Jackson, Acting Chair	Note		Verbal
2.3	**Declarations of Interest** Linda Jackson, Acting Chair	Note		Verbal
2.4	**To approve the minutes of the previous Public meeting held on Tuesday, 1 June 2021** Linda Jackson, Acting Chair	Approve		NLG(21)147 Attached
2.5	**To approve the minutes of the Trust Board Self-Certification Event held on Tuesday, 25 May 2021** Linda Jackson, Acting Chair	Approve		NLG(21)148 Attached
2.6	**Urgent Matters Arising** Linda Jackson, Acting Chair	Note		Verbal
2.7	**Trust Board Action Log - Public** Linda Jackson, Acting Chair	Note		NLG(21)149 Attached
2.8	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	10.25 hrs	Verbal
2.9	**Quarter 1 - Trust Priorities and Integrated Performance Report (IPR)** Helen Harris, Director of Corporate Governance	Note	10:30 hrs	NLG(21)150
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Executive Report – Quality & Safety** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	10.35 hrs	NLG(21)151 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	Note	10:40 hrs	NLG(21)152 Attached
3.3	**Executive Report – Performance** Shaun Stacey, Chief Operating Officer	Note	10:45 hrs	NLG(21)153 Attached

3.4	**Finance & Performance Committee Highlight Report and Board Challenge – June & July 2021 (Performance only)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:50 hrs	NLG(21)154
3.5	**Annual Quality Account** Dr Kate Wood, Medical Director	Approve	10:55 hrs	NLG(21)155 Attached
3.6	**Annual Complaints Report** Ellie Monkhouse, Chief Nurse	Note	11:05 hrs	NLG(21)176 Attached
BREAK (11.10 hrs – 11.15 hrs)				
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)157 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)158 Attached
4.3	**Guardian of Safe Working Hours – Annual Report** Dr Liz Evans, Guardian of Safe Working Hours	Note	11:25 hrs	NLG(21)180 Attached
4.4	**Freedom to Speak Up Guardian Update – Quarter 1** Liz Houchin, Freedom to Speak up Guardian	Note / Approve	11.30 hrs	NLG(21)159 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Executive Report – Finance – Month 03** Lee Bond, Chief Financial Officer	Note	11.35 hrs	NLG(21)160 Attached
5.2	**Executive Report – Digital Strategy 6 Month Update** Chris Evans, Associate Director of Information Services	Note	11:40 hrs	NLG(21)161 Attached
5.3	**Finance & Performance Committee Highlight June & July 2021 (Finance & Digital)** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:45 hrs	NLG(21)162
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Executive Report – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:50 hrs	NLG(21)164 Attached
6.2	**Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – July 2021** Gill Ponder, Non-Executive Director	Note	11:55 hrs	NLG(21)165 Attached
6.3	**Committees in Common Highlight Report & Board Challenge – June 2021** Michael Whitworth, Non-Executive Director	Note	12:00 hrs	NLG(21)166 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	**Board Development Timetable** Helen Harris, Director of Corporate Governance	Note	12:05 hrs	NLG(21)167 Attached

8.	**Governance**			
8.1	**Audit Risk & Governance Committee (AR&GC) Higlight Report & Board Challenge – May & July 2021** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Note	12:10 hrs	NLG(21)168 Attached
8.2	**Board Assurance Framework** Helen Harris, Director of Corporate Governance	Note	12:15 hrs	NLG(21)169 Attached
8.3	**Fire Annual Report** Jug Johal, Director of Estates & Facilities	Note	12:20 hrs	NLG(21)170 Attached
8.4	**LSMS Annual Report & Workplan including Security Annual Report** Jug Johal, Director of Estates & Facilities	Approve	12:25 hrs	NLG(21)171 Attached
8.5	**Emergency Preparedness Resilience & Response Annual Report** Shaun Stacey, Chief Operating Officer	Note	12:30 hrs	NLG(21)172 Attached
9.	**Approval (Other)**			
9.1	**North East Lincolnshire Health & Care – Memorandum of Understanding** Dr Peter Reading, Chief Executive	Approve	12:35 hrs	NLG(21)173 Attached
10.	**Items for Information / To Note (please refer to Appendix A)** Linda Jackson, Vice Chair	Note	12:40 hrs	
11.	**Any Other Urgent Business** Linda Jackson, Vice Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 7 September, Time TBC **Public & Private Meeting** Tuesday, 5 October 2021, Time TBC	Note		Verbal

- In accordance with Standing Order 14.2 (2007), any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Chairman, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Chairman. Divisional Directors and Managers may also submit agenda items in this way.
- In accordance with Standing Order 14.3 (2007), urgent business may be raised provided the Director wishing to raise such business has given notice to the Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.

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

APPENDIX A

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

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

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – April & May 2021** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(21)174 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – April – June 2021** Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(21)175 Attached
	Workforce Committee	
10.3	**Workforce Committee Minutes – April 2021** Michael Withworth, Non-Executive Director & Chair of the Workforce Committee	NLG(21)179 Attached
10.4	**Medical Appraisal & Revalidation Annual Report (AOA)** Dr Kate Wood, Medical Director	NLG(21)181 Attached
	Audit, Risk & Governance Committee	
10.5	**Audit, Risk & Governance Committee Minutes – April 2021** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)182 Attached
10.6	**Audit, Risk & Governance Committee Annual Report 2020 / 21** Andrew Smith, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(21)183 Attached
	Other	
10.7	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(21)184 Attached
10.8	**Document Signed Under Seal** Helen Harris, Director of Corporate Governance	NLG(21)185 Attached
10.9	**Updated Register of Directors' Interests** Helen Harris, Director of Corporate Governance	NLG(21)186 Attached

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 1 June 2021 at 10.00 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
Mrs Gillian Ponder	Non-Executive Director
Mr Michael Proctor	Non-Executive Director
Mr Andrew Smith	Non-Executive Director
Mr Michael Whitworth	Non-Executive Director

In Attendance:

Mr Abdi Abolfazl	Acting Deputy Chief Operating Officer
Mr Adrian Beddow	Associate Director of Communications
Mrs Christine Brereton	Director of People
Mrs Elaine Criddle	Deputy Improvement Director
Mrs Helen Harris	Director of Corporate Governance
Ms Liz Houchin	Freedom to Speak up Guardian (for item 4.3)
Mr Jug Johal	Director of Estates & Facilities
Mrs Jo Loughborough	Lead Nurse – Patient Experience (for item 1)
Mr Ivan McConnell	Director of Strategic Development
Mrs Shauna McMahon	Chief Information Officer
Mr Crispin Pettifer	Capsticks Solicitors
Mr Ian Reekie	Lead Governor
Mr Maneesh Singh	Associate Non-Executive Director
Mrs Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

Terry Moran welcomed everyone to the meeting and declared it open at 10.00 am.

1. Patients' Story and Reflection

Jo Loughborough advised of recent visits to the wards undertaken with Ellie Monkhouse, the feedback received from staff was how immensely proud they had been of the staff on wards at the Trust. It was also highlighted that there would be

some long term emotional difficulties due to Covid-19, the effect of this may not be known for some time.

As this had caused such an impact Jo Loughborough advised the story was from a member of staff Chris Storrer, Ward Manager, Ward A1, Diana, Princess of Wales Hospital (DPOWH).

Chris Storrer advised the past year had been something that had not been experienced previously. When staff had been told they would be working on a ward that would become a Covid-19 Ward it had caused some distress. Chris Storrer explained how staff experienced initial panic as the ward was not equipped with the relevant equipment and how staff had not wanted to work on the ward. The experience of caring for patients who sadly died and the liaison with the patients families was very difficult. Staff had supported each other and were aware of where to receive additional support. Jo Loughborough explained how proud she had been of the staff spoken to. This had impacted on many staff personally and this would continue for some months.

Ellie Monkhouse thanked Jo Loughborough for sharing the story and hoped the Trust would realise what the teams had dealt with and would continue to deal with. As a Trust the staff had dealt with this very well.

Terry Moran wanted to again thank staff for the hard work undertaken over the past year. Linda Jackson had found the story very upsetting to hear but was pleased to see staff had the support required, however, it would need to be recognised some teams may not have had the same support.

2. Business Items

2.1 Chair's Opening Remarks

Terry Moran thanked teams for what support they have offered over the past year.

Neil Gammon had formally stepped down as Non-Executive Director (NED) on the 31 May 2021 and Gill Ponder would now formally become Chair of the Finance & Performance Committee (F&PC) as of the 1 June 2021. This would also be Andrew Smith's last meeting of the public board, Terry Moran advised Andrew Smith would be leaving the role of NED due to unforeseen reasons and would be missed. A recruitment exercise would be launched that week to replace the Chair of the Audit, Risk & Governance Committee (AR&GC).

2.2 Apologies for Absence

Apologies for absence were received from Stuart Hall.

2.3 Declarations of Interest

No declarations of interests were declared.

2.4 To approve the minutes of the Public Meeting held on Tuesday, 6 April 2021 – NLG(21)103

The minutes of the meeting held on the 6 April 2021 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Lee Bond referred to page nine of the minutes, final paragraph and asked if the word "a" could be deleted before the Committees in Common reference.

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. No items were raised.

2.6 Trust Board Action Log – Public by exception NLG(21)104

Terry Moran invited Board members to raise any further updates by exception in relation to the Trust Board Action Log, none were received.

2.7 Chief Executive's Briefing – NLG(21)105

Dr Peter Reading referred to the Chief Executive's Briefing. Discussions had taken place around governance and leadership arrangements at Integrated Care System (ICS) Board level. A workshop at 'Place' was scheduled for the East Riding of Yorkshire early June and NLAG would be represented by Dr Peter Reading. A series of development sessions had taken place within North East Lincolnshire with board level representation.

Dr Peter Reading advised the Trust had no inpatients with Covid-19 and this had been for a period of around ten days, however, there was concern due to the Delta variant spreading. There had been increased pressure in Accident & Emergency (A&E) which had affected performance and handover times, this was being managed.

2.8 Performance Report against Trust Priorities – NLG(21)106

Dr Peter Reading referred to the report and wanted to note a change to the front sheet as the paper had been discussed at the NED meeting on the 4 May and not the private board. One item to note was in respect of the People Directorate as there had been no achievement of a number of goals, as some of these had not been followed through due to the redeployment of staff, alongside maintaining other issues that were required. The Trust Board noted the paper.

2.9 Operational and Financial Plan 2021 / 22

2.9.1 Financial Plan 2021 / 22 – NLG(21)107

Lee Bond went through the highlights of the paper which included the appendices. The pandemic continued to be a risk and it was hoped an exercise would be

completed to review the Covid-19 expenditure, there would continue to be some recurrent expenses but it was hoped this would be restricted. The Elective incentive fund would be a major opportunity in reducing waiting lists and from a financial perspective if the Trust could go above the threshold set it could hopefully generate some small surplus to contribute to the position. The attendances in A&E could cause some threat to this financially.

At month one, plans were being met, however, there were some pressures with medical staffing that would need to be reviewed. The biggest issue for the Trust and ICS would be how to treat and recognise income within the position that contributed to the elective incentive fund. Lee Bond commended the plan to the Trust Board for the first six months of the year in line with the National Planning Guidance which was consistent with Operational Plans to be submitted. Dr Peter Reading advised a version of the paper had been shared and approved at Trust Management Board (TMB) and as Accountable Officer, Dr Peter Reading also wanted to commend the paper to the Trust Board.

Terry Moran referred to page seven of the paper where it detailed the potential risks. With the Trust now being in June, could it be identified how big the risk was. Lee Bond advised the Trust had almost delivered the full 2%, the issue was that not all of it was recurrent. The current delivery of cost savings was a challenge for the organisation, however there was limited concern about the achievement of £9 million target at this time. The concern was that if the Trust did not plan in any recurrent savings or secure any increase in income base, this could mean further deterioration to the underlined position. At a recent Financial Special Measures meeting the Trust were being encouraged to concentrate on costs and the management of costs. Mike Proctor queried community nursing as this was not detailed within the paper. Lee Bond advised this was included at Appendix 3. Conversations had taken place with Ellie Monkhouse to review the community nursing costs. Mike Proctor queried whether there would be a contribution from Commissioners. Lee Bond advised this was not included at the moment.

The Trust Board approved the paper.

2.9.2 Operational Plan – NLG(21)108

Shaun Stacey advised the Operational Plan had been shared at TMB and linked to the Financial plan. The funding linked into the Financial Plan paper showed the activity that would need to be undertaken. The Trust was also planning to improve the position from an elective perspective and the trajectories showed what this would be. The thresholds would be achieved which was a positive position in terms of the ICS and region. This would also put the Trust in a better position when bidding for funds. Terry Moran referred to theatres and whether they had opened as expected. Shaun Stacey confirmed they had opened as specified within the paper. Due to the secured beds, elective work had now continued for the last five months. This was well managed against the risk in the finance paper. However, there was a continued risk in terms of workforce.

Terry Moran queried where Shaun Stacey perceived the sense of the task ahead compared to previous years. Shaun Stacey advised it had been a difficult year due

to the variable risks. The workforce was a particular difficulty due to what staff had experienced over the past few months, and balanced against demand of recovery and the waiting lists, this presented a challenge. The start of the year illustrated the Trust was in a better position due to sustaining activity for most of the year. Finally, there had been tremendous support from system partners with the opening of the "step up" "step down" beds throughout the pandemic which enabled patients to flow through the organisation. The support with waiting list management from the development of the Connected Health Network Programme had assisted with the management of patients. Lee Bond referred to the figures on page 18 which detailed the margin that would be made by driving activity through internal resources against buying activity from the independent sector. This showed that if the Trust carried out additional activity from Trust resources, the organisation would make a 75% profit, if this was carried out through the independent sector it would incur costs.

The Trust Board approved the paper.

2.10 Integrated Performance Report (IPR) – NLG(21)109

Helen Harris advised the IPR provided a detailed discussion of what had been discussed at sub-committees, the paper had been shared for assurance.

Terry Moran felt it was a useful paper that had highlighted some trends that were of concern. Lee Bond referred to risk stratification for outpatients which was detailed as 26% on page seven and whether this would be an issue. Shaun Stacey advised this was not a worrying position and reflected an honest position. It showed the activity that was being undertaken to highlight patients with higher risks who were long waiters. It also showed patients that were on a follow up and had not attended an appointment but were being risk stratified. The figures showed the work that promoted risk stratification that was being undertaken with the Trust primary care colleagues. The numbers would show a steady increase, and this would be benchmarked against the inpatient number which was sustained at a high percentage. It had been agreed as a board that the process would be a clinically led exercise and covered a significant volume of patients.

3. Strategic Objective 1 – To Give Great Care

3.1 Executive Report – Quality & Safety - NLG(21)110

Terry Moran noted the new layout of the paper, as it read well.

Linda Jackson queried why the 20% incentive payment was due to stop and whether the Trust were now confident ward areas could be safely staffed with substantive staff. Ellie Monkhouse was not fully confident of this but would continue to staff wards safely. Linda Jackson queried whether there would be a need to use agency staff when the incentive discontinued. Shaun Stacey advised a review had been undertaken and there had been limited evidence to show the scheme had helped. It had been identified that agency spend had risen which meant the Trust had paid this along with the incentive money. The focus for this year needed to be on the recruitment of staff to the Trust. Dr Peter Reading advised the incentive had been extended from the original timeframe due to added pressures.

Lee Bond explained work was to be undertaken with NHSE/I on how the Trust used agencies and which ones were used to try and standardise the rate that they charged. The vacancy rate for Health Care Assistants (HCAs) should have been at 0% by April 2021 but this had not been reached. Christine Brereton advised the Trust had consulted with NHSE/I for an operational zero vacancy rate and this had been achieved. The vacancy rate had changed due to starters and leavers along with the establishment change, however, all vacancies had been filled at the time.

Terry Moran referred to paper number NLG(21)110, regarding the structured judgement review issues, in particular when the six week requirement of 100% would be in a better place. There was concern that some reviews had not been undertaken for patients that had passed away in August 2020. Dr Kate Wood advised the next Mortality Improvement Group (MIG) was to be held that week and this issue would be discussed and agreed that those that had waited since August was a concern for the group. One of the biggest issues was the delays due to Covid-19 as it had taken attention away from other issues. Terry Moran asked if the Quality & Safety Committee (Q&SC) could oversee this after MIG had met. Dr Kate Wood advised this would be included within the next IPR.

3.2 Executive Report – Performance – NLG(21)111

Shaun Stacey highlighted the A&E issues as there had been high numbers of attendance that had presented challenge with flow. Patients had been using A&E when other options of access should have been used within community care through a pharmacy or 111. As patients were struggling to access General Practitioner (GP) care they had attended A&E which added to the pressure including staff not being able to care for urgent patients. Some patients were sent home with treatment methods to avoid admitting to wards.

Mike Proctor referred to the 78% increase in A&E attendance from last year and queried whether the 2019 figure should have been reviewed in respect of the pandemic. Performance in 2019 was 80% and was now 70% which showed a significant deterioration. Where the Trust aware of what had changed this position. Terry Moran noted a different model had been used due to Covid-19 in respect of social distancing. Shaun Stacey advised the different model in delivery at the front door had been used which had created delays. Secondly, the volume of activity that had arrived at the department had required investigation. Audits were to be undertaken to review who had attended to see how to address the issues. Gill Ponder referred to the Covid-19 swabbing and queried if it could be undertaken any quicker due to this being an enabler for patients being discharged into the community. Shaun Stacey explained work had been undertaken and it had improved from swabs taking 17 hours to now taking between four and 11 hours. The Trust had looked at introducing machines in A&E to enable this to be carried out quicker but the quality of the process outweighed this. This issue had been recognised across the country, however, the Trust had performed better than other parts of the country due to the in house pathology services.

3.3 Quality & Safety Committee Highlight Report and Board Challenge – NLG(21)112

Mike Proctor advised the Q&SC had reviewed the ophthalmology follow up waiting list. The report received had revealed there was no effective system of risk stratification which had meant the committee was not assured of the process in place. This meant clinical harm could not be assessed for 9,000 patients. The Divisions were to put in place a process whereby each speciality was identified by the risk stratification process but this would not be completed until October. It was noted that two maternity serious incidents (SIs) had been reported to the committee and discussion had taken place in respect of Ockenden requirements.

3.4 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(21)113

Gill Ponder noted that at the April meeting the Board Assurance Framework (BAF) report had been reviewed and the committee had been briefed on the operational plan. The cancer performance had not met standards but had performed well compared to other trusts in the region. The pandemic continued to impact on the Trust and recovery plans had been discussed.

3.5 Nursing, Midwifery & AHP Strategy – NLG(21)114

Ellie Monkhouse advised the report had been launched prior to being shared at the board and had been well received. It had also been shared at the Q&SC and TMB.

The Trust Board approved the strategy.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Executive Report - Workforce – NLG(21)115

Christine Brereton referred to the workforce data now being in a position to be included within the next IPR. Highlights to note were the restructure of the Directorate and thanks were noted for support received by the Executive team. The consultation would start the formal process to enable the directorate to strengthen. An implementation plan was in place in respect of the People Strategy for the next year which had been approved at the Workforce Committee (WC). Christine Brereton wanted to celebrate with Ellie Monkhouse the tremendous efforts put in place to reduce current vacancy rates.

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(21)116

Michael Whitworth advised that the committee had reviewed the work plan for the year and the BAF.

Terry Moran asked if Lee Bond was now satisfied with the confirmation on vacancy numbers. Lee Bond was now happy with the position but advised a review of the Trust vacancies would need to be undertaken. It was agreed further discussion by Lee Bond, Ellie Monkhouse and Christine Brereton would be undertaken outside of

the meeting. Ellie Monkhouse wanted to highlight the Trust was in the middle of reset so the establishment data had just been completed. The ward reviews were also due to start over the next couple of weeks so data may not be available the following month.

4.3 Freedom to Speak Up Guardian Update – NLG(21)117

Liz Houchin advised the main themes were around behaviour. There had also been an increased awareness of the guardian role. The Freedom to Speak Up (FTSU) index recently published had seen an improvement from the previous year figures. The Trust had, therefore, moved up 10 places. Christine Brereton explained the culture would also link into the FTSU work due to be undertaken at the Board Development session in July 2021 where Rachel Clarke would attend from NHSE/I. There would be a need to encourage a culture for freedom to speak up at the Trust. It was noted that the Trust had also received a low proportion of anonymous issues compared to other Trusts which was positive. Linda Jackson noted that although the Trust was a high reporter this was positive as staff felt confident to raise concerns. Elaine Criddle advised NHSE/I had undertaken key lines of enquiry with staff and it had been identified staff were aware of how to raise concerns. Liz Houchin thanked everyone for the continued support.

5. Strategic Objective 3 – To Live Within our Means

5.1 Executive Report - Finance – Month 01 - NLG(21)118

Lee Bond advised there was nothing further to raise following the earlier update in the Financial Plan 2021 / 22 – NLG(21)107.

5.2 Executive Report – Estates & Facilities – NLG(21)119

Jug Johal advised the report was separated into the different functions within Estates & Facilities.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – April & May 2021 – Finance - NLG(21)120

Gill Ponder advised that the non-validated report shared in May had highlighted the Trust had suggested it had over delivered activity against the threshold in Month one. This was positive in terms of securing the additional income for exceeding the threshold, however, this would only be received if the whole system exceeded the threshold.

Shaun Stacey advised that in terms of the performance of the ICS, the joint Chief Operating Officers across the system meet regularly to support each other with elective delivery to ensure the thresholds are met.

Lee Bond queried whether a report on the Digital infrastructure should be provided by Shauna McMahon. Terry Moran agreed with the point raised and asked if Dr Peter Reading felt this should be shared. Dr Peter Reading agreed this was important and felt the profile of digital should be recognised. It was agreed a report

would be provided going forward.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Executive Report – Strategic & Transformation – NLG(21)121

Ivan McConnell advised there had been significant progress made with the Humber Acute Services Review (HASR). Richard Barker and Stephen Eames had undertaken a stocktake and assurance review of the programme and highlighted issues of collaboration, pace and determination including the great work undertaken. Dr Peter Reading advised a meeting had taken place with Richard Barker and positive feedback was received.

The board were advised Amanda Pritchard would visit the Scunthorpe site on Friday, 11 June and as part of the visit a presentation would be shared on HASR. It was hoped Amanda Pritchard would recognise the improvements made at the Scunthorpe site.

6.2 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – May 2021 – NLG(21)122

Linda Jackson advised the committee had reviewed seven business cases and all had been approved. Although Neil Gammon had left the NED role, his role as the Chair of the Health Tree Foundation Trustees' Committee would continue.

6.3 Health Tree Foundation Trustees' Committee Terms of Reference (TOR) – NLG(21)123

Linda Jackson sought approval of the updated TOR. The Trust Board approved the TOR.

7. Strategic Objective 5 – To Provide Good Leadership

There were no papers under this item.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – NLG(21)124

Andrew Smith advised the Trust Risk Strategy had been built into the work programme, which had previously been delayed but progress was now due to start.

8.2 Non-Executive Director Statutory Roles – NLG(21)125

Terry Moran referred to Maneesh Singh and Stuart Hall and advised they were not formal members of the Remuneration Committee as they were Associate NEDs (ANEDs). A further amendment was to align Mike Proctor as the NED Champion for Maternity. It was agreed the paper would be approved with the amendments made.

8.3 Executive Director Statutory Roles – NLG(21)126

Shaun Stacey advised changes needed to be made under the Chief Operating Officer section. A further amendment was to be made in respect of Ellie Monkhouse in respect of the Chief Nurse role. It was agreed that both updates would be provided to Sarah Meggitt. The paper was agreed with the amendments being made.

8.4 Health & Safety Policy Statement – NLG(21)127

Jug Johal highlighted there was a key addition to paragraph three of the report due to significant ongoing work on all sites. The Trust Board approved the paper.

8.5 Trust Board – Business Reporting Framework – NLG(21)128

Helen Harris advised the reporting schedule went up to December 2022. The report included additional detail on page five in terms of guidance on the paper being for approval or assurance. A further supplementary page was included on page six which detailed NED and Executive reports.

The Trust Board approved the paper.

9. Approval (Other)

9.1 Committees in Common Terms of Reference – NLG(21)129

Terry Moran advised the Terms of Reference related to Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospital (HUTH) working together and how to achieve this in a structured way. This did not, however, relate to a merger of the Trusts. HUTH had approved the same Terms of Reference at its Trust Board meeting. Dr Kate Wood referred to Appendix A as it did not include the Director of People as a core member. Terry Moran advised that when core membership was discussed it was agreed this role would be invited if an item was on the agenda. It was felt they could be added at a later stage and any changes would be submitted to the boards for further approval.

The Trust Board agreed to approve the paper.

10. Items for Information

11. Any Other Urgent Business

There were no items of any other urgent business raised.

12. Board Reflection – NLG(21)130

Terry Moran noted the paper and highlighted some low scoring on some of the feedback. Terry Moran advised board members would be asked to comment on this meeting. Terry Moran sought any comments for the paper. None were received.

13. Questions from the Public

Terry Moran sought comments from members of the public. No questions were received.

13. Date and Time of the next meeting

CQC Board Briefing
Tuesday, 15 June 2021

Board Development
Tuesday, 6 July 2021, Time TBC

Formal Trust Board Meeting
Tuesday, 3 August 2021, Time: TBC
Via video conference

The Private Trust Board meeting was due to follow at 13:30 hours via video conference.

Terry Moran closed the meeting at 12.33 hours.

Cumulative Record of Board Director's Attendance (2021/22

Name	Possible	Actual	Name	Possible	Actual
Mr Terry Moran	2	2	Mrs Shauna McMahon	2	2
Dr Peter Reading	2	2	Mrs Ellie Monkhouse	2	2
Mr Lee Bond	2	2	Mrs Gillian Ponder	1	1
Mrs Christine Brereton	2	2	Mr Michael Proctor	2	2
Mr Neil Gammon	1	1	Mr Maneesh Singh	1	1
Mr Stuart Hall	2	1	Mr Andrew Smith	2	2
Mrs Helen Harris	2	2	Mr Shaun Stacey	2	2
Mrs Linda Jackson	2	2	Mr Michael Whitworth	2	2
Mr Jug Johal	2	2	Dr Kate Wood	2	2
Mr Ivan McConnell	2	2			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PRIVATE) – SELF CERTIFICATION

Minutes of the Private Meeting held on Tuesday, 25 May 2021 at 1.30 pm
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
Mr Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Mrs Linda Jackson	Vice Chair
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
Mrs Helen Harris	Directorof Corporate Governance
Mr Jug Johal	Director of Estates & Facilities
Mr Ivan McConnell	Director of Strategic Development
Mrs Gillian Ponder	Associate Non-Executive Director
Mr Maneesh Singh	Associate Non-Executive Director
Mrs Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Trust Secretary (note taker)

Business Items

1. Chair's Opening Remarks

Terry Moran welcomed Board members to the meeting and declared it open at 1.30 pm.

2. Apologies for Absence

Apologies of absence were received from Stuart Hall and Neil Gammon.

3. Declarations of Interest

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

4. Minutes of the previous event held on the 27 May 2020 – NLG(21)102a

The minutes of the Trust Board Self-Certification meeting held on Wednesday, 27 May 2021 were approved as a true and accurate record and would be duly signed by the Chair.

5. Introduction to & Purpose of the Event

Helen Harris thanked the Executive team and colleagues for the support provided to undertake the self-certification process. The purpose of the meeting was to review and provide assurance that the Trust were compliant with the licence against G6(3) – The Provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution, G6(4) – Publication of condition G6(3) self - certification, FT4(8) – The provider has complied with required governance arrangements and CoS(7)3 – The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of Care Records Service. The board were asked to note and consider those areas that were not confirmed.

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

Tom Watson advised Internal Audit had reviewed in detail the evidence provided and this had supported the statements made. The programme of work had also been considered which highlighted no major concerns. The process had shown significant assurance on overall governance and risk management at Northern Lincolnshire & Goole NHS Foundation Trust (NLAG). Terry Moran queried any concerns or matters of clarification, no comments were received.

7. Self-Certification Review – NLG(21)102

Helen Harris advised those not confirmed had not met the standard, however, this had no impact on the Trust continuing as a provider.

Terry Moran referred to A&E on page 22 of the report and questioned if board members had a different view to it not being confirmed. Andrew Smith queried whether the organisation had improved with performance from the previous year as it had been not confirmed in 2020. Abdi Albofazl advised the performance for this year had been constant and the performance compared to the previous year had improved. The performance in A&E needed to be reviewed due to the increased activity. Ellie Monkhouse queried whether the context within the report was worded strongly enough to show the impact of Covid-19. The Trust Board agreed this should remain not confirmed.

Terry Moran went through the other sections listed as not confirmed and queried whether the Trust Board required any further clarification. The Trust Board agreed the following statements should remain as not confirmed:

- Cancer performance
- Referral to Treatment
- Care Quality Commission (CQC)

Terry Moran questioned whether board members had any queries that related to the confirmed statements.

Dr Kate Wood referred to the Integrated Performance Report (IPR) as it stated this had been established and embedded. Due to the concern with data quality Dr Kate Wood felt the wording should be changed to say that there was still work to be carried out with the IPR. Helen Harris agreed to change the wording to be more specific to ensure it reflected this in both statements. It was agreed this should remain confirmed.

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

Andrew Smith queried whether this would be shared with other Trusts and if any comparison would be made. Helen Harris explained there was currently no comparison or benchmarking in place. The organisation had to evidence that the process had been undertaken in case any criteria was asked for in the future. Andrew Smith queried whether the not confirmed statements had to be included in recovery plans so that confirmation could be seen when the exercise was undertaken again. Terry Moran felt the points raised were fair to evidence this had been recognised, however, it was felt the Trust Priorities directly addressed the issues in the not confirmed statements.

Dr Kate Wood referred to page 43 as an alteration was required in respect of the national guidance where it referred to the Quality Account. It was agreed this change would be made to the paper.

Helen Harris queried if the board were happy to hold the self-certification event in a similar way going forward. The Trust Board agreed to this process.

8. Any Other Urgent Business

There were no items of any other urgent business.

6. Date and Time of next meeting

Public & Private Meeting
Tuesday, 1 June 2021, Time TBC

The meeting closed at 14:00 hours.

Cumulative Record of Board Director's Attendance (2021/22)

Name	Possible	Actual	Name	Possible	Actual
Mr Terry Moran	2	1	Mrs Shauna McMahon	2	2
Dr Peter Reading	2	1	Mrs Ellie Monkhouse	2	1
Mr Lee Bond	2	2	Mrs Gillian Ponder	1	1
Mrs Christine Brereton	2	2	Mr Michael Proctor	2	2
Mr Neil Gammon	2	2	Mr Maneesh Singh	1	1
Mr Stuart Hall	2	2	Mr Andrew Smith	2	2
Mrs Helen Harris	2	2	Mr Shaun Stacey	2	2
Mrs Linda Jackson	2	2	Mr Michael Whitworth	2	2
Mr Jug Johal	2	2	Dr Kate Wood	2	2
Mr Ivan McConnell	2	2			

NLG(21)149

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?
None										

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?

Key:

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

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)150

DATE OF MEETING	03 August 2021
REPORT FOR	Trust Board
REPORT FROM	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Quarter 1 - Trust Priorities and Integrated Performance Report (IPR)
BACKGROUND DOCUMENT (if any)	Access and Flow – IPR (June Data) Quality and Safety – IPR (May Data) Workforce – IPR (May Data) Trust Priorities Quarter One Report
OTHER GROUPS WHO HAVE CONSIDERED PAPER AND OUTCOME	Quality and Safety Committee (Q&SC) – 16 July 2021 Executive Team – 27 July 2021 Workforce Committee – 27 July 2021 Finance and Performance Committee (F&PC) – 28 July 2021
EXECUTIVE SUMMARY	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures, and describes the specific actions that are under way to deliver the required standards. Quarter 1 performance updates against the Trust Priorities are also incorporated into each section, with an overview section following the IPR scorecards. **2. Access and Flow** The key areas to note are: - The Emergency Departments are currently seeing increased levels of attendances and the department is facing pressure in moving patients through the system 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, Emergency Department waits and ambulance handover delay target - The Trust is already being challenged by the Wave three COVID19 which is being managed by the teams as proactively as possible - The Department has recently implemented a new East Midlands Ambulance Service (EMAS) direct streaming to Same Day Emergency Care (SDEC) service at both sites - Continued frailty pilot at DPOW which provides improved patient experience for frail patients with 95% discharged during the initial pilot - All wards now have senior consultant presence at board

	rounds before 10am to aid patient discharges - Referral to Treatment (RTT) continues to see an increasing number of patients waiting, resulting in performance of 68.3% for June 2021; (unvalidated 67.07% as of 21st July 2021). There were 1,285 patients that have waited in excess of 52 weeks at our peak at the end of February 2021, this has since reduced to 511 in June 2021; (unvalidated 490 as of 21st July 2021) - The cancer two week wait standard continues to be achieved at 98.2% in June 2021 (96.4% as at 21st July 2021). Pressures remain in achieving the 31 day first treatment standard but the target of 96.0% was met for June 2021 (97.4% as at 21st July 2021). The 62 day standard for GP referrals was 65.9% for June 2021 against the target of 85.0% (70.4% as at 21st July 2021), this is due to capacity, primarily within the diagnostic modalities - Diagnostic services has seen an increase in performance but was limited due to treating patients on urgent and cancer pathways and reduced capacity in some modalities - Performance against H1 Elective Recovery Fund (ERF) currently demonstrates 93% achievement with over achievement in first attendances and day cases and under achievement in other point of delivery (PODs) including ordinary electives For full details, please see executive summary on page 5. **3. Quality and Safety** The performance of all indicators was considered and reviewed at the July Quality and Safety Committee meeting. Statistical Process Control (SPC) charts have been removed for the majority of indicators performing within the set limits or where limits have not yet been established. Development of the Quality and Safety IPR section is ongoing and the scorecard continues to detail all indicators. The key points to note are: - The mortality position (sustained 'as expected' SHMI, with continued focus on Out of Hospital position through the system End of Life work) - Number of Structured Judgement Reviews (SJRs) undertaken is not at the anticipated level due to operational pressures - Venous Thromboembolism (VTE) monitoring and reporting has many actions in place - A number of IPR metrics are also under development with the Information and Performance team. **4. Workforce** It is recommended that the full Workforce IPR will be shared at the Trust Board meeting in August 2021 and the Workforce Committee will consider exemption reporting for future Trust Board meetings, for indicators that are delivering or within the control limits. **5. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and

	measures. c) Note the report describes the specific actions which are under way to deliver the required standards.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓	✓			✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	✓
Quality and Safety	✓	**Digital**	
Estates, Equipment and Capital Investment		**Strategic Service Development and Improvement**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Objective 1: To Give Great Care** **a) Description of Strategic Objective 1 - 1.1:** To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. **Risk to Strategic Objective 1 - 1.1:** The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience. **b) Description of Strategic Objective 1 - 1.2:** To provide treatment, care and support which is as safe, clinically effective, and timely as possible. **Risk to Strategic Objective 1 - 1.2:** The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care. **c) Description of Strategic Objective 2:** To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviors, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. **Risk to Strategic Objective 2:** The risk that the Trust does not

	have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients. **d) Description of Strategic Objective 5:** To ensure that the Trust has leadership at all levels with the skills, behaviors and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. **Risk to Strategic Objective 5:** The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
				✓	

Access and Flow
Objective: To give great care
The Emergency Departments are currently seeing increased levels of attendances and the department is facing pressure in moving patients through the system 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, Emergency Department waits and ambulance handover delay target. The Trust is already being challenged by the Wave three COVID19 with increasingly more numbers at Grimsby Hospital (DPOW) compared to Scunthorpe Hospital (SGH). The workforce challenges particularly medics and nursing due to sickness and self-isolation yet again has created a serious challenge which is being managed by the teams as proactively as possible. The Department has recently implemented a new EMAS direct streaming to SDEC service at both sites and the trust is an early adopter in the region to go live with direct bookable arrival slots in ED at Grimsby for the SPA as part of the "NHS111 First" initiative programme to try and increase performance. Also in conjunction with the system partners 3 audits at the front door have been undertaken and the identified opportunities are being progressed through the newly established Patient Flow Improvement Group led by the Trust's Chief Operating Officer. A frailty service pilot at DPOWH commenced on 12 May 2021 for four weeks providing improved patient experience for frail patients on SDEC instead of ED with 93% of patients being discharged from SDEC. This service has been continued beyond the pilot. Pathways for EMAS to access advice and guidance through SPA to avoid acute attendances where possible have been implemented. All wards now have senior consultant presence at board rounds before 10am to aid discharge and are able to report if and when a patient no longer meets the criteria to reside in an acute hospital bed, by completing webV. RTT continues to see an increasing number of patients waiting, resulting in performance of 68.3% for June 2021; (unvalidated 67.07% as of 21st July 2021). There were 1,285 patients that have waited in excess of 52 weeks at our peak at the end of February 2021, this has since reduced to 511 in June 2021; (unvalidated 490 as of 21st July 2021). 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 COVID19 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 two week wait standard continues to be achieved at 98.2% in June 2021 (96.4% as at 21st July 2021) though there are some pressures in achieving the 31 day first treatment standard but the target of 96.0% was met for June 2021 (97.4% as at 21st July 2021) and the 62 day standard was 65.9% for June 2021 (70.4% as at 21st July 2021), again this is as a result of capacity, primarily within the diagnostic modalities. Diagnostic services has seen an increase in performance but was limited due to treating patients on urgent and cancer pathways and reduced capacity in some modalities, which has been partially addressed through the opening of the new scanning facilities at DPOW recently 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. Performance against H1 Elective Recovery Fund (ERF) currently demonstrates 93% achievement with over achievement in first attendances and day cases and under achievement in other PODs including ordinary electives.

Quality & Safety
Objective: To give great care
The Trust's Summary Hospital-level Mortality Indicator (SHMI) remains as expected and has shown statistically significant improvement throughout the year, with the Hospital Standardised Mortality Ratio (HSMR) also presented which also shows a reduction to beneath 100 which is positive. Patient observations recorded in line with timescales (with 30mins grace period) has remained above the 85% target set even during the pandemic and the related challenges with donning/doffing personal protective equipment (PPE) and zoning changes. This is a significant achievement. May shows performance remaining above 90%. Blood glucose being recorded for paediatric patients with a paediatric early warning score (PEWS) of >1 has improved to 90%. The monthly audit data is being reviewed with the Paediatric team. Priority cases (based on national guidance) or those identified from the quality screening process as requiring more in depth mortality review using structured judgment reviews (SJR) are not happening within timescales with a backlog of cases. There are older cases from 2020 that have been outstanding a review using SJR. During the month of June, from escalation within medicine, this number has been reduced. Further focus will be given to this in July to reduce further. The data also demonstrates some areas where performance is not yet meeting agreed targets. Sepsis remains as a gap with regard to assurance data available. No data is currently available to determine the rate of sepsis screening either via e-screening (using WebV) or paper based processes still in use throughout the Trust (as measured through audit). Plans are in place to undertake an audit and improve the process for accessing the e-screening tool. Duty of candour performance reported in the IPR is related to Serious Incidents and is positive. There are some gaps still in completion of duty of candour for instances of moderate harm through COVID19. This is not currently shown in the reported data. The Trust's response to COVID19 pressures has resulted in less capacity in Divisions to fully resolve this, but work is currently underway with Divisions. Venous thromboembolism (VTE) risk assessments are reporting as special cause variation with the last six months data being under the lower control limit. Latest data had suggested an improving picture, but performance dipped during May. This will be monitored and an update is due to the Quality Governance Group (QGG) in July on VTE. New Quality Priorities agreed for 2021/22 that now feature in the report are: • Deaths within 24 hours of admission. This is to focus on end of life (EOL) patients being admitted for unplanned acute care which could signal a failure in their advanced care plan. It is not possible to identify EOL patients from the data, so this quality indicator will be used to focus deep dives to investigate this in greater detail and share learning with System partners.

Workforce
Objective: To be a good employer

Trustwide Vacancies
Trustwide vacancies are outside the median range but has reduced since an increase in establishment in April 2021. Recruitment activity, across various workstreams including regular recruitment and projects for international nursing and healthcare assistants (HCAs), is ongoing at an increased rate. In the last 12 months recruitment activity has increased by 25%. Travel difficulties are delaying starts for new employees for overseas, with regular engagement taking place to facilitate starts as quickly as possible.

Registered Nurse Vacancies
Registered nurse vacancies are below the median range. Recruitment activity is ongoing across projects, including sourcing candidates from overseas via the Trust's Talent Acquisition Team, Yeovil NHS Trust's international nurse recruitment programme, and newly qualified nurse recruitment which has resulted in circa 80 newly qualified nurses (NQNs) sourced so far to commence in Q3. This activity is overseen by the project group led by the Deputy Chief Nurse.

Medical Vacancies
Medical vacancies are outside of target, this is largely due to an increase in establishment in April 2021. Recruitment activity is ongoing, with a pipeline of 76 doctors appointed awaiting start who the recruitment team are engaging with regularly and supporting to facilitate starts as quickly as possible.
Travel difficulties are causing some issues with delaying start dates. Alongside regular recruitment activity, including medical training initiative (MTI) scheme recruitment, the Talent Acquisition Team will now start to attempt to source senior medical staff for particularly hard to fill roles.

Unregistered Nurse Vacancies
Unregistered nurse vacancies are below the median range. Overall vacancies have reduced significantly since the implementation of a recruitment project focusing on this staff group. This project continues through regular recruitment to recruit to a pool of staff who are appointed and ready for allocation to roles to cover vacancies and ongoing turnover. Retention of unregistered nurses is a potential risk, with turnover increasing in newly appointed staff recently. This will be mitigated by effective use of information to inform candidates who are new to healthcare what the role entails and the environment they will be working in. This activity is overseen by a project group led by the Deputy Chief Nurse.

Turnover
The 12 month Trust wide turnover rate stands at 9.50% in May 2021, within the annual target of <9.4%. This time last year the annual turnover rate stood at 9.33%. Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%. An increased emphasis on prevention of avoidable leavers by improving cultures and strengthening leadership where appropriate. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround.

Sickness
The Trust's Sickness Percentage in April 2021 stood at 4.94% which is outside the Trust target of <4.1%. The Trust has now employed a new Health and Wellbeing business partner to specifically drive the Health and Wellbeing agenda due to commence on the 31st August. Daily monitoring has recommenced with Incident Coordination Centre (ICC) and Infection Control lead to monitor specifically COVID absences. Staff who are shielding due to Post Travel, Household Member with Symptoms and Track and Trace are not reflected on the chart's enclosed, however this impacts staffing levels as the special leave type is starting to increase. High portion of NLAG staff are double vaccinated ,the end to test and trace self-isolation from the 16th August, those employees that have come to contact with a positive case of coronavirus will be except from quarantining at home for up to ten days.

PADR
The Trust PADR Percentage is 79% In May 2021. Please note that this figure does not include Medical Staff this is due to Medical Staff PADR's being extended for a six month period due to COVID19 which ESR does not reflect. The Training and Development Department will continue targeting Managers with low compliance by sending out reminders, and guidance for completion. We will continue to target and consider an escalation process for those areas not complying.

Mandatory Training
The Core Mandatory Training Percentage for May 2021 stood at 91% which is over the trust target of 90%. Over the last three months Core Mandatory Training compliance has increased and is now close to pre-COVID19 levels for this time of year. The Core Mandatory Training compliance position has been static for the last three months.
The Role Specific Training Percentage for May 2021 stood at 80% which is on target. Role Specific Mandatory Training saw a rise in August and September last year, over the last three months the compliance position has been static. A new target has been made for Role specific which is 80% by end of December 2021 and 85% by end of March 2022 , this is a slight change from the previous target which was 80% by September 2021.
The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. We will continue to target and consider an escalation process for those areas not complying. The Training and Development Department will ensure all data is processed and support class administrators are supported with data collections. Auto enrolment has now been switched on in Electronic Staff Record (ESR) making this easier for staff to complete eLearning modules.

Ref	Metrics	Jun 2021	Target	Variance	Assurance Inconsistency	Indicator Status
	RTT waiting times for non-urgent consultant-led treatment					
AF001	Maximum time of 18 weeks from point of Referral To Treatment (RTT) in aggregate - patients on an incomplete pathway. 18 week % - Unvalidated snapshot	68.25%	92.00%			NNS
AF002	Total outpatient follow up waiting list size	102,265	105,474			LSAR
AF003	Total inpatient waiting list	10,312	11,536			LSAR
AF004	Number of incomplete RTT pathways 52 weeks - Unvalidated snapshot	511	0			NNS
AF005	Maximum 6-week wait for diagnostic procedures (Diagnostic Measurement 01)	33.28%	1.00%			NS
	A&E waits					
AF006	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (4 hour target)	74.63%	95.00%			NS
AF007	Count of Ambulance Handover delays 15-30mins	1034	0			NS
AF008	Count of Ambulance Handover delays 30-60mins	303	0			NS
AF009	Count of Ambulance Handover delays 60+ mins	127	0			NS
AF010	Waits in A+E not longer than 12 hours from Decision To Admit	0	0			NS
	Cancer waits					
AF011	Cancer Waiting Times - 2 week wait	98.23%	93.00%			NNS
AF012	Cancer 2 week wait (breast symptoms)	98.95%	93.00%			NNS
AF013	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	61.54%	75.00%			NNS
AF014	Cancer Waiting Times - 31 Day First Treatment	96.00%	96.00%			NNS
AF015	Cancer Waiting Times - 31 Day Surgery	100.00%	94.00%			NNS
AF016	Cancer Waiting Times - 31 Day Drugs	100.00%	98.00%			NNS
AF017	Cancer Waiting Times - 62 day GP referral	65.87%	85.00%			NNS
AF018	Cancer Waiting Times - 62 day Screening	70.00%	90.00%			NNS
	Trust Priorities - Improve the Trust's waiting list with a focus on 40 week waits, total list size and out patient follow up					
AF019	The number of patients overdue their follow up for an outpatient review	27,065	9,000			LSAR
AF020	Overall size of the RTT waiting list	31,454	25,227			LSAR
AF021	50% of out-patient summary letters to be with GPs within 7 days	35.02%	50.00%			LTBC
AF022	Reduce the number of face to face follow up appointments by 10% by 31 March 2021.	13,401	15,903			LTBC
	Improve the effectiveness of cancer pathways focussing on time to diagnosis					
AF023	Cancer waiting times - 104+ day backlog	33	0			LSAR
AF024	Care of patients with confirmed cancer diagnosis transferred by day 38 to be at 75%	6.67%	75.00%			LSAR
AF025	100% Cancer request to test report to be no more than 14 days	79.82%	100.00%			LSAR

Ref	Metrics	Jun 2021	Target	Variance	Assurance Inconsistency	Indicator Status
	Trust Priorities - Improve safe flow and dscharge through the hospital focussing on outliers, late night patient transfers and discharges bfore noon					
AF026	Average Length of Stay (all)	*3.79*	4.00			LSAR
AF027	% of patients who were discharged on the same day as admission (excl Daycase)	*39.95%*	32.00%			LSAR
AF028	Non Elective Average Length of Stay	*3.98*	4.10			LSAR
AF029	Elective Average Length of Stay	*2.59*	2.40			LSAR
AF030	30 day emergency re-admission rate	*7.99%*	0.00%			LSAR
AF031	Number of Medical Outliers	2501	No Target		N/A	LTBC
AF032	Discharge letters to be completed within 24 hours post discharge	87.42%	85.00%			LTBC
QS043	Discharge Letters - Trauma and Orthopaedics	95.62%	85.00%			LTBC
QS044	Discharge Letters - Ophthalmology	*24.77%*	85.00%			LTBC
AF033	Progressive improvement in the number of golden discharges from April 2020	*17.30%*	35.00%			LTBC
AF050	Discharges before 5pm	*70.55%*	70.00%			LTBC
AF034	Increase in A&E performance to 83.5%	*74.63%*	80.00%			LSAR
AF035	Reduction of non emergency patient transfers at night after 10pm by 10%	*6.64%*	2.80%			LTBC
AF036	Reduction in average ward moves for non elective patients for non clinical reasons by 7%	*9.63%*	4.60%			LTBC
AF037	Risk Stratification Inpatients	99.82%	99.00%			LSAR
AF038	Risk Stratification Outpatients	*28.83%*	99.00%			LSAR
AF039	40-51 week waiters - Unvalidated snapshot	*1,433*	0			NNS
AF047	Stranded Patients - 7+ days	238	No Target		N/A	LSAR
AF057	Stranded Patients - 14+ days	103	No Target		N/A	LSAR
AF048	Stranded Patients - 21+ days	49	No Target		N/A	LSAR
AF047	COVID patients in ICU beds	1	No Target		N/A	LSAR
AF048	COVID patients in other beds	4	No Target		N/A	LSAR
AF049	COVID staff absences	7.27%	No Target		N/A	LSAR

Ref	Metrics	May 2021 unless otherwise stated	Target / Trajectory	Variation	Assurance
	National Requirements				
QS001	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	0.00		
QS002	Methicillin - susceptible Staphylococcus aureus (MSSA) bacteraemias	1	0.00		
QS003	Escherichia coli (E.coli) bacteraemia bloodstream infection (BSI)	1	0.00		
QS004	Trust attributed C-Diff	3	No Target		No Target
QS005	Number of gram-negative bloodstream infections	3	No Target		No Target
QS006	Venous Thromboembolism (VTE) risk assessment	77.73%	95.00%		
QS007	Duty of candour	100.00%	No Target		No Target
QS008	Emergency C-section rate	16.27%	15.20%		
QS009	Patient Safety Alerts to be actioned by specified deadlines	100.00%	0.00%		
QS010	Serious incidents - Raised in month	7	No Target		No Target
QS011	Occurrence of any Never Event	0	0.00		
QS012	Hospital Standardised Mortality Ratio (HSMR) **- Data is for April 2021**	84	As expected		As expected
QS013	Summary Hospital level Mortality Indicator (SHMI) **- Data is for January 2021**	106	As expected		As expected
QS014	Formal Complaints per 1000 WTE	7.8	No Target	Not an SPC	Not an SPC
QS015	Mixed-sex accommodation breaches	Submission paused	0		
QS016	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	Process not fully rolled out	No data		
QS017	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	No electronic data	90%		
QS018	Proportion of Service Users **inpatients** who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	No electronic data	90%		
QS019	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	Submission paused	90%		
QS020	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	Submission paused	90%		
QS021	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 b) was positive or inconclusive, are referred on to specialist services	Submission paused	90%		
QS022	Inpatient scores from Friends and Family Test - % positive	95.80%	No target	Not an SPC	Not an SPC
QS023	A&E scores from Friends and Family Test - % positive	71.70%	No target	Not an SPC	Not an SPC
QS024	Maternity Scores from Friends and Family Test - % positive	94.20%	No target	Not an SPC	Not an SPC
QS025	Community Services Score from Friends and Family Test - % positive	94.50%	No target	Not an SPC	Not an SPC
QS026	Staff Friends and Family Test - % positive	no data this month	No target		
	Trust Priorities				
	End of Life and Related Mortality				

QS027	Reduction in the number of patients dying within 24 hours of admission to hospital	15.8%	No Target		Not set
QS028	Reduction in the number of emergency admissions for people in the last 3 months of life	In development			
QS029	Reduction in the out of hospital SHMI to 110 by March 2022 **- Data is for January 2021**	129.91	110.00		
QS030	Structured Judgement Reviews	50.00%	100.00%		
	Deteriorating Patient and Sepsis				
QS031	90% of adult observations are recorded (with a 30 min grace)	91.66%	90.00%		
QS032	90% of child observations are recorded (with a 30 min grace)	90.00%	90.00%		
QS033	Escalation of NEWS in line with Policy	In development			
QS034	Sepsis screen in 90% of patients with a sepsis 6 indicator	Data not available			
	Reduction of Medication errors				
QS035	Improvements in recording patient weights in relation to paracetamol prescribing on the integrated admissions ward	In development			
QS036	Insulin administered on time on 85% within wards using EPMA	In development			
QS037	Reduction in medication omissions without a valid reason for ward areas using EPMA	In development			
	Safety of Discharge to be reported through access and flow				
QS038	Improve the proportion of patients discharged before 12 noon	15.95%	30.00%		
QS039	Improve the proportion of patients discharged before 5pm	68.91%	70.00%		
QS040	Improving trend showing a reduction in length of hospital stay above 7 days	255	No Target		N/A
QS041	Improving trend showing a reduction in length of hospital stay above 14 days	102	No Target		N/A
QS042	Improving trend showing a reduction in length of hospital stay above 21 days	60	No Target		N/A
QS043	Improve the timeliness of discharge letters within Orthopaedics	98.35%	95.00%		
QS044	Improve the timeliness of discharge letters within Ophthalmology	40.43%	95.00%		
	Diabetes Management				
QS045	Diabetes Audit finding	75.00%	0.00%	Not an SPC	Not an SPC
QS046	100% of BM taken in ECC in adults when NEWs of >1	97.5%	100.00%		
QS047	100% of BM taken in ECC in paediatrics when PEWs of >1	90.00%	100.00%		
QS048	90% Relevant staff have completed mandatory diabetes training	86.14%	90.00%		

Ref	Metrics	May 2021 unless otherwise stated	Target / Trajectory	Variation	Assurance
	National Requirements				
W001	Unregistered Nursing Vacancy Rate	6.20%	2.00%		
W002	Registered Nursing Vacancy Rate	9.70%	8.00%		
W003	Medical Vacancy Rate	15.80%	15.00%		
W004	Turnover Rate	9.50%	9.40%		
W005	PADR Rate	79.00%	85.00%		
W006	Sickness **- April 2021**	4.87%	4.10%		
W007	Trustwide Vacancy Rate	9.50%	7.00%		
W008	Core Mandatory Training Compliance	91.00%	90.00%		
W009	Role Specific Mandatory Training Compliance	80.00%	80.00%		

Trust Priorities 2021/22

Methods of Measurement and Timescales

	Operational Standards	Audience	Cross reference KPI
TP1 Pandemic Response	**We will maintain and deliver as full and urgent and elective service as resources will allow during and after the pandemic including:** delivery of the Phase 3 (H1) recovery plan	IPR (F&P)	AF
	an emergency response, through 80% of patients managed within 4 hours	IPR	AF006(a)
	Community Single Point of Access (SPA) with 70% of patients receiving a crisis response within 4 hours	IPR	AF056
	a reduction to zero by 31.3.22 of patients waiting in excess of 52 weeks	IPR	AF004
	reduction in those waiting in excess of 104 days for cancer treatment	IPR	AF023
	Full risk stratification of outpatients	IPR	AF038
	Full risk stratification of inpatients	IPR	AF037
TP2 Workforce & Leadership	**We will strenghten recruitment and retention**		
	Medical Vacancy Rate	IPR	WF005
	Total Nurse vacancy rate	IPR	WF006
	Staff Fill rate	IPR	WF007
	Registered Nurse vacancies	IPR	WF012
	Unregistered Nurse vacancies	IPR	WF008
	Turnover rate	IPR	WF002
TP3 Quality & Safety	We will redesign our **QI** offer	IPR	TBC
	End of Life: Reduction in the number of patients dying within 24 hours of admission to hospital	IPR	QS007
	Reduction in the number of emergency admissions for people in the last 3 months of life	IPR	QS028
	Reduction in the out of hospital SHMI to 110 by March 2022	IPR	QS029
	Deteriorating patient and Sepsis: Adults: Timeliness of observations within 30 minutes of due time >90%	IPR	QS031
	Children: Timeliness of observations within 30 minutes of due time >90%	IPR	QS032
	Improve frequency of sepsis screening and robustness of reporting: Escalation of NEWS in line with policy	IPR	QS033
	Sepsis screen in 90% of patients with a sepsis six indicator	IPR	QS034
	Reduction in medication errors: Improvements in recording patient weights in relation to paracetemol prescribing on the AAU	IPR	QS035
	Insulin administered on time in 85% within wards using EPMA	IPR	QS036
	Reduction in medication omissions without a valid reason for ward areas using EPMA	IPR	QS037
	Improve the proportion of patients discharges before 12noon (30%)	IPR	AF033
	Improve the proportion of patients discharges before 5pm (70%)	IPR	AF050
	Reduction in LOS 7 days	IPR	AF047
	Reduction in LOS 14 days	IPR	AF057
	Reduction in LOS 21 days	IPR	AF048
	Diabetes findings: 100% of BM taken in ECC in adults when NEWS <1	IPR	QS046
	Diabetes findings: 100% of BM taken in ECC when PEWS <1	IPR	QS047
	Blood Glucose taken in ECC if NEWS >1 in adults	IPR	QS056
	Blood Glucose taken in ECC if PEWS >1 in children	IPR	QS057
TP7	Achievement of the financial plan	IPR	FUR004
	Achievement 21/22 HCV system financial control total	IPR	FUR005

Indicator: AF001 RTT 18 weeks - Latest month represents the unvalidated snapshot — National Indicator

Period	Lower CL
Jun 2021	65.6%

Value	Median
68.3%	71.1%

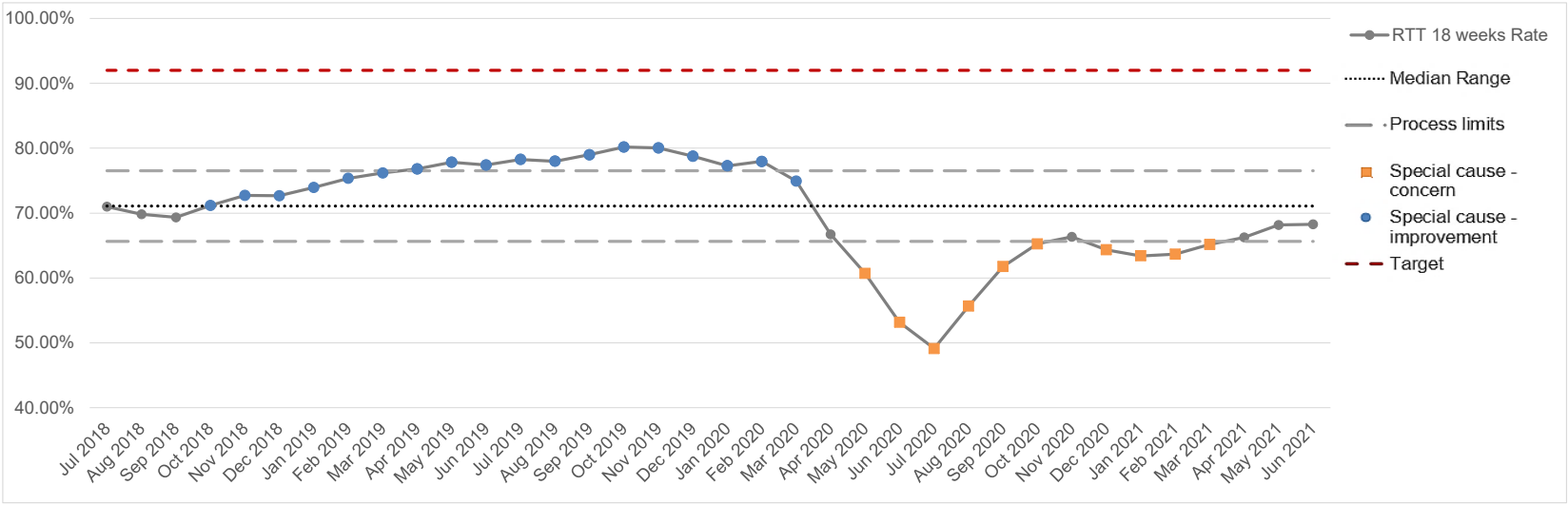
Target	Upper CL
92.0%	76.5%

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
Note: The latest month figure represents the most recent month end snapshot which is currently unvalidated. Medicine division performance is currently 75.57% with a week on week improvement for the last few weeks. The division has 7/11 specialties above 92% threshold with the remaining specialties showing improvements in RTT performance week on week.	Medicine Division Activity Recovery Plans for 2021-22 for every specialty are in place, External Providers sourced for Gastroenterology, Respiratory, Cardiology, Endocrinology. Additional sessions being delivered by internal consultants also.

Issues And Risks	Mitigations
Across most specialties in medicine, there remains some capacity risks in the coming weeks due to the summer months and annual leave being taken reducing clinic capacity as clinicians are sometimes required to cover inpatient services due to colleagues being on leave. Time waited for diagnostics has an impact on ability to achieve RTT as demand is greater than capacity in Radiology and other diagnostic services.	Medicine Division continue with recovery with additional sessions by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment.

Indicator: AF004 Number of 52 Week RTT Incomplete Breaches - Latest month represents the unvalidated snapshot — National Indicator

Period	Lower CL
Jun 2021	0

Value	Median
511	129

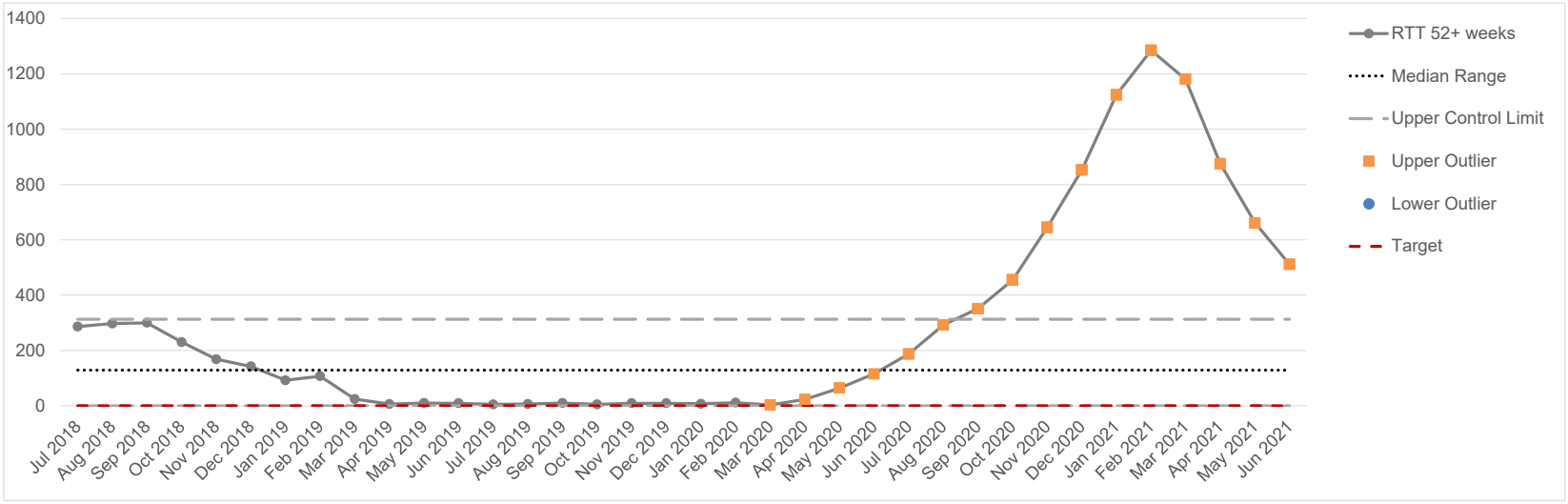
Target	Upper CL
0	313

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
Medicine has been decreasing the number of patients waiting more than 52 weeks for treatment over the recent weeks. S&CC have a decreasing number of patients waiting more than 52 weeks within the division. Many patients waiting over the 52 weeks are those who are difficult to work-up requiring multiple diagnostic treatments, input from different specialties, high risk assessments and require a critical care level bed post op.	Medicine have secured external provider for New RTT patients which has seen a further reduction in the number of 40+wks patients S&CC apply close scrutiny to the over 52 week patients and ensure all patients have a valid preassessment 12 weeks prior to TCI for all routine patients. In addition the focus is also on the >40 weeks to fill lists with these patients if 52 week patients are unable to attend to reduce the number of patients tipping over to 52 weeks.

Issues And Risks	Mitigations
Potential further COVID waves Carry over of annual leave - clinician availability Inability to resource additional sessions as lockdown lifts	Medicine are progressing with securing additional external provider sessions. Locum staff in place Blocking booking of agency and bank Theatre productivity programme has commenced

Indicator: AF005 Diagnostic Measurement 01 (DM01) — National Indicator

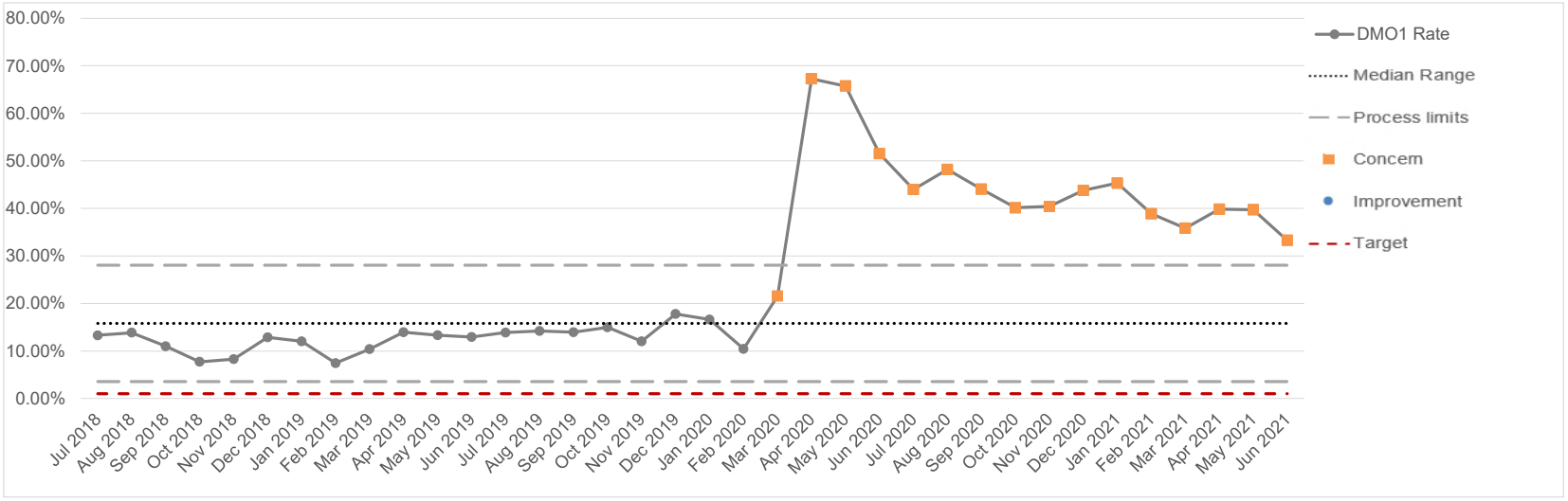
Period	Lower CL
Jun 2021	3.6%
Value	**Median**
33.3%	15.8%
Target	**Upper CL**
1.0%	28.0%

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
Medicine Division DM01 submission for Echocardiography - position has improved to 33.3% From January 2021 to March 2021, the DM01 improved from 45.3% to 35.8%. DM01 performance improved as a result of the endoscopy recovery plan and the extra CT capacity due to the opening of the new CT scanner suite and holding on to the mobile DPOW CT scanner. From March 2021 to May 2021 the DM01 experienced a slight deterioration due to a large increase in Audiology referrals as a result of the ENT recovery program and the streamlining of the pathway which meant a large number of ENT patients were moved to Audiology to have their audiological assessments done before being referred to ENT. Ultrasound also had a large percentage of patients waiting over 6 weeks in May (57.1%) due to an increase in obstetric and non-obstetric ultrasound demand. DM01 performance continues to improve across most modalities with overall performance at 32% (breaches) as of 15 July 2021, compared with 39.8% in April. Audiology is starting to recover following the pathway change. Main concern continues to be NOUS, however this stabilised at the end of June when recovery commenced and is showing a small improvement in the early part of July.	Medicine Division Cardiology Team have been delivering additional Echo sessions on weekends, and Locum sessions secured too. Recovery programs in Audiology, Ultrasound and MRI are underway and expected to yield significant improvements in the DM01. Increase in capacity e.g. access to independent sector capacity (St Hugh's and BMI Lincoln), mobile CT and MRI scanners on site (both at DPOW and SGH), and departments working seven days a week. A new static CT scanner opened at DPOW in January 2021, and two new static MRI scanners commenced operations in May 2021 at DPOW. In addition, a new MRI static scanner will be operational at SGH in October 2021. Radiology reporting - extra sessions by Consultant Radiologists and outsourcing of reports. Radiographer reporting has increased by 43% in the last 12 months and includes chest and abdomen reports as well as upper GI fluoroscopy reports. Actions taken in Audiology are yielding the expected improvement; NOUS recovery work started towards the end of June, with further additional capacity coming on line during July, and an agreement from NEL CCG to support NLAG work going through their IS provider. New MRI scanners operational, and delivering significant reduction in waiting list trust-wide.

Issues And Risks	Mitigations
Medicine Division have seen significant increases in referrals for Echo have been seen throughout Q1 (3460 compared to 3201 in Q4 20-21) Consultant Radiologists: 50% vacancy rate. Endoscopy: 7-day diagnostics turnaround for suspected cancer patients to meet 28-day faster diagnosis target. Audiology DM01 has deteriorated from 1.6% in January 2021 to 49.9% in May 2021 as a result of the ENT recovery program and the Ultrasound DM01 has grown to 57.1% in May 2021. Consultant Radiologists: 50% vacancy rate. Endoscopy: 7-day diagnostics turnaround for suspected cancer patients to meet 28-day faster diagnosis target. Staffing levels becoming a concern in all modalities due to COVID19 related absence (sickness and contact / isolation)	Medicine Division Cardiology Team have been delivering additional Echo sessions on weekends, and Locum sessions secured too. Ongoing recruitment of Consultant Radiologists both in the UK and abroad. Endoscopy mitigation – Funding approved to support additional activity (endoscopy recovery program). Funding for Audiology recovery program and the Ultrasound recovery program has been approved by the Trust and the programs are being implemented starting this month (June 2021) to clear the waiting list backlog. Business cases are being written to appoint more substantive staff in these departments in order to bridge the gap between demand and capacity. Radiologists - ongoing recruitment attempts, increased radiographer reporting; insourcing and outsourcing of reporting. Endoscopy - recovery program ongoing. Staffing - working with EPRR / IPC to ensure guidance is followed in order to protect staff and patients. Backfilling staggin gaps with bank / agency as required and available

Indicator: AF006 Percentage Of A&E Waits Under Four Hours — National Indicator

Latest Month	Lower CL
Jun 2021	72.5%

Value	Median
74.6%	80.7%

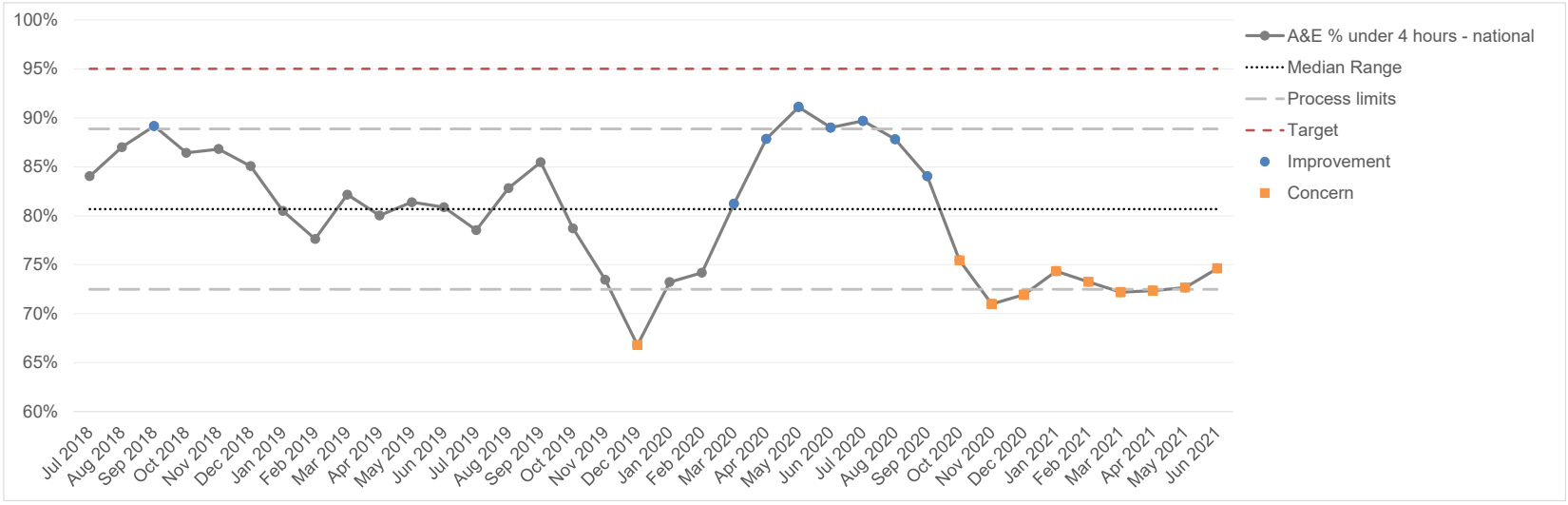
Target	Upper CL
95.0%	88.9%

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?	Actions
Increased attendances (recent weeks higher than pre-covid) are creating challenges within the emergency departments due to physical capacity within the department, workforce capacity, COVID19 implications and patient flow out of ED into the hospital. The challenges are having a negative effect on the Trust's performance against the four hour target. The performance during March 2020 to August 2020 was an improved position due to the reduced number of attendances and a Trust bed occupancy that allowed for prompt patient flow out of the ED into the hospital. Longer patient delays are being experienced at DPOWH with improvement shown at SGH compared to previous month.	• ED Performance Task and Finish Group to progress improvement action plans • Discharge to assess initiative to enable prompt discharges and create improved bed occupancy levels • IAAU to enable improved access for incoming admissions • SDEC Task and Finish Group to increase SDEC and avoid admissions • NHS111 First Initiative to reduce avoidable ED attendances • CQC Action Plan • ED Medical Recruitment Strategy • NHSE/I ECIST Support, point of prevalence study and missed opportunities audit • New ED/AAU build in development • Frailty service continuing at DPOWH due to success of pilot with 93% of frailty patients discharged home from SDEC • Patient Flow Improvement Group established to progress the cross-divisional actions identified through the ECIST audits

Issues And Risks	Mitigations
• Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED • Implications of COVID19 (zoning segregation, PPE, awaiting swab results, staff sickness and isolation) creating challenges and delays for patient pathway through the ED • Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skill mix • Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience • Delays in diagnostic imaging at times • Delays in specialty in-reach not meeting the less than 30min attendance to review Emergency Care Standards • Lack of clinical cubicle capacity to see incoming patients and hold patients awaiting admission • Delays in mental health input out of hours resulting in long patient delays within ED for vulnerable patients • Inappropriate attendances to ED due to lack of access to alternative, more appropriate services	• Fast track paediatric process in place • 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 • Alternatives to trolleys – beds, recliner chairs • Choice of meals for patients during prolonged ED stays • Medication and observations as required • Support offered to staff for health and wellbeing

Indicator: AF007 Ambulance Handover Delays 15-30 Minutes — National Indicator

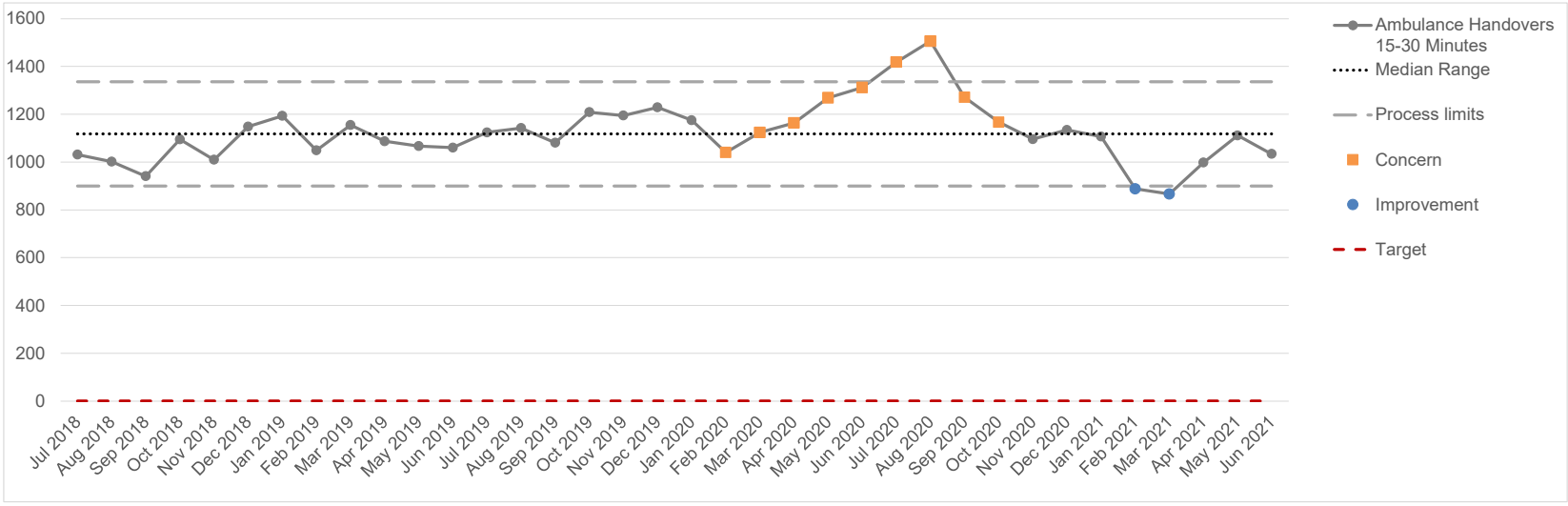
Period	Lower CL
Jun 2021	899.5
Value	**Median**
1034	1117.5
Target	**Upper CL**
0	1335.5

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
15-30min handover breaches normally occur when ambulances turn up at the same time resulting in one patient waiting to start their handover once the patient before is completed. Delays in the patient information becoming available on the EMAS siren system for the NLAG team to commence booking the patient in can also lead to several minutes of delay. There has been improvement in the reduction of 15-30 minute handovers from 35% in November 2020 down to 30% in June 2021. For June 2021, SGH ranked 2nd out of 22 hospitals in the EMAS regional handover performance rankings and DPOWH placed 4th.	• Ambulance Handover Task and Finish Group with system partners to drive improvement plan • UTC at SGH moved out of ED footprint to increase ED physical capacity • System-wide Ambulance Handover Improvement Plan which includes 36 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; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place • Exploring options to interface and data share patient details between EMAS Siren system and NLAG's Symphony system

Issues And Risks	Mitigations
• Bed occupancy levels and COVID19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements • Lack of IT interface ability between EMAS and NLAG systems • Temporary ambulance drop off locations due to new ED build works creating longer physical journey for ambulance patients • 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 • Negative impact on A&E 4hr performance	• 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 • Fast track option for paediatric patients and recording assessments of patient being held in ambulances

Indicator: AF008 Ambulance Handover Delays 30-60 Minutes — National Indicator

Period	Lower CL
Jun 2021	247.94

Value	Median
303	439.0

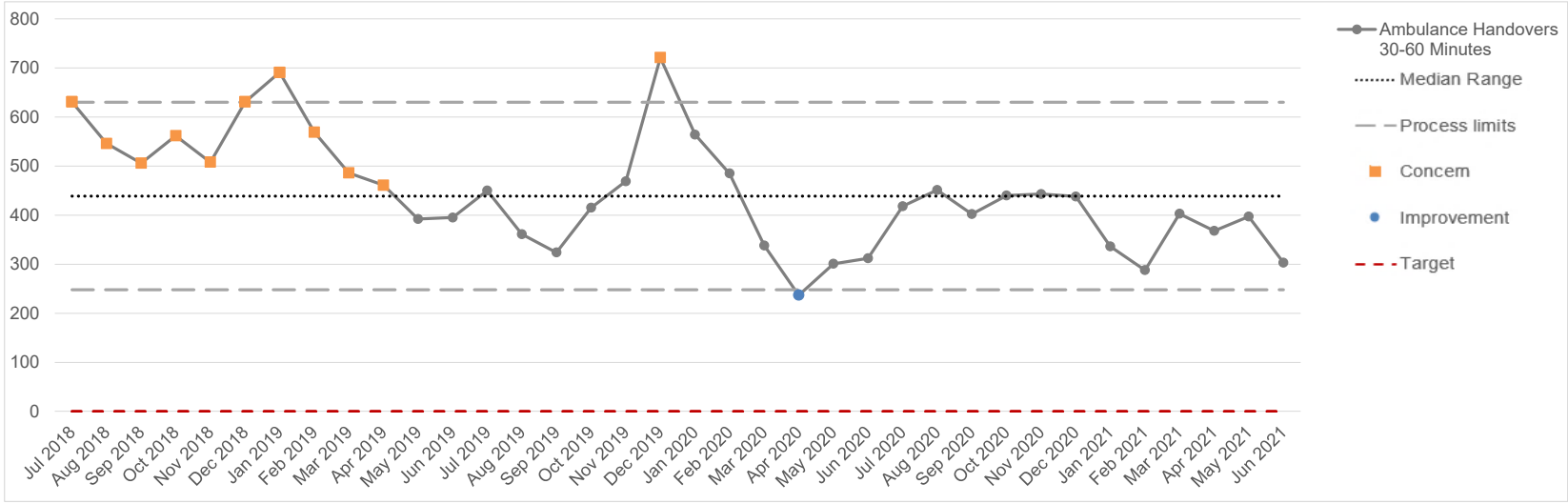
Target	Upper CL
0	630.1

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
30-60min handover breaches occur when the handover area is full and there are no clinical cubicles available to accept incoming patients due to exit block from ED. Increased ED attendances and lack of patient flow out of the ED is resulting in crowding within the department and lack of physical capacity. There has been improvement in the reduction of 30-60 minute handovers from 14% in November 2020 down to 9% in June 2021.	• Ambulance Handover Task and Finish Group with system partners to drive improvement plan • UTC at SGH moved out of ED footprint to increase ED physical capacity • System-wide Ambulance Handover Improvement Plan which includes 36 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; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place • Exploring options to interface and data share patient details between EMAS Siren system and NLAG's Symphony system

Issues And Risks	Mitigations
• Bed occupancy levels and COVID19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements • Lack of IT interface ability between EMAS and NLAG systems • Temporary ambulance drop off locations due to new ED build works creating longer physical journey for ambulance patients • 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 • Negative impact on A&E 4hr performance	• 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 • Fast track option for paediatric patients and recording assessments of patient being held in ambulances

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: AF009 Ambulance Handover Delays 60+ Minutes — National Indicator

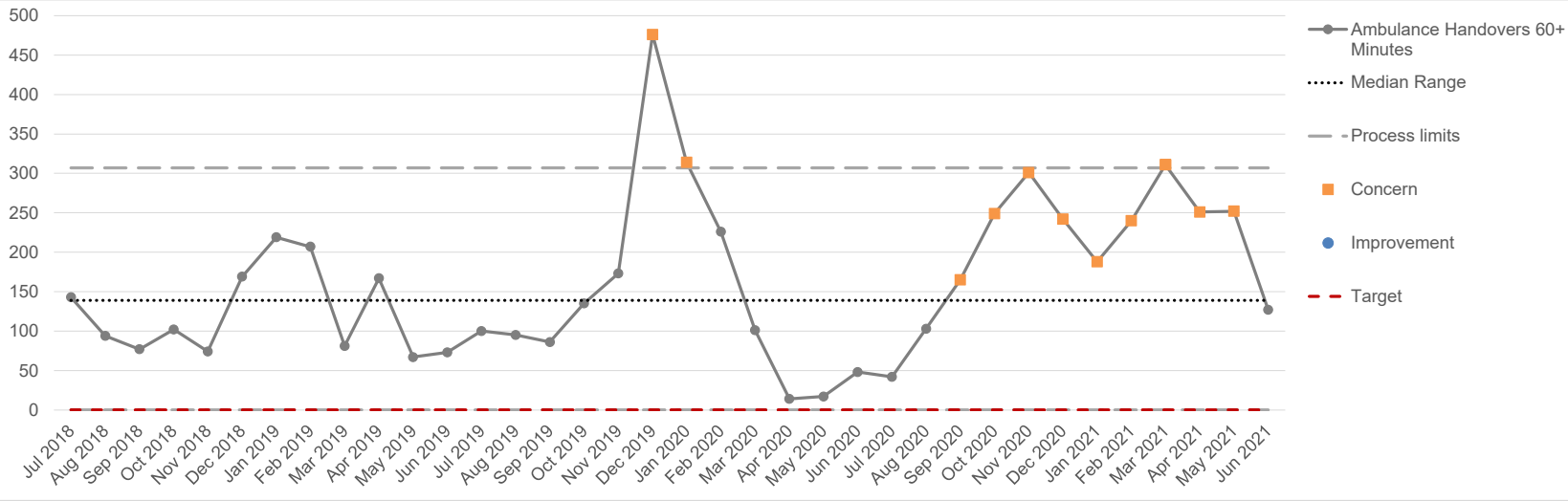
Period	Lower CL
Jun 2021	0.0
Value	**Median**
127	139.0
Target	**Upper CL**
0	306.8

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
60min+ handover breaches occur when the handover area is full and there are no clinical cubicles available to accept incoming patients due to exit block from ED. Increased ED attendances and lack of patient flow out of the ED is resulting in crowding within the department and lack of physical capacity. There has been improvement in the reduction of over 60 minute handovers from 9% in November 2020 down to 4% in June 2021.	• Ambulance Handover Task and Finish Group with system partners to drive improvement plan • UTC at SGH moved out of ED footprint to increase ED physical capacity • System-wide Ambulance Handover Improvement Plan which includes 32 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; and improving patient flow to reduce the exit block from preventing handovers from commencing due to lack of clinical cubicle availability for incoming patients • New ambulance handover process with digital triage now in place • New ED/AAU build in development • New direct streaming process from EMAS to SDEC now in place • New EMAS patient self-handover SOP now in place • Exploring options to interface and data share patient details between EMAS Siren system and NLAG's Symphony system

Issues And Risks	Mitigations
• Bed occupancy levels and COVID19 implications have created challenges in balancing the ward configuration to meet the changing demand of bed requirements • Lack of IT interface ability between EMAS and NLAG systems • Temporary ambulance drop off locations due to new ED build works creating longer physical journey for ambulance patients • 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 • Negative impact on A&E 4hr performance	• 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 • Fast track option for paediatric patients and recording assessments of patient being held in ambulances

Indicator: AF010 A&E Decision To Admit 12+ Hours — National Indicator

Period	Lower CL
Jun 2021	0.0

Value	Median
0.0	0.0

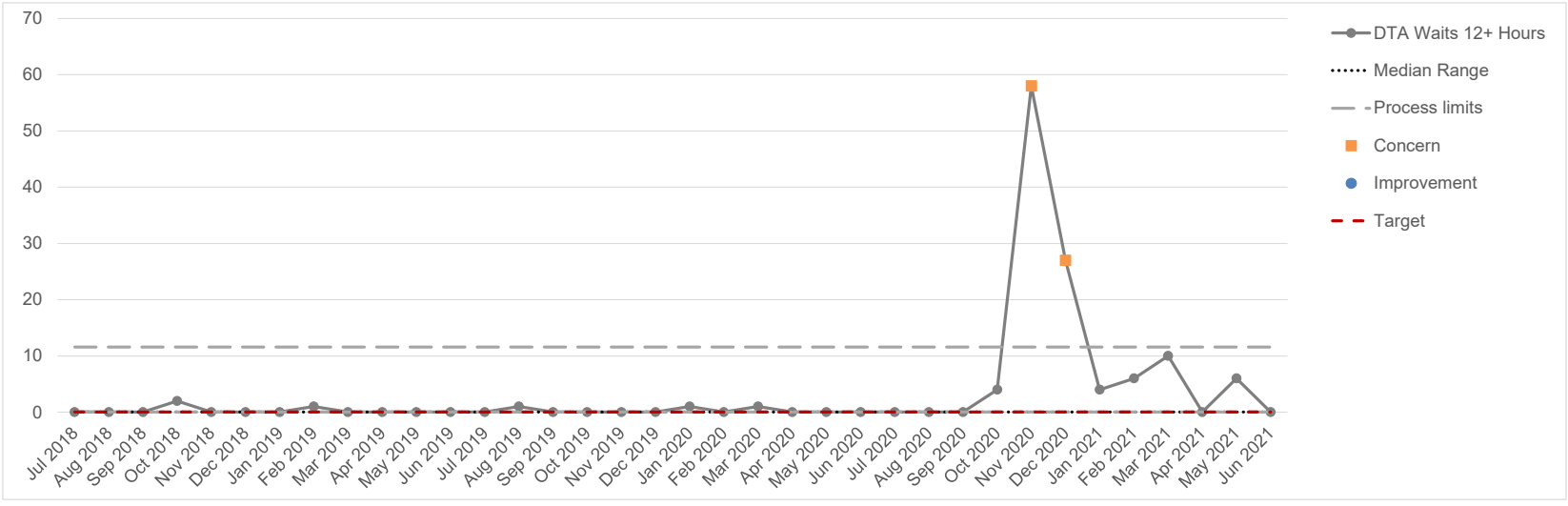
Target	Upper CL
0.0	11.6

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 overall aim is to have zero 12 hour trolley breaches within the Trust. 12 hour breaches are when a patient within the Emergency Department has had a decision to admit made and accepted by the relevant specialty but there is a delay of 12 hours or more for a bed to be made available for their admission. This lack of required patient flow across the hospital results in patients having long waits in the emergency department, negatively affecting the department's ability to see and treat new patients and offload ambulance arrivals. There were no DTA breaches during June 2021 despite significant challenging patient flow.	• Daily operational meetings to review and amend the ward zoning and patient movements to enable bed availability for the patients requiring admission. • Discharge to assess initiative to ensure patients are discharged in a timely manner to support adequate patient flow throughout the hospital. • Review of the 12 hour escalation process to support early exploration of radical options to support prompt patient admission and 12 hour DTA breach avoidance. • Validation of all 12 hour breaches to identify themes and lessons to be learned to avoid future breaches.

Issues And Risks	Mitigations
• There is a risk of 12 hour breaches occurring due to a lack of bed availability and patient flow out of the Emergency Department. • Risk of harm to patients kept in ECC for more than 12 hours.	• Increased staffing to ECC • 2 hourly board round with EPIC (Emerg. Physician in Charge) and Band 7 coordinator to identify risk Nursing care needs monitored through Care Round document (risk assessments for pressure ulcers, falls, nutrition, hydration and comfort) • Alternatives to trolleys – beds, recliner chairs • Red mattresses provided where needed • Choice of meals including hot meals • Medication and observations as required

Indicator: AF011 Cancer 2 Week Wait — National Indicator

Period	Lower CL
Jun 2021	94.4%

Value	Median
98.2%	97.3%

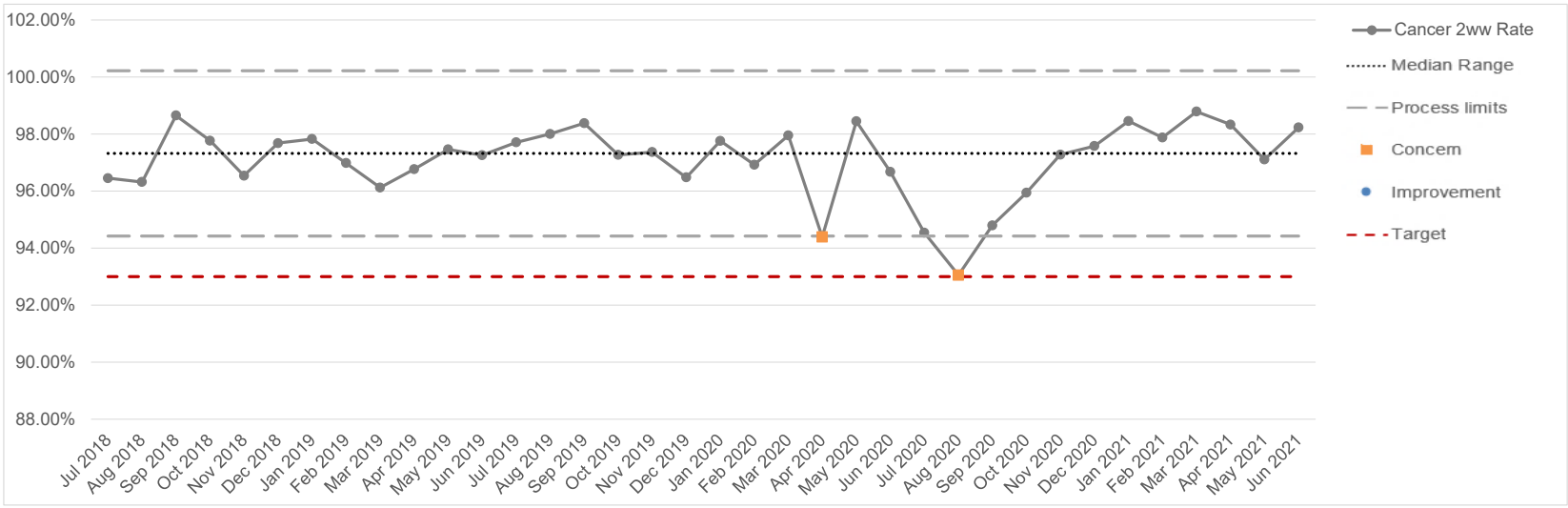
Target	Upper CL
93.0%	100.2%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently passing the target



Background And What Is The Chart Telling Us?	Actions
The volume of 2ww referrals has continued to increase and has exceeded pre-pandemic levels (156% at end March 21). The Trust performance against the 93% 2ww has continued to increase month on month since august 2020. Even at its lowest point, the Trust was just on the verge of performance. The Trust has consistently met the 2ww 93% national standard.	Rapid Diagnostic Centre (RDC) commenced June 2021 in GI pathways expected to see a reduction in 2ww referrals and therefore the ability to see these patients quicker, improving the 28 day Faster Diagnosis standard. To date only 10 referrals have been received. S&CC have delivered on this standard since October 2020, but experienced difficulties during July-Sep 2020. This was mainly around Urology and UGI due to pathway diagnostic issues. Work is ongoing with all specialties to deliver Straight to Test (STT) services or to enable patients to be seen <7 days from referral

Issues And Risks	Mitigations
Impact of another surge in COVID Inability to deliver STT diagnostics at first appointment RDC is in pilot and may not deliver the results expected	Daily monitoring to ensure patients are booked timely, appropriate escalation when unable to date Flexibility of capacity to treat cancer patients (although has a negative impact on other conditions) Working to deliver first OPA within 7 days

Indicator: AF012 Cancer 2 Week Wait - Breast Symptomatic — National Indicator

Period	Lower CL
Jun 2021	88.3%

Value	Median
98.9%	95.9%

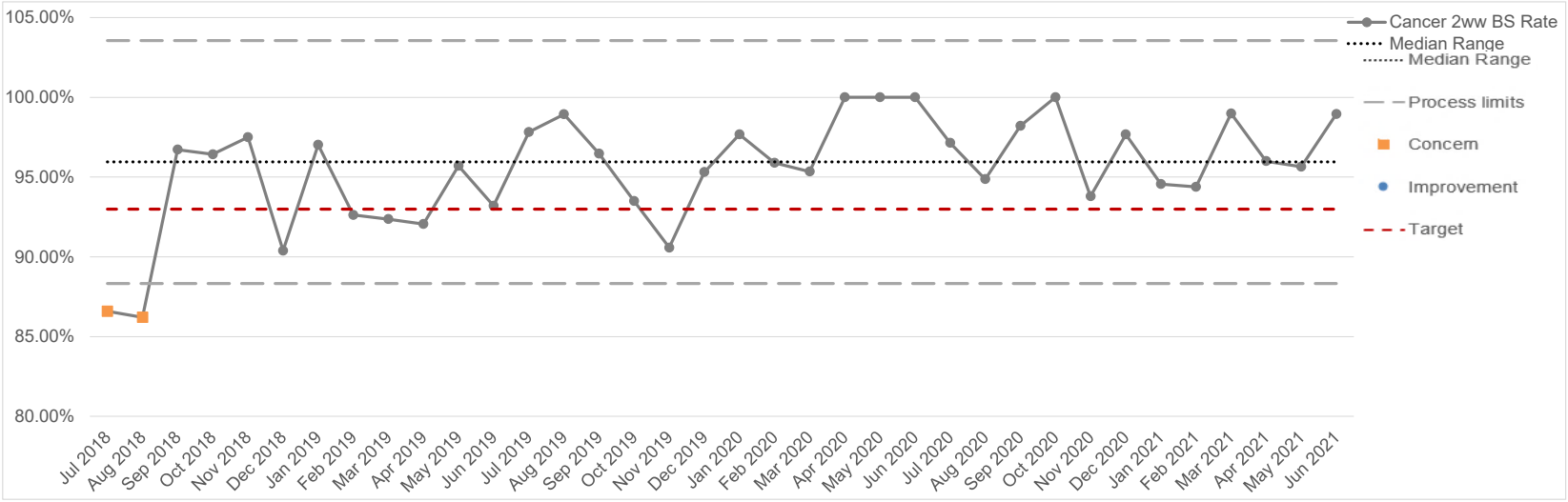
Target	Upper CL
93.0%	103.6%

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
With the exception of a dip in performance (Nov 19) the Trust has consistently met the 2ww breast symptomatic standard (93%).	Family Services division are looking at ways to manage this increased level of referral.

Issues And Risks	Mitigations
The Breast team have seen increased levels of breast symptomatic referrals above pre-pandemic levels since Feb 21. At end March, the Trust received 149% of expected referrals.	Divisions are working towards patients 1st appointment (or test) being within days 0-7 of the pathway.

Indicator: AF013 Cancer Diagnosis Within 28 Days — National Indicator

Period	Lower CL
Jun 2021	47.4%

Value	Median
61.5%	61.6%

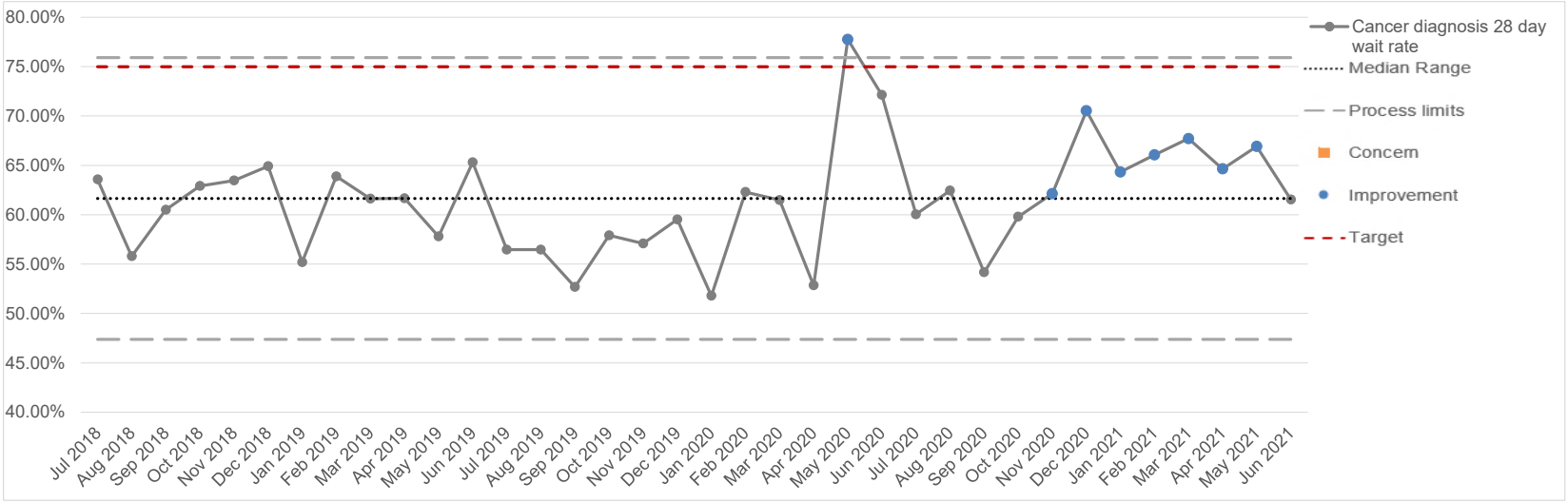
Target	Upper CL
75.0%	75.9%

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?	Actions
Since August 2020, the Trust has increased performance against the Faster Diagnosis Standard of 75%. Performance has dipped between March and April.	S&CC continue to struggle to deliver on this standard due to access to diagnostics and subsequent reporting of results Work is ongoing with all specialties to enable patients to be seen <7 days from referral, enabling diagnostics 3 weeks to turnaround patients

Issues And Risks	Mitigations
Impact of another surge in COVID Inability to deliver diagnostics within a timely manner Variation in performance delivery	Daily monitoring to ensure patients are booked timely, appropriate escalation when unable to date

Indicator: AF014 Cancer Waiting Times - 31 Days 1st Treatment — National Indicator

Period	Lower CL
Jun 2021	91.9%

Value	Median
96.0%	97.7%

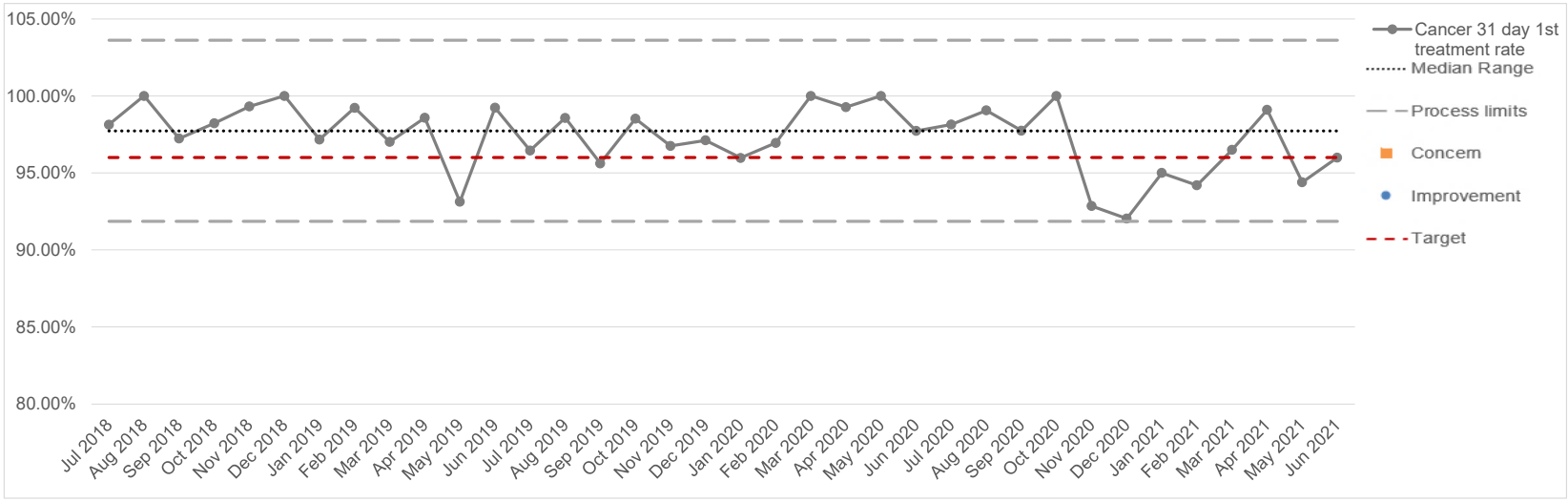
Target	Upper CL
96.0%	103.6%

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 Trust fell below the national standard (96%) in November and failed the standard through to the end of March (95.9%). The Trust performance has improved and is on track to achieve the standard for April (current position is 96%).	The majority of our specialties are able to deliver this standard with the exception of Colorectal and Urology due to capacity constraints within theatre

Issues And Risks	Mitigations
Impact of another surge in COVID Inability to deliver agreed interventions within a timely manner	Daily monitoring to ensure patients are booked timely, appropriate escalation when unable to date Flexibility of capacity to treat cancer patients (although has a negative impact on other conditions)

Indicator: AF015 Cancer 31 Days Surgery — National Indicator

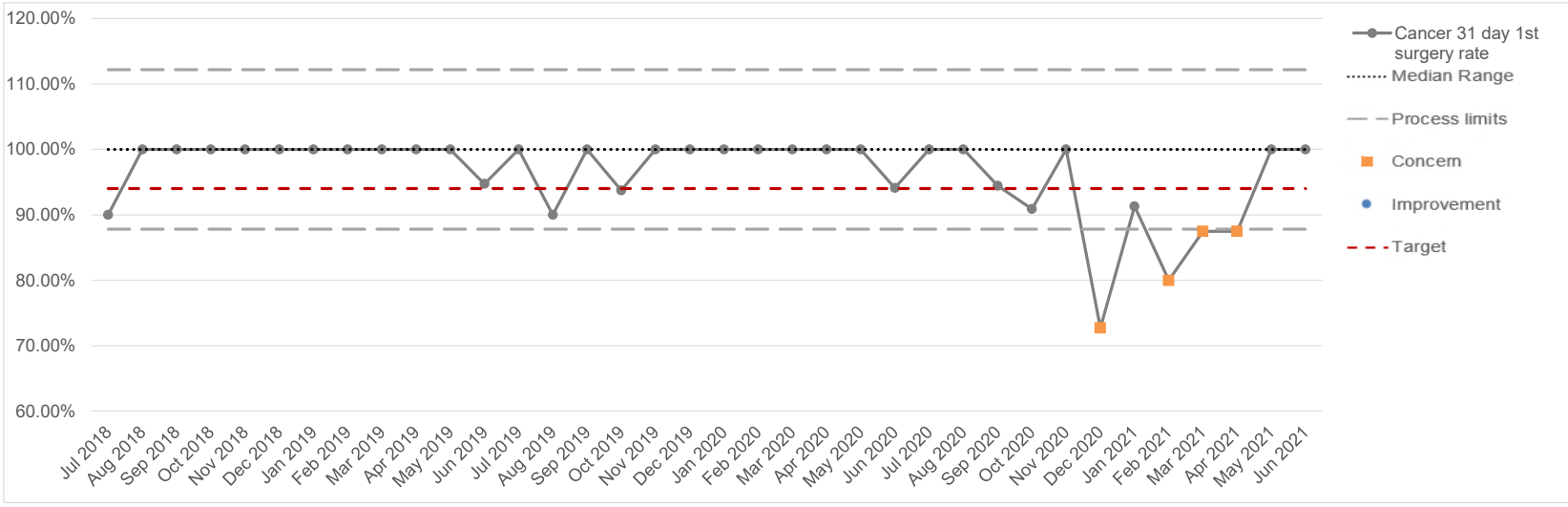
Period	Lower CL
Jun 2021	87.8%
Value	**Median**
100.0%	100.0%
Target	**Upper CL**
94.0%	112.2%

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 Trust has consistently met this standard until Nov 2020. During the surge in the pandemic, surgery was cancelled and the Trust has continued to fail the national standard (94%). There have been 16 treatments and 2 breaches in April 21.	The majority of our specialties are able to deliver this standard with the exception of Colorectal and Urology due to capacity constraints within theatre

Issues And Risks	Mitigations
Impact of another surge in COVID Inability to deliver agreed interventions within a timely manner	Daily monitoring to ensure patients are booked timely, appropriate escalation when unable to date Flexibility of capacity to treat cancer patients (although has a negative impact on other conditions)

Indicator: AF016 Cancer 31 Days Drugs — National Indicator

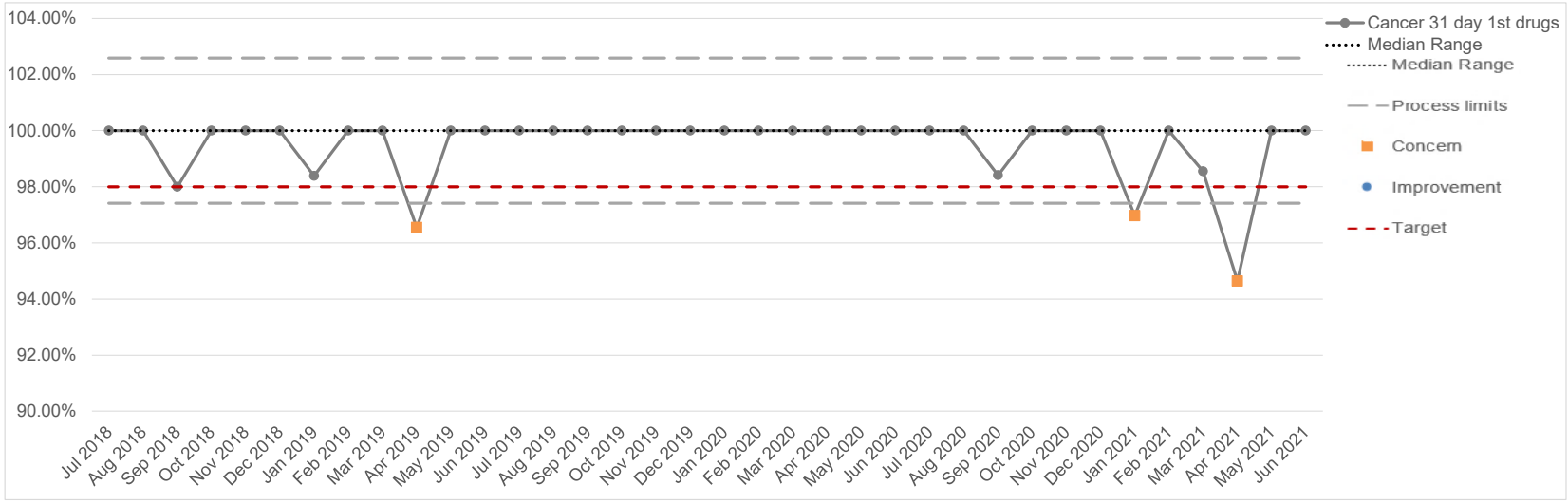
Period	Lower CL
Jun 2021	97.4%
Value	**Median**
100.0%	100.0%
Target	**Upper CL**
98.0%	102.6%

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
	All our specialties achieve this standard the majority of the time, even during the height of COVID19

Issues And Risks	Mitigations

Indicator: AF017 Cancer 62 Day GP Referral — National Indicator

Period	Lower CL
Jun 2021	52.5%

Value	Median
65.9%	68.1%

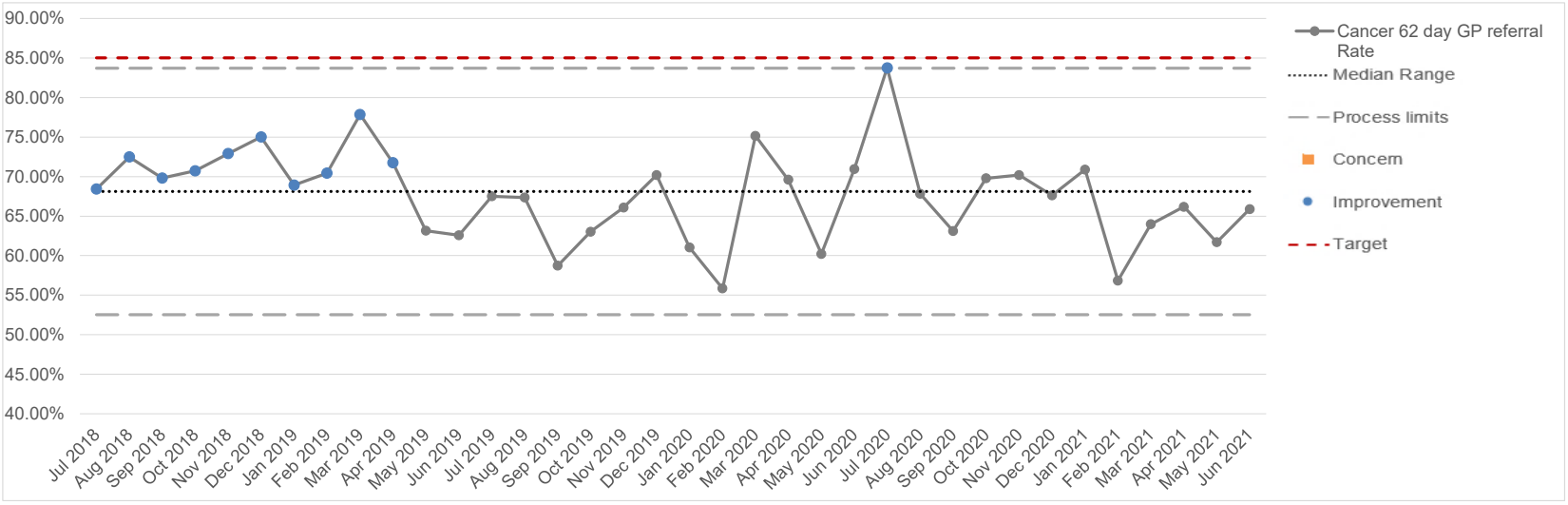
Target	Upper CL
85.0%	83.7%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
	Colorectal: significant improvement in delivery of this standard but still averaging 70% - lack of theatre capacity during November resulted in significant backlog of patients to date - drop in performance in May to 46.7% due to number of patients already breached but now requiring treatment; June 70.6% H&N: historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. Currently averaging about 30% achievement; June 25% UGI: historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. Currently averaging about 60% achievement; June 100% Urology: historically struggle to achieve this standard due to complex diagnostic pathways and referral to HUTH for treatment. Currently averaging about 70% achievement; June 54.4%

Issues And Risks	Mitigations
Impact of another surge in COVID Inability to deliver agreed interventions within a timely manner - diagnostics, surgery, oncology	Improving achievements of 28 day faster diagnosis standard Implementing national best practice pathways in Lower GI, Lung, Prostate and Upper GI Implementing Rapid Diagnostic pathway for iron deficiency anaemia patients in both Upper & Lower GI Implementing cancer transformation programme within NLAG to complement Humber and HASR programmes (to include RDC, MDT streamlining, pathway transformation, and the Living With and Beyond Cancer implementation)

Indicator: AF018 Cancer 62 Day Screening — National Indicator

Period	Lower CL
Jun 2021	17.8%

Value	Median
70.0%	81.7%

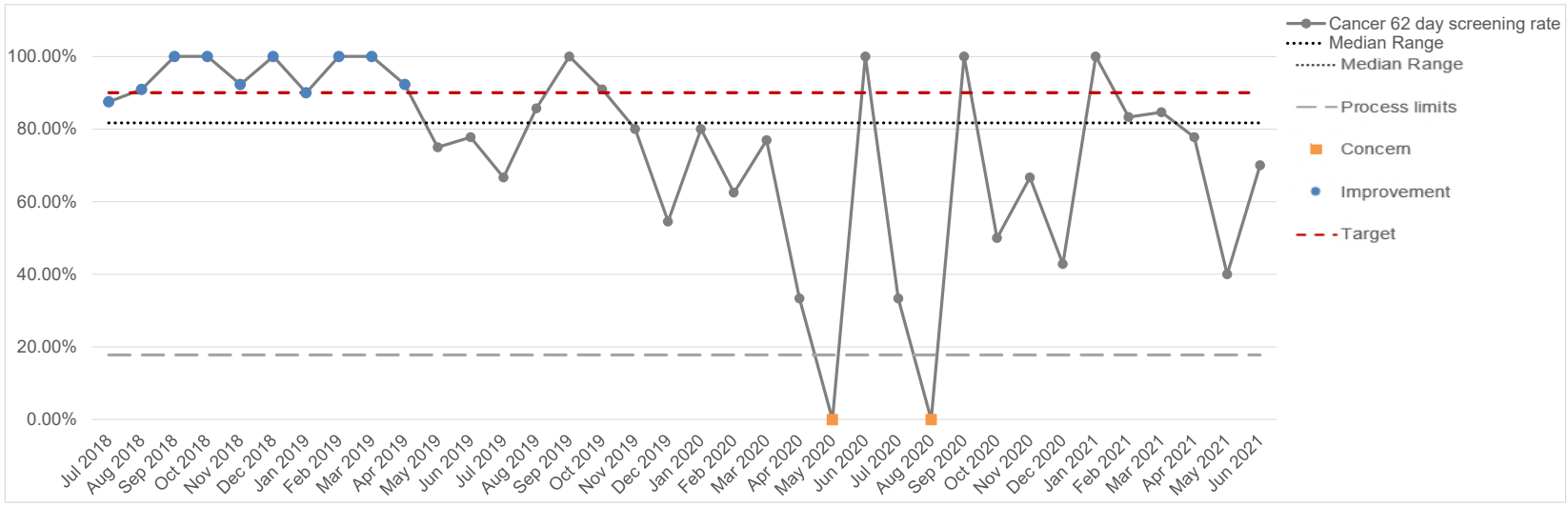
Target	Upper CL
90.0%	145.5%

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
The Trust continues to struggle to achieve 62 day screening standard (90%). The total number of treatments across all 3 screening programmes total between 4 and 5 per month (max). It only needs one breach to fail the target. The most common breaches are in the bowel screening pathway. In April there were 4.5 treatments and 1.0 beaches resulting in a performance of 77.8% (trustwide).	Significant backlog of bowel screening patients from first wave of COVID due to inability to undertake colonoscopies - patients managed through the system over recent months. Patient choice on where they have their endoscopy has resulted in significant number of breaches due to delays in scoping - CSS seeking to increase bowel screening accredited scopists

Issues And Risks	Mitigations
Lack of bowel screening accredited scopists results in patients often waiting beyond 62 days for Colonoscopy. Any that become confirmed cancer are already past 62 days when diagnosed and so are a confirmed breach Patients choose to wait for an available colonoscopy appointment nearest to home	Patients are offered earlier appointments at alternative sites Increase number of bowel screening accredited scopists

Indicator: AF019 Number of outpatients overdue their follow up appointment — Local Indicator - Specification Agreed and Reviewed

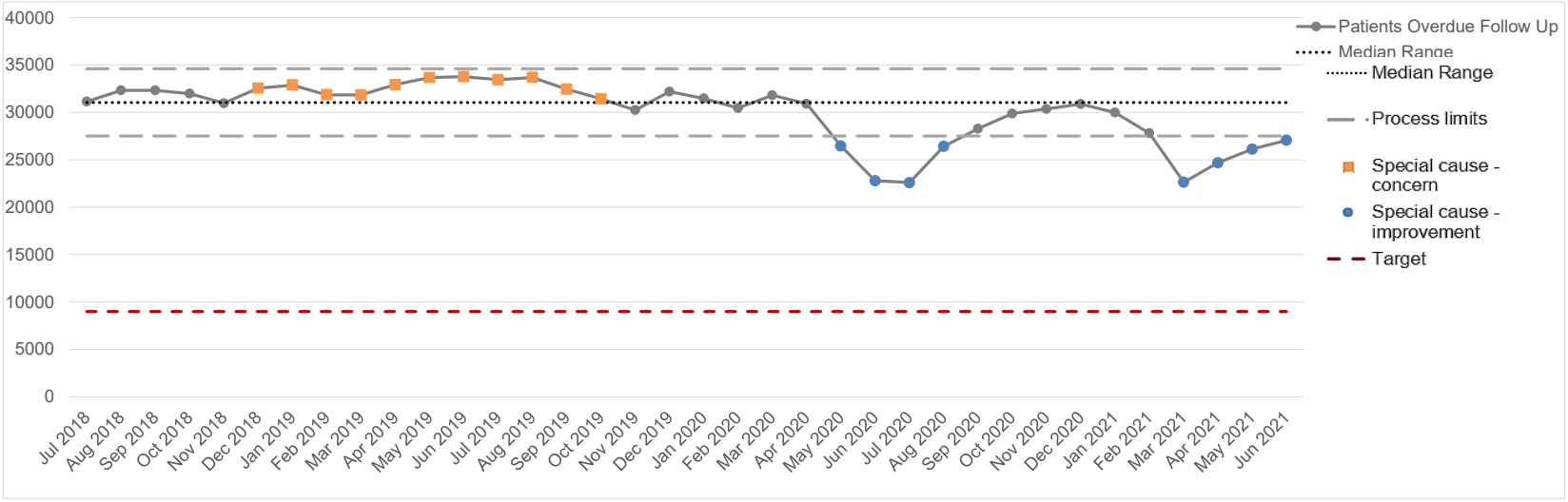
Period	Lower CL
Jun 2021	27,505
Value	**Median**
27,065	31,056
Target	**Upper CL**
9,000	34,606

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
	S&CC monitor all overdue follow-ups closely. Division has developed a risk stratification plan - an example of this is Ophthalmology based on Royal College guidelines were patients are stratified against sub speciality and clinical timescales. In order to commence risk stratification the service are required to manually add diagnosis codes in order to filter the waiting list by subspecialty - this is because ophthalmology do not have a dedicated ophthalmic system eg Medisoft. All diagnosis codes will be added by the end of June 2021. All other specialties have processes in place to ensure that diagnosis codes are added and risk stratification is underway. Other actions include identification of patients that have had 2 follow-ups and remain in the system - to be reviewed by consultant and admin validation of the Outpatient PTL to identify patients for discharge.

Issues And Risks	Mitigations
Carry over of annual leave - clinician availability. Inability to resource additional sessions as lockdown lifts.	Locum staff in place

Indicator: AF020 Number of patients on an RTT Incomplete pathway - Latest month represents the unvalidated snapshot

Local Indicator - Specification Agreed and Reviewed

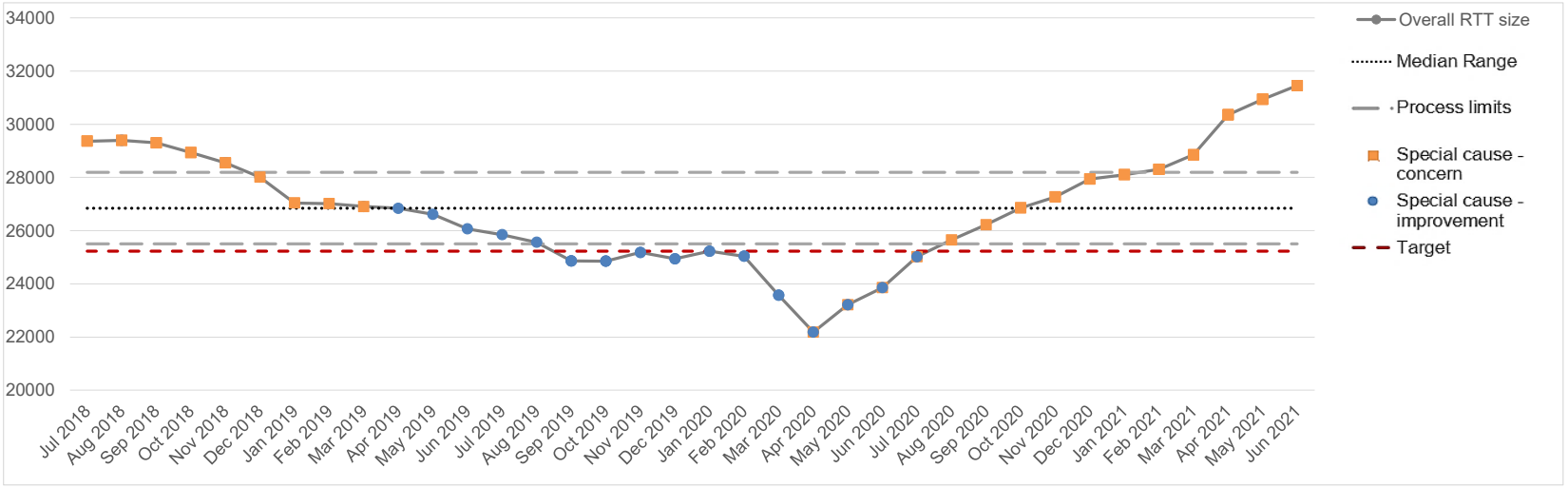
Period	Lower CL
Jun 2021	25,502
Value	**Median**
31,454	26,849
Target	**Upper CL**
25,227	28,195

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
	S&CC apply close scrutiny to the incomplete patients

Issues And Risks	Mitigations
Potential further COVID waves	Locum staff in place
Carry over of annual leave - clinician availability	Blocking booking of agency and bank
Inability to resource additional sessions as lockdown lifts	Theatre productivity programme has commenced

Indicator: AF021 Outpatient Letters — Local Indicator: Specification To Be Confirmed

Period	Lower CL
Jun 2021	27.2%

Value	Median
35.0%	35.6%

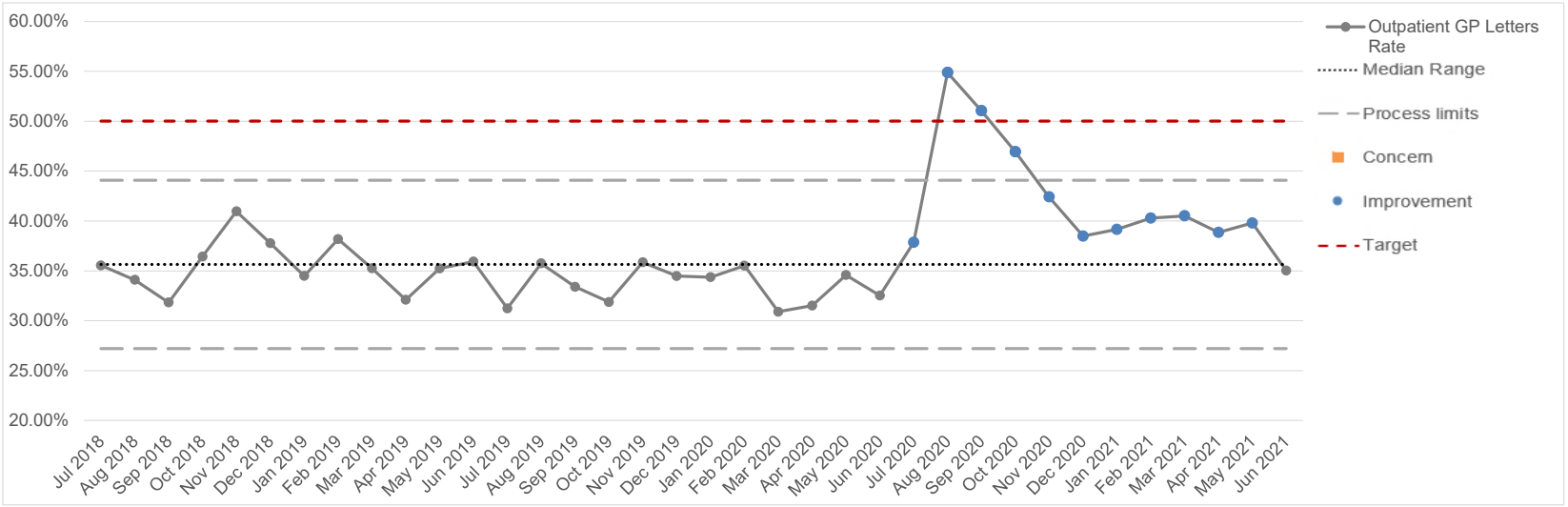
Target	Upper CL
50.0%	44.1%

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

Issues And Risks	Mitigations

Indicator: AF022 Number of Outpatient Face To Face Follow Ups — Local Indicator: Specification To Be Confirmed

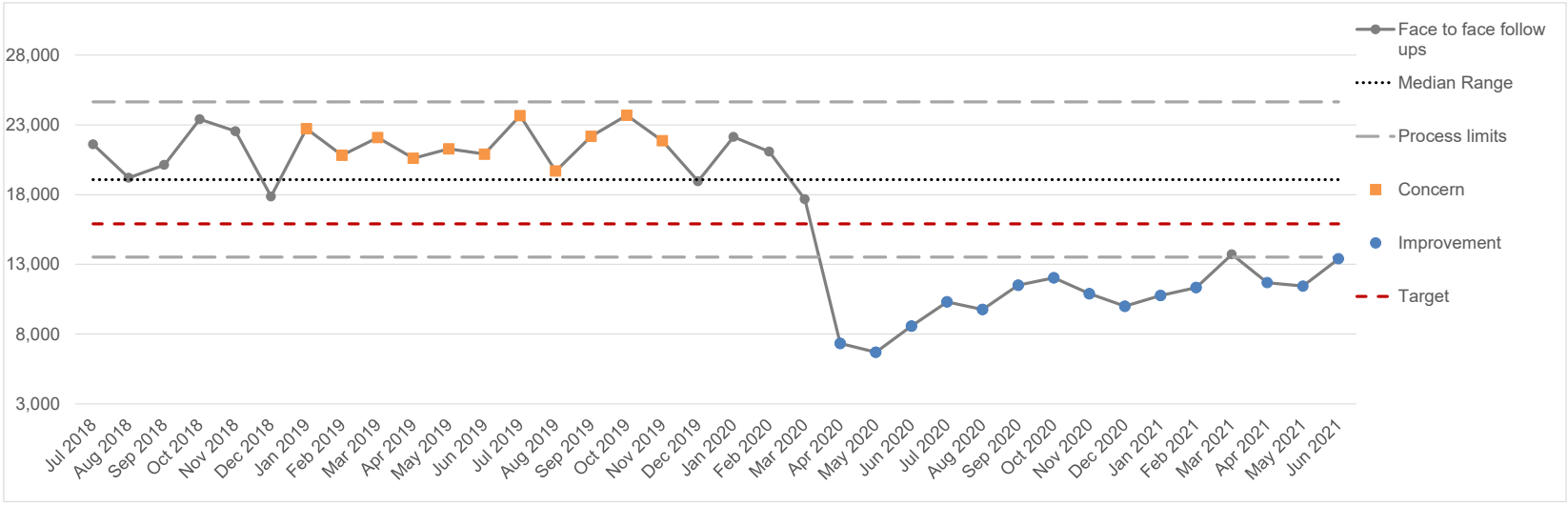
Period	Lower CL
Jun 2021	13,518
Value	**Median**
13,401	19,079
Target	**Upper CL**
15,903	24,640

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF023 Cancer 104+ Days

Period	Lower CL
Jun 2021	9.1

Value	Median
33	32.0

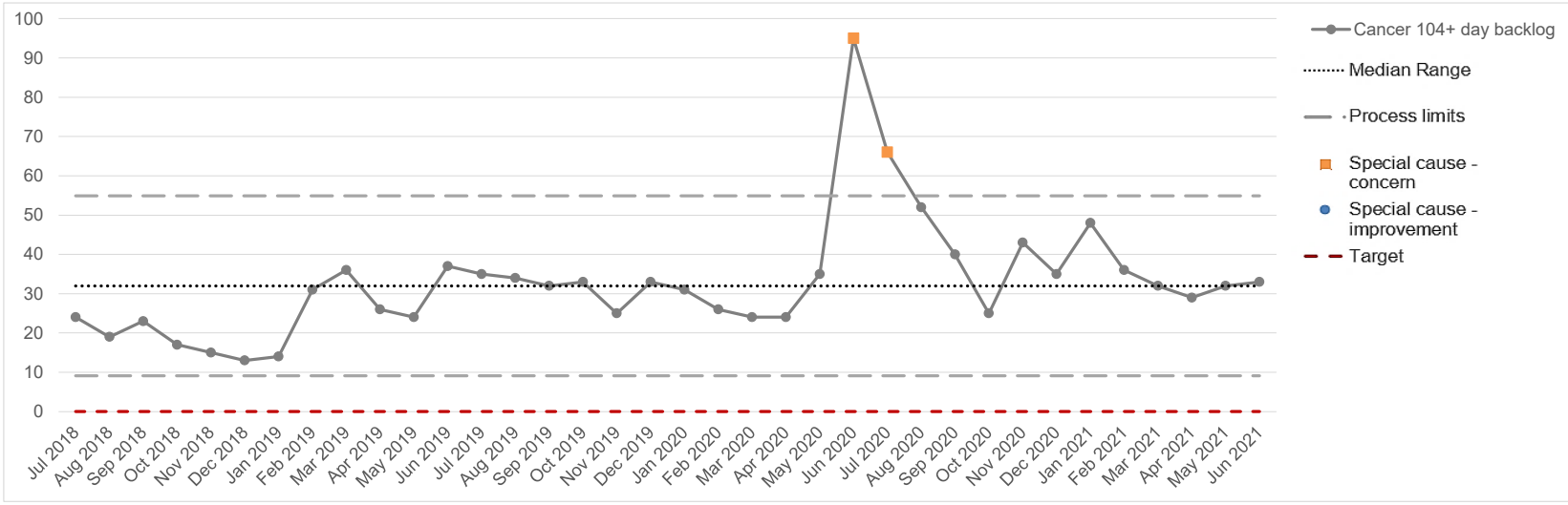
Target	Upper CL
0	54.9

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
The volume of patient pathways over 104+ days continues to reduce. At June 2020 it reached a peak of 95 patients and represented 4.0% of the total 62 day PTL. The current level of patients over 104 days has returned to pre-covid levels (29). The largest cohort of patients remains 'suspected' cancer patients (i.e. those without diagnosis).	Trajectories in place to reduce 104+ pathways to 0.9% of PTL. Trajectories being presented to Divisional Boards S&CC currently have 17 patients waiting over 104 days - 14 suspected and 3 confirmed

Issues And Risks	Mitigations
Longer waiting times for diagnostic/staging (including tertiary centres) and oncology 1st appointments risks increasing volumes over 104+ days.	Weekly cancer PTL meetings go through every 104+ patient pathway to ensure the next step is in place and pathways are progressing. Escalation to tertiary centre if pathway appears stalled (for those patients awaiting treatment and/or staging at tertiary centre).

Indicator: AF024 Care Of Patients With Confirmed Cancer Diagnosis Transferred By Day 38

Period	Lower CL
Jun 2021	2.7%

Value	Median
6.7%	31.8%

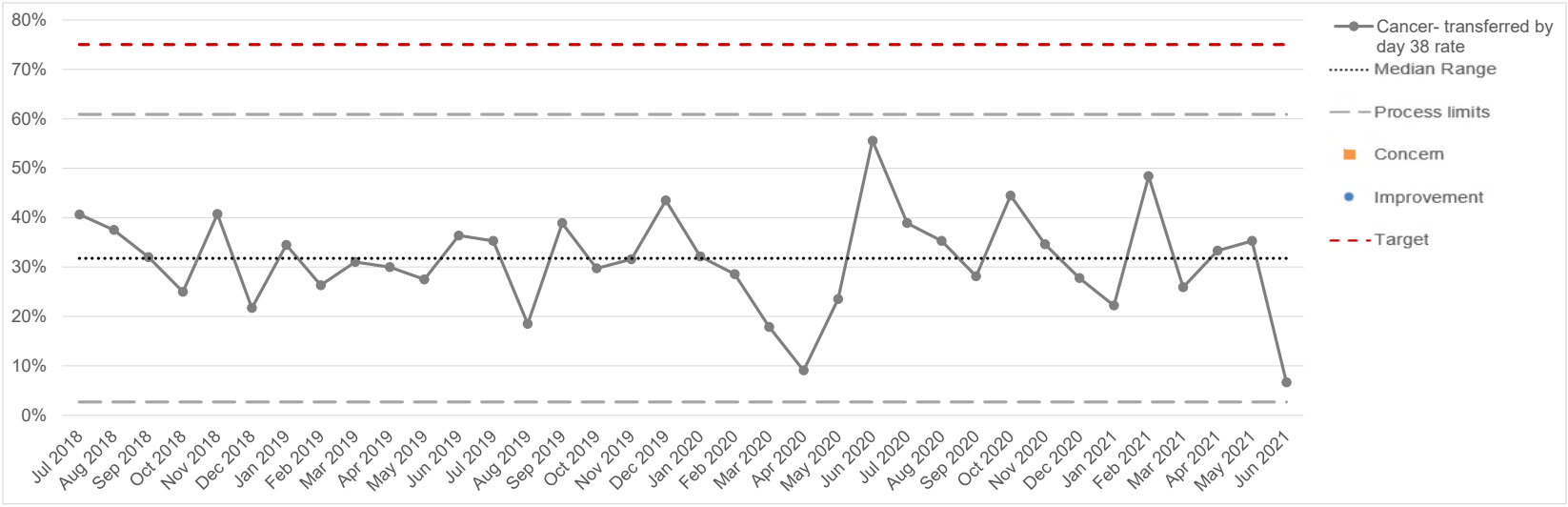
Target	Upper CL
75.0%	60.9%

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
The trust continues to struggle to meet the 38 day standard. This is largely because for some tumour types tertiary diagnostics/staging/biopsy is required to confirm treatment options - longer waiting times (up to 21 days in some cases, e.g. EUS/lung biopsies) result in the pathway being beyond Day 38 when results are received back at NLAG, This is then followed by local/specialist MDT discussion, and agreement with the patient, to transfer care to a tertiary consultant for treatment. If the tertiary provider treats within 24 days of receipt, the 1.0 whole breach is reallocated to NLAG (increasing the volume of accountable breaches).	Transformation pathway work has commenced between NLAG and HUTH as part of the Humber Cancer Transformation programme (overseen by the Humber Cancer Board). Some single services are proposed, e.g. Upper GI and Lung.

Issues And Risks	Mitigations
Capacity within the tertiary centre for diagnostics/staging scans within 7 days Treatment capacity within tertiary centre - robotic prostatectomy, head & neck surgery Oncology - capacity for consultant 1st appointments to be within 7 days of referral	Same as 62 day pathway challenges

Indicator: AF025 Cancer Request To Test In 14 Days

Period	Lower CL
Jun 2021	75.4%

Value	Median
79.8%	83.2%

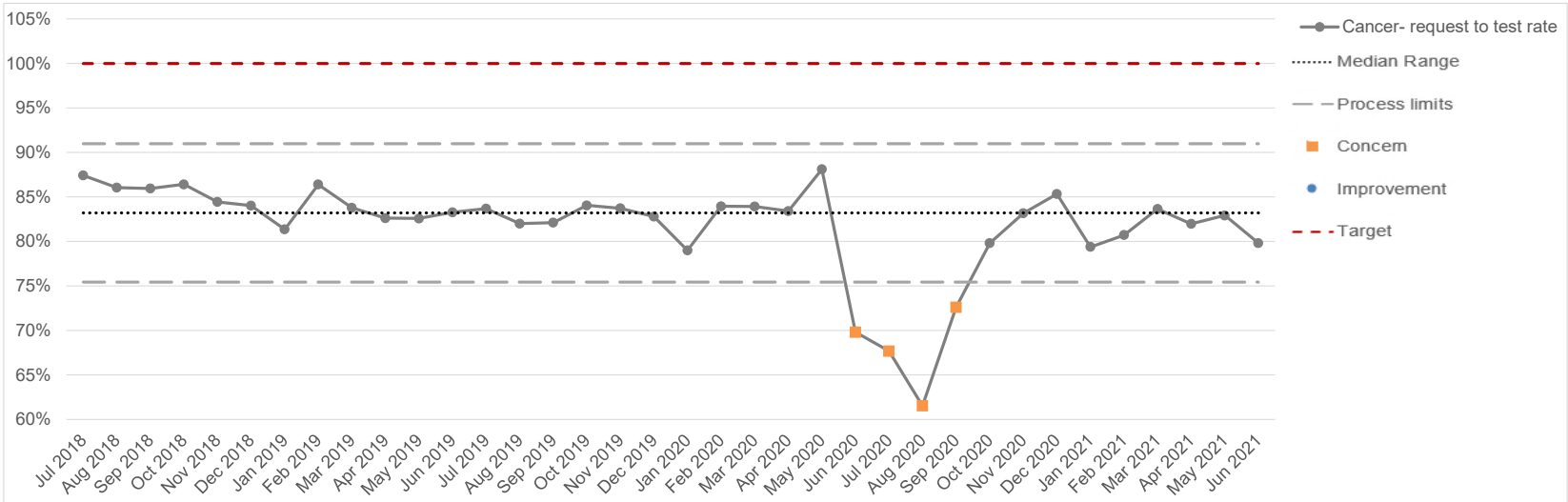
Target	Upper CL
100.0%	91.0%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF026 Average Length Of Stay (Elective and Non Elective)

This is a Local Indicator: Specification To Be Confirmed

Period	Lower CL
Jun 2021	3.7

Value	Median
3.79	4.2

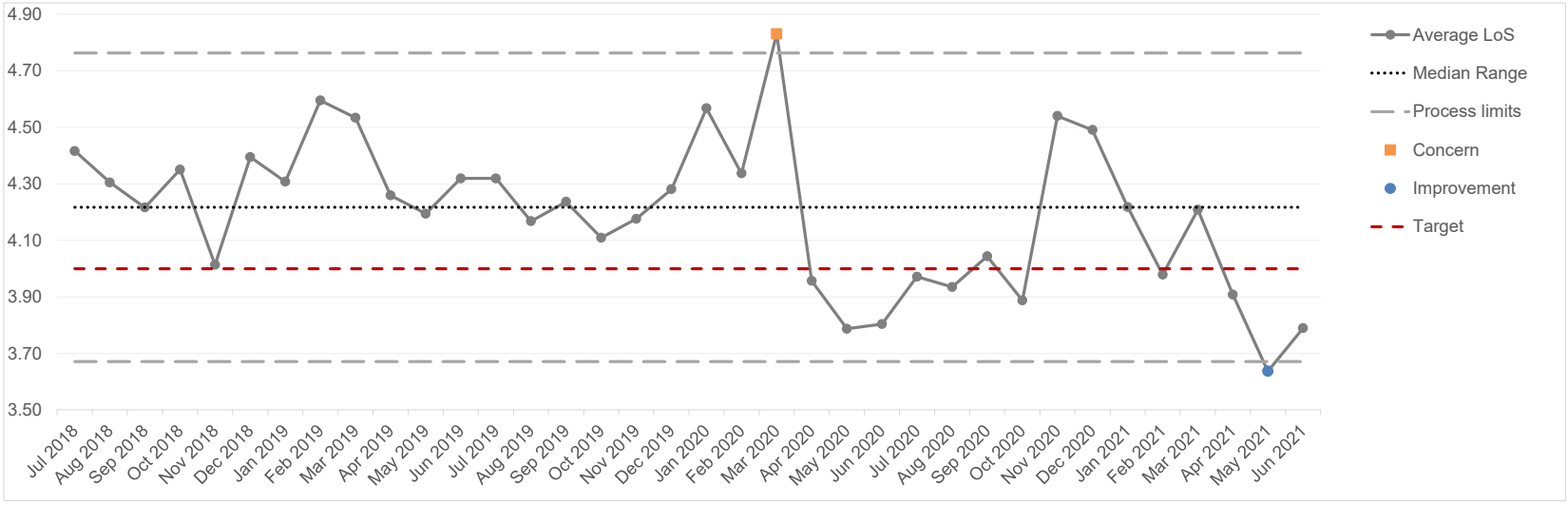
Target	Upper CL
4.0	4.8

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?	Actions
Average length of stay is showing an a slight increase for June although still sitting under the agreed target this is reflecting the improvement work done on both discharge to assess and effective board rounds.	Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement length of stay are: * Conb * Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning * Working with the ward MDT to carry out effective board rounds * Patients requiring support on discharge leave following a discharge to assess pathway on the same day * Escalation process in place to ensure any delays in patient pathways are highlighted and actioned * Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

Issues And Risks	Mitigations

Indicator: AF027 Inpatient Zero Day Length Of Stay (excl Daycase) — Local Indicator: Specification To Be Confirmed

Period	Lower CL
Jun 2021	28.6%

Value	Median
40.0%	31.8%

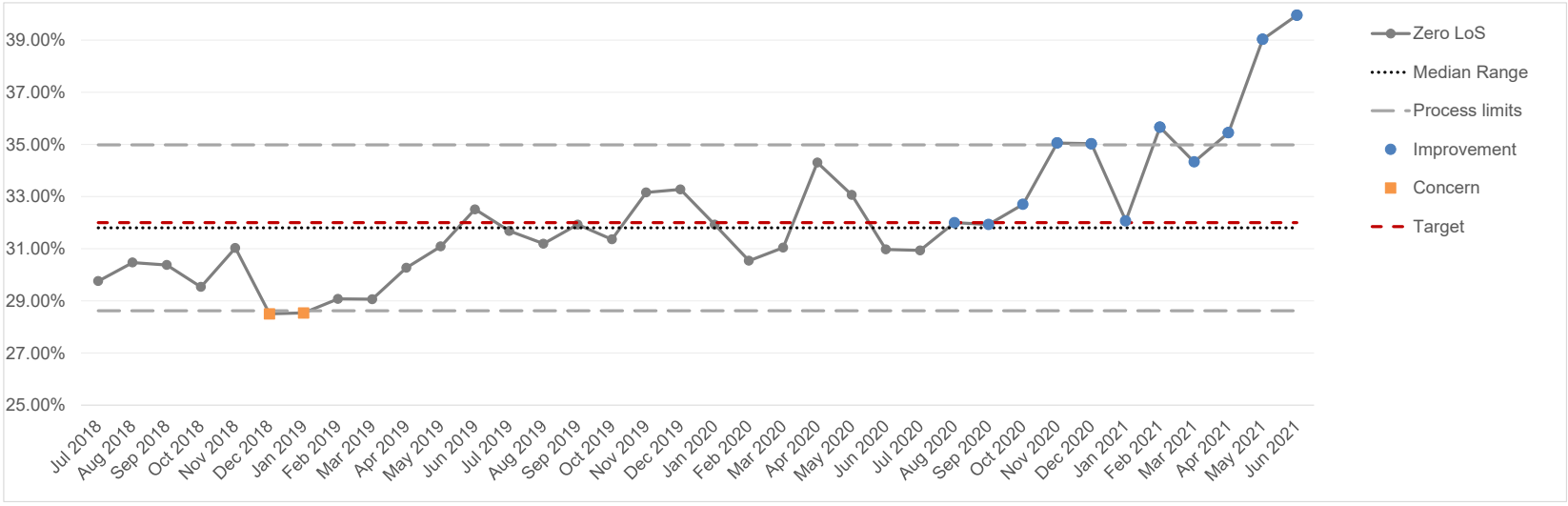
Target	Upper CL
32.0%	35.0%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
O length of stay has seen a huge improvement and has seen an improving trajectory since February 2021 this is reflective of the implementation of integrated SDEC across the trust	Currently working to improve flow into and out of SDEC and identifying SDEC patients earlier in their pathway

Issues And Risks	Mitigations
Issues around physical space & capacity on both sites	New ED/SDEC Builds will see ED & SDEC areas expand on both sites

Indicator: AF028 Non Elective Average Length Of Stay — Local Indicator: Specification To Be Confirmed

Period	Lower CL
Jun 2021	4.2

Value	Median
3.98	4.8

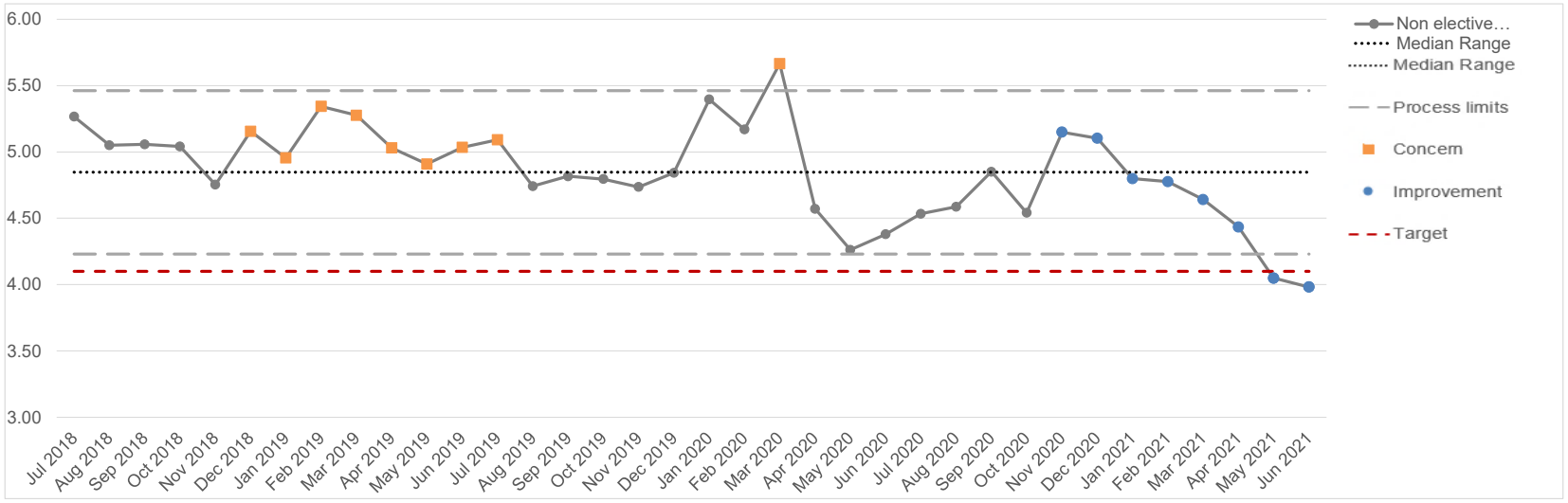
Target	Upper CL
4.10	5.5

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
Non Elective length of stay is showing an improvement for June this is reflecting the improvement work done on both discharge to assess and effective board rounds.	Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement length of stay are: * Conb * Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning * Working with the ward MDT to carry out effective board rounds * Patients requiring support on discharge leave following a discharge to assess pathway on the same day * Escalation process in place to ensure any delays in patient pathways are highlighted and actioned * Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

Issues And Risks	Mitigations

Indicator: AF029 Elective Average Length Of Stay — Local Indicator: Specification To Be Confirmed

Period	Lower CL
Jun 2021	1.1

Value	Median
2.6	2.3

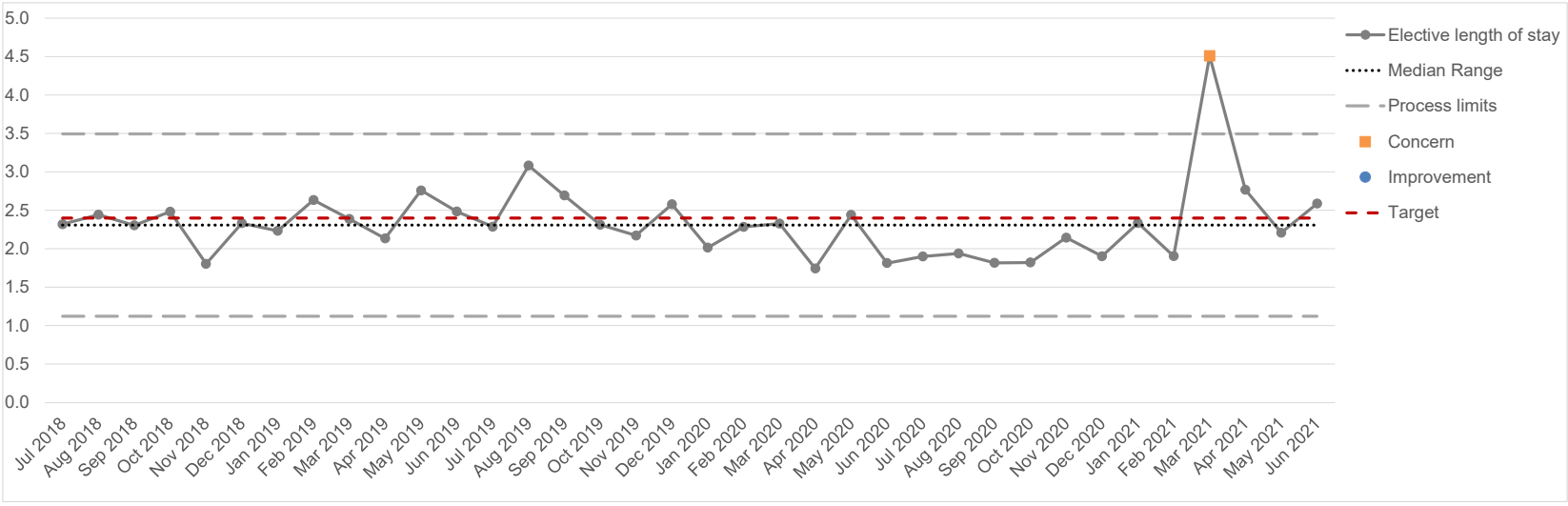
Target	Upper CL
2.4	3.5

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

Issues And Risks	Mitigations

Indicator: AF030 30 day Emergency Readmissions — Local Indicator - Specification Agreed and Reviewed

Period	Lower CL
Jun 2021	6.4%

Value	Median
8.0%	7.5%

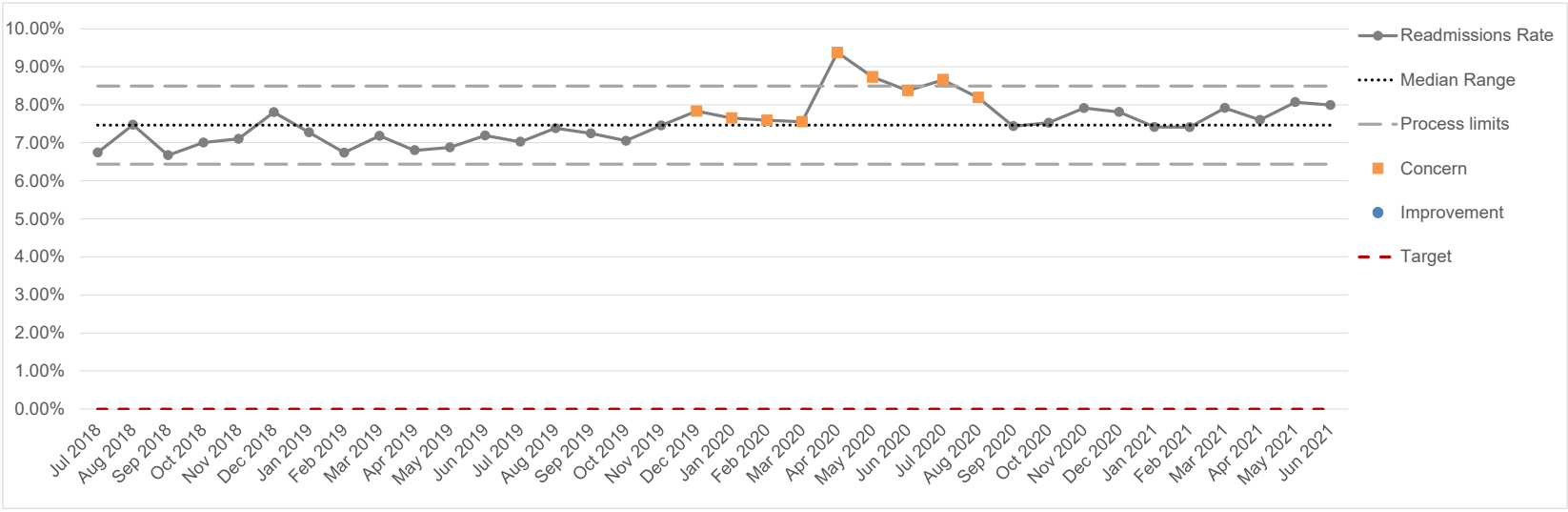
Target	Upper CL
0.0%	8.5%

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
Emergency readmissions for the trust has improved with the implementation of the Discharge to Assess pathways, the new policy enables patients to be assessed and care prescribed by the integrated discharge teams.	* Emergency Readmissions is monitored as part of the discharge to assess work as a system

Issues And Risks	Mitigations

Indicator: AF031 Medical Ward Outliers

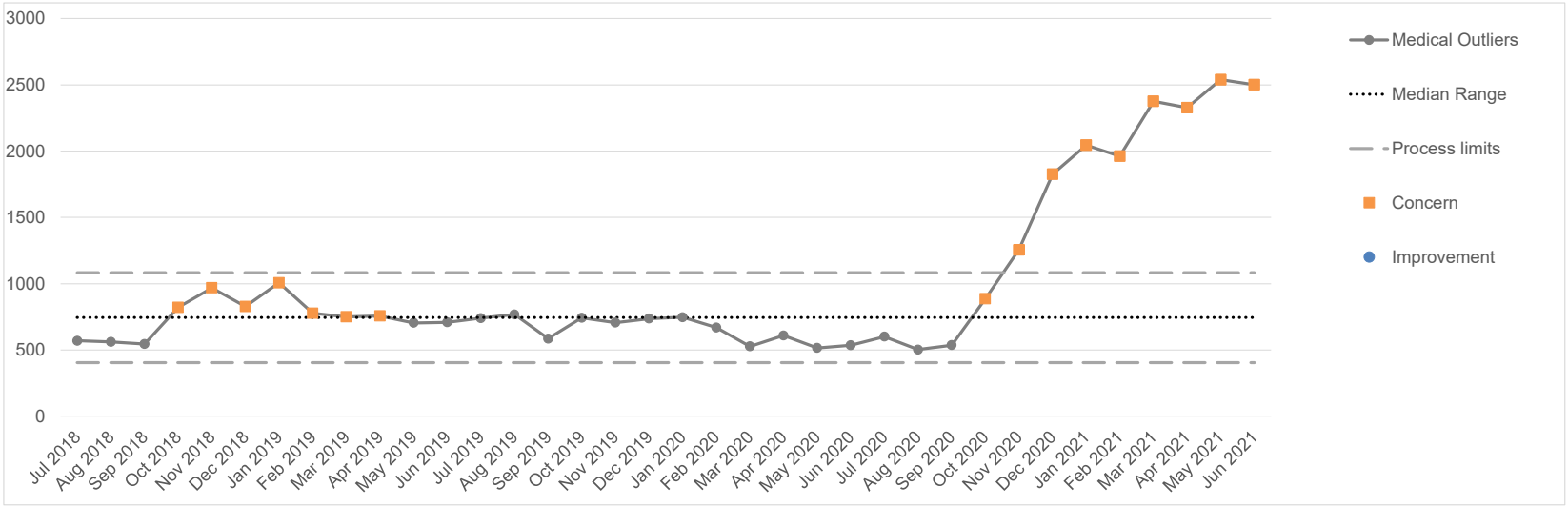
Period	Lower CL
Jun 2021	404.1
Value	**Median**
2,501	744.0
Target	**Upper CL**
No Target	1083.9

Variance

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

Assurance Inconsistency

There is no target for ths metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF032 Discharge Letters To Be Completed Within 24 Hours Of Discharge — Local Indicator: Specification To Be Confirmed

Period	Lower CL
Jun 2021	80.4%

Value	Median
87.4%	86.0%

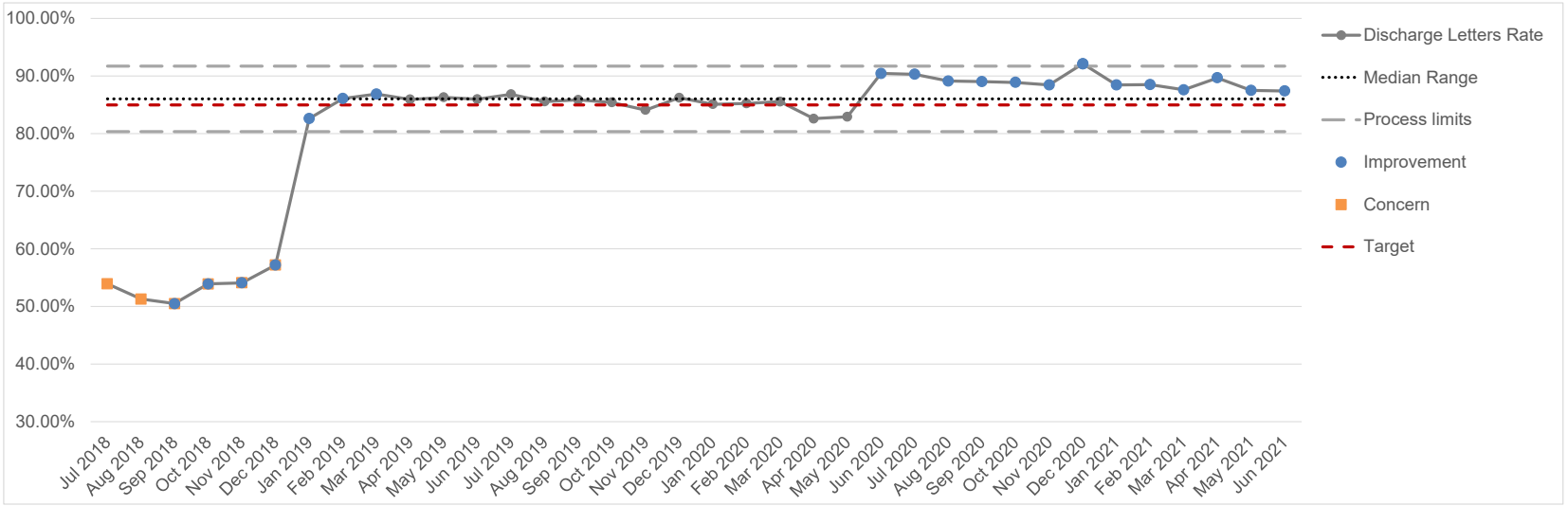
Target	Upper CL
85.0%	91.7%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions
Work has been ongoing to implement the new hospital discharge policy, one of the outcomes of implementation of this policy is identifying discharges at morning board round and facilitating a patients discharge much earlier in the day. Engagement with clinical teams around the discharge process has been taking place on a continuous basis around how to facilitate a tinley discharge.	* Continue engagement with clinical teams * work with wards to ensure escalation process is being followed where they may be a delayed discharge due to discharge letter

Issues And Risks	Mitigations
* Workforce continues to be an issue across the trust therefore discharge letters at times are not completed in a timely manner	Ensure wards and integrated discharge teams are following the escalation process to highlight any discharge delays.

Indicator: QS043 Discharge Letters - Trauma and Orthopaedics

Period	Lower CL
Jun 2021	94.45%

Value	Median
95.62%	97.64%

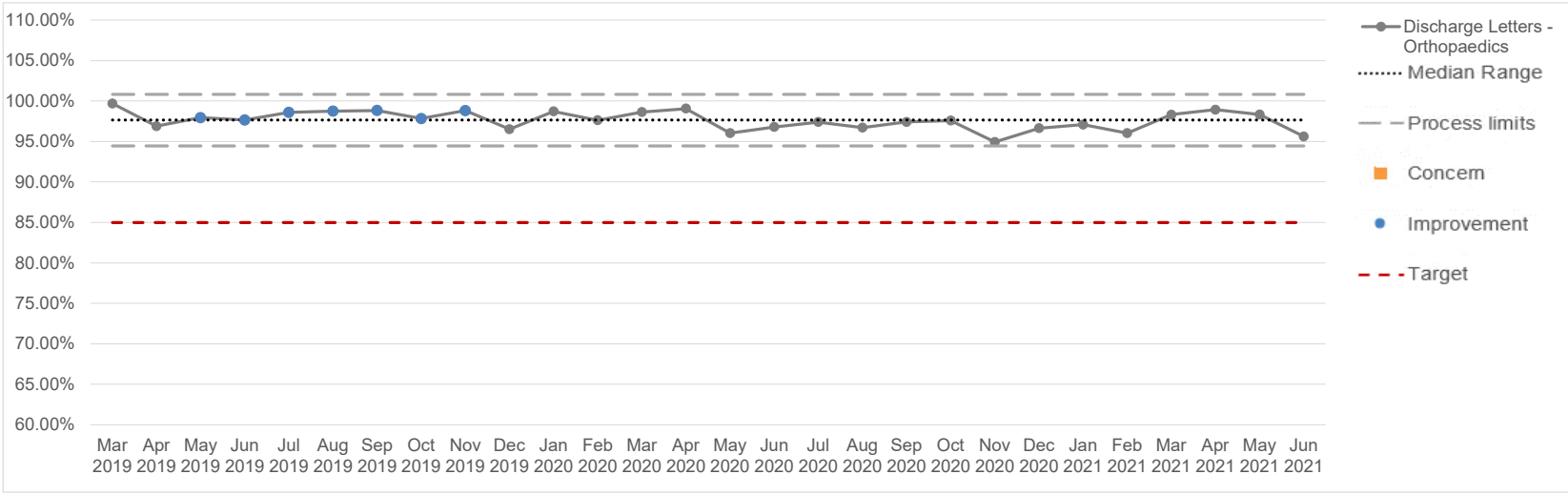
Target	Upper CL
85.00%	100.82%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently passing the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: QS044 Discharge Letters - Ophthalmology

Period	Lower CL
Jun 2021	11.93%

Value	Median
24.77%	33.23%

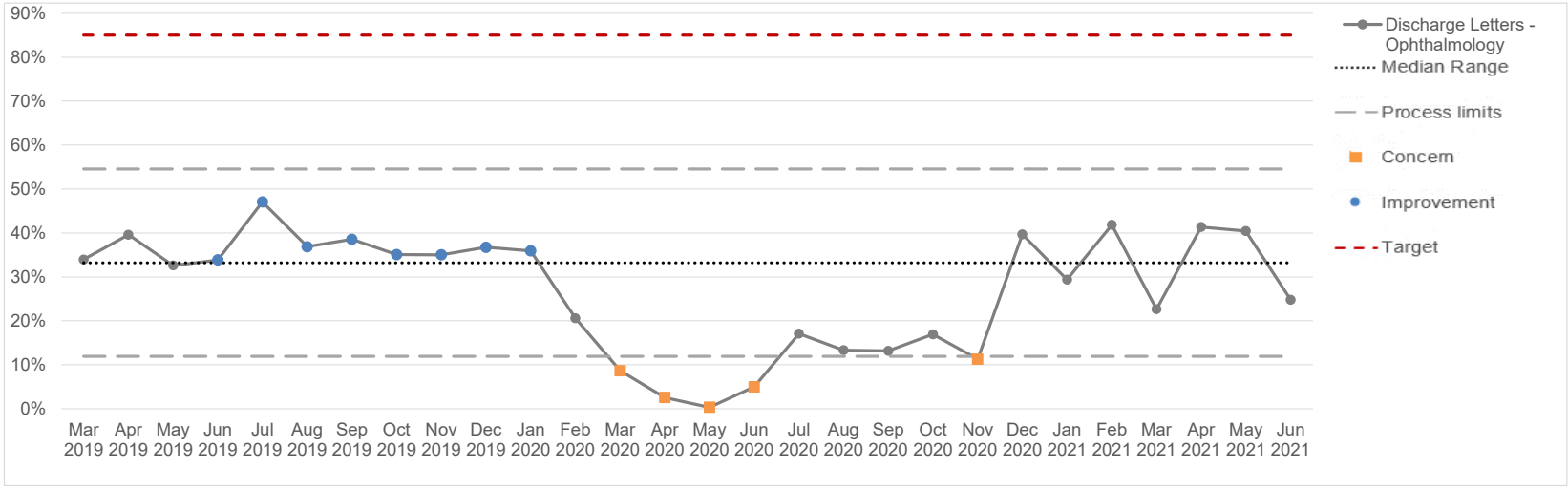
Target	Upper CL
85.00%	54.53%

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

Issues And Risks	Mitigations

Indicator: AF033 Progressive Improvement In The Rate Of Golden Discharges — Local Indicator: Specification To Be Confirmed

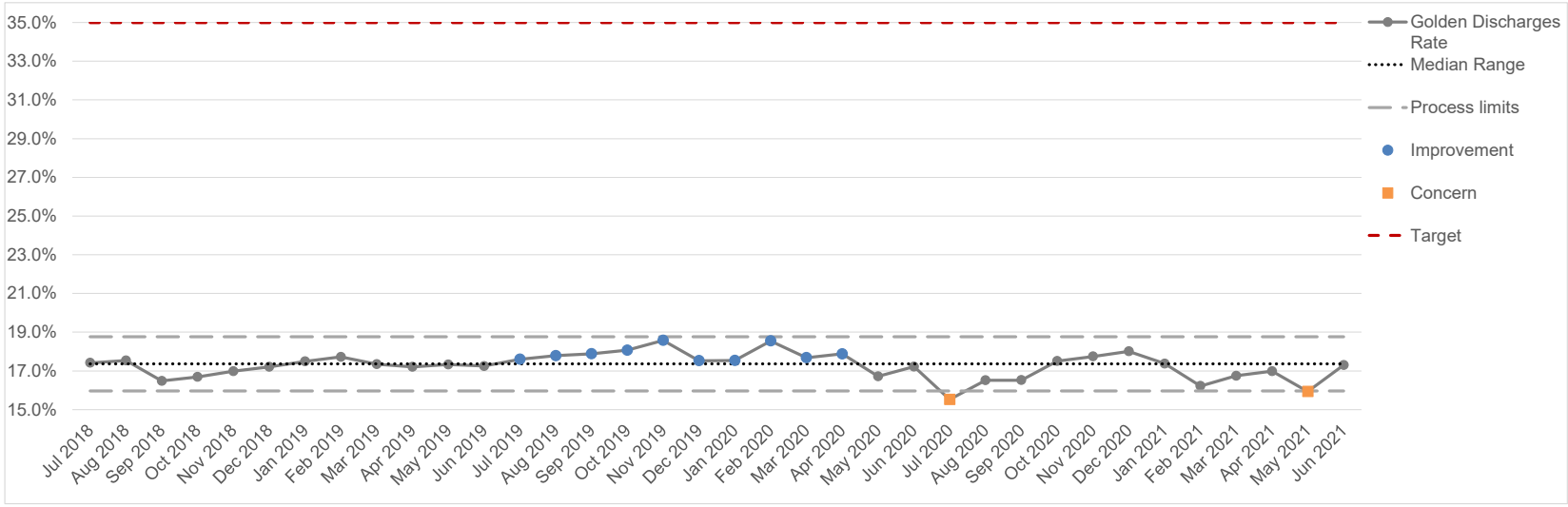
Period	Lower CL
Jun 2021	16.0%
Value	**Median**
17.3%	17.4%
Target	**Upper CL**
35.0%	18.8%

Variance

Common cause - no significant change

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
Work has been ongoing to implement the new hospital discharge policy, one of the outcomes of implementation of this policy is identifying discharges at morning board round and facilitating a patients discharge much earlier in the day. Support and education currently being rolled out across all wards to ensure effective MDT board rounds are taking place resulting in clear plans for all patients.	* Board round Support & Education * Embedding Discharge to Assess pathway * Work with the wider system to facilitate discharge in the morning

Issues And Risks	Mitigations
* Workforce continues to be an issue across the trust therefore not all actions following a board round are carried out in a timely manner * Capacity & Resource issues within our community services	* Support & Monitoring across all wards taking place on a daily basis and introduced an escalation process working with the operations centre to support wards * Working with our system partners to look at Demand & Capacity

Indicator: AF050 Discharges before 5pm

Period	Lower CL
Jun 2021	68.38%

Value	Median
70.55%	70.88%

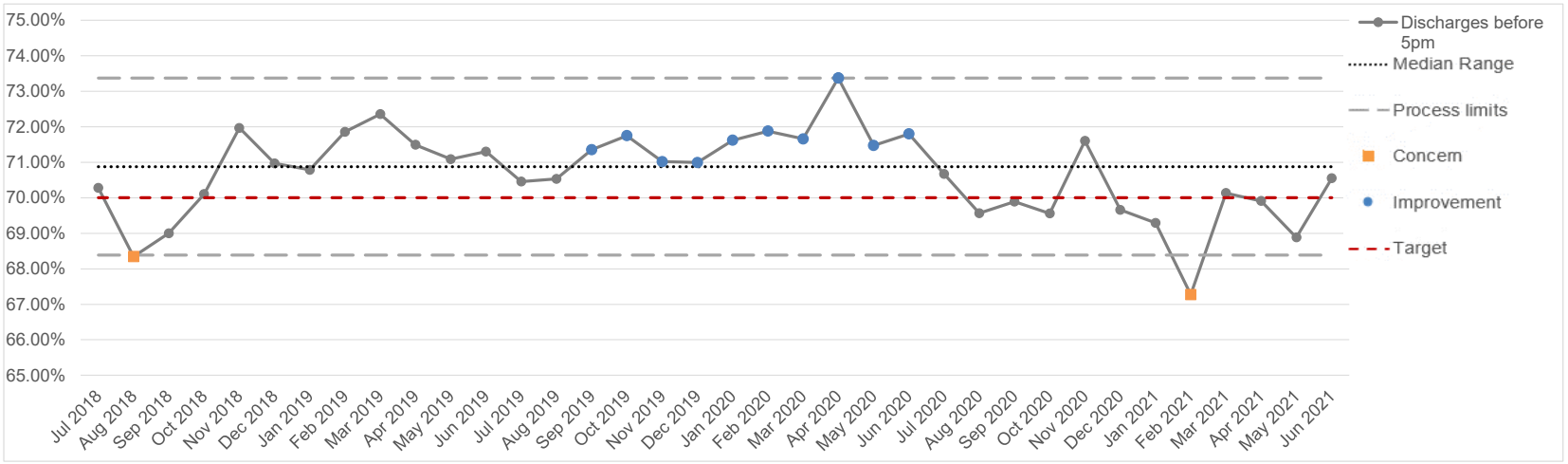
Target	Upper CL
70.00%	73.37%

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
Discharges before 5pm did drop under the target in May, however there has been PDSA work taking place around board rounds which has shown an improvement for June at over 70%.	Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement length of stay are: * Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning * Working with the ward MDT to carry out effective board rounds * Patients requiring support on discharge leave following a discharge to assess pathway on the same day * Escalation process in place to ensure any delays in patient pathways are highlighted and actioned * Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

Issues And Risks	Mitigations

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator: AF034 Percentage Of A&E Under Four Hours Local Target (Trust Priority) — Local Indicator - Specification Agreed and Reviewed

Period	Lower CL
Jun 2021	72.5%

Value	Median
74.6%	80.7%

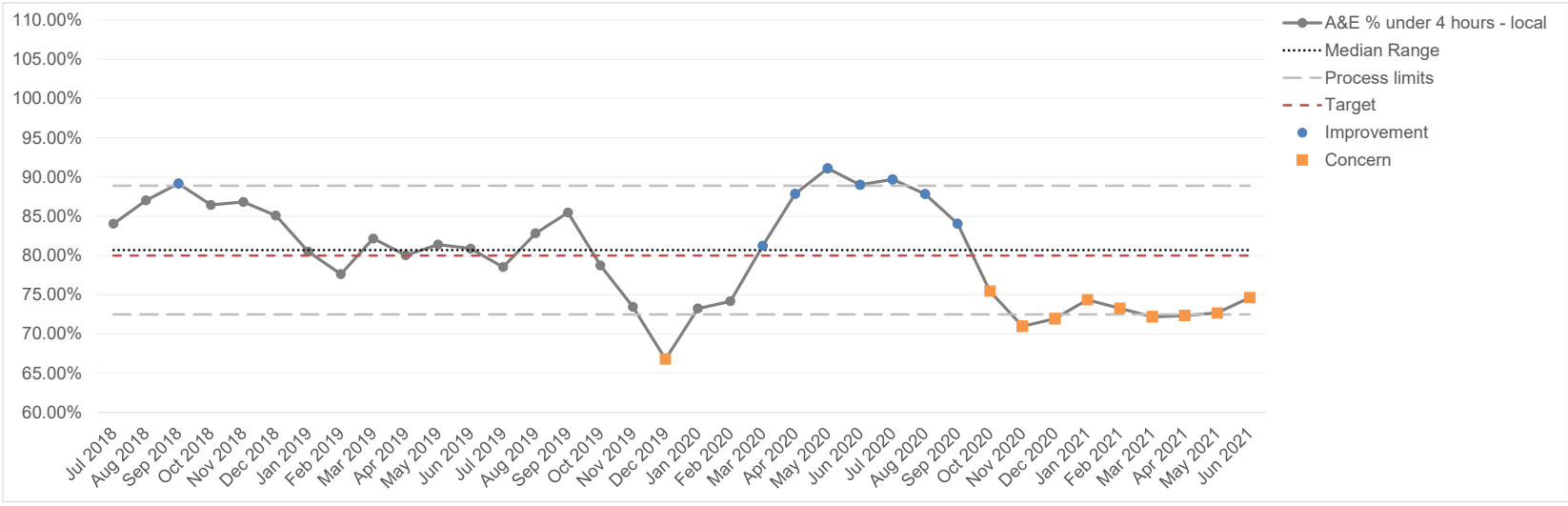
Target	Upper CL
80.0%	88.9%

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



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF035 Non Emergency Patient Transfers between 22:00 and 06:00

Period	Lower CL
Jun 2021	1.9%

Value	Median
6.6%	4.6%

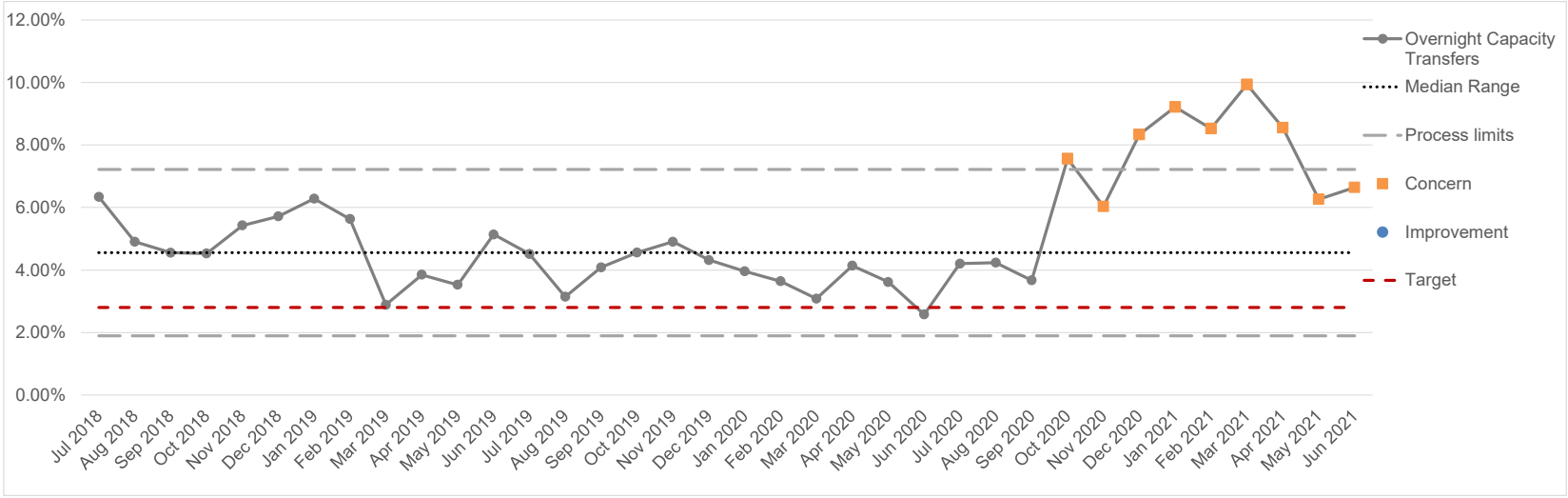
Target	Upper CL
2.8%	7.2%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF036 Non Elective, Non Clinical Ward Moves

Period	Lower CL
Jun 2021	3.9%

Value	Median
9.6%	7.5%

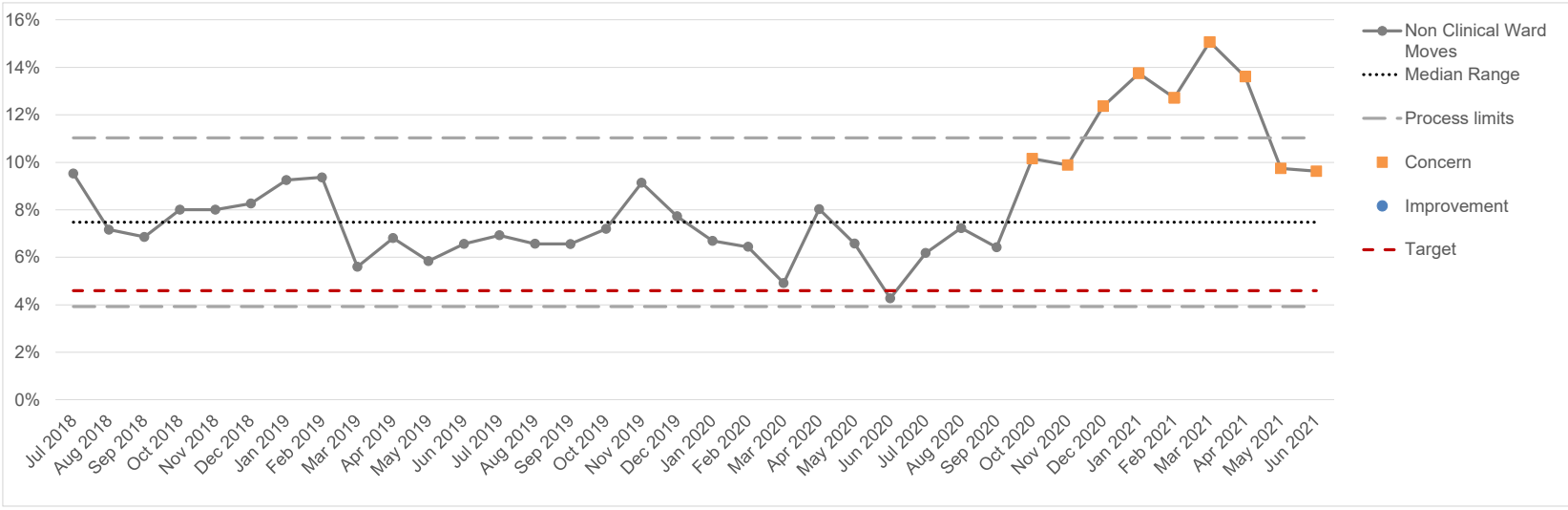
Target	Upper CL
4.6%	11.0%

Variance

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

Assurance Inconsistency

Variation indicates inconsistently hitting passing and falling short of the target



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF039 Risk Stratification - Inpatients

Local Indicator - Specification Agreed and Reviewed

Period	Lower CL
Jun 2021	99.0%

Value	Median
99.8%	99.4%

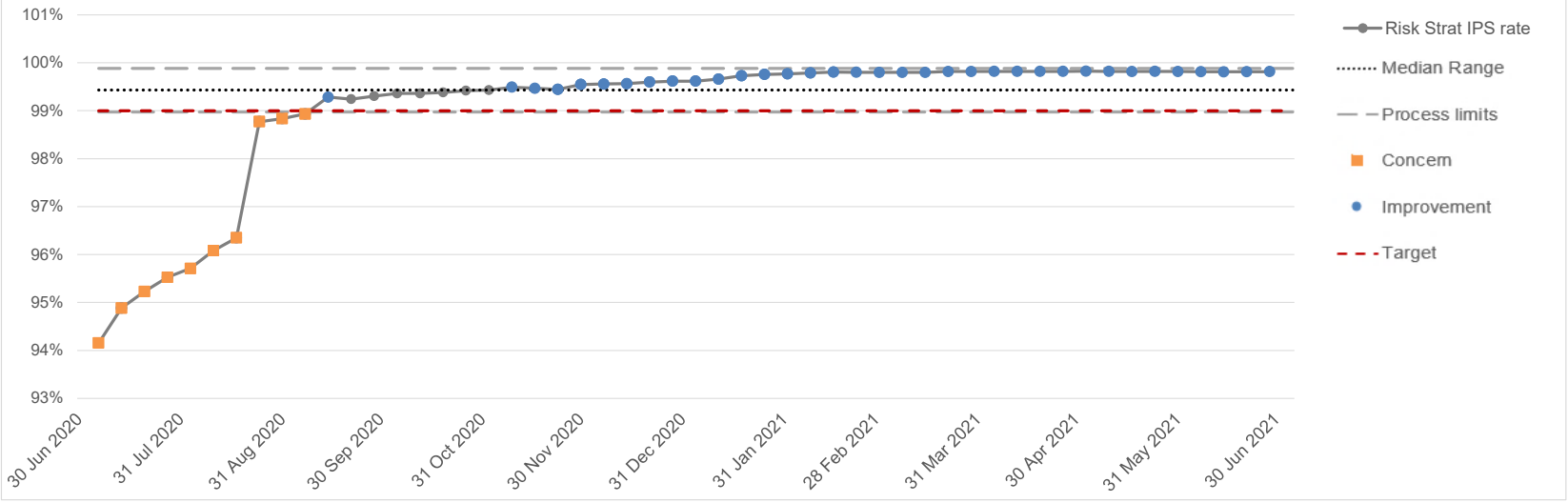
Target	Upper CL
99.0%	99.9%

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?	Actions

Issues And Risks	Mitigations

Indicator: AF047 Risk Stratification - Outpatients — Local Indicator - Specification Agreed and Reviewed

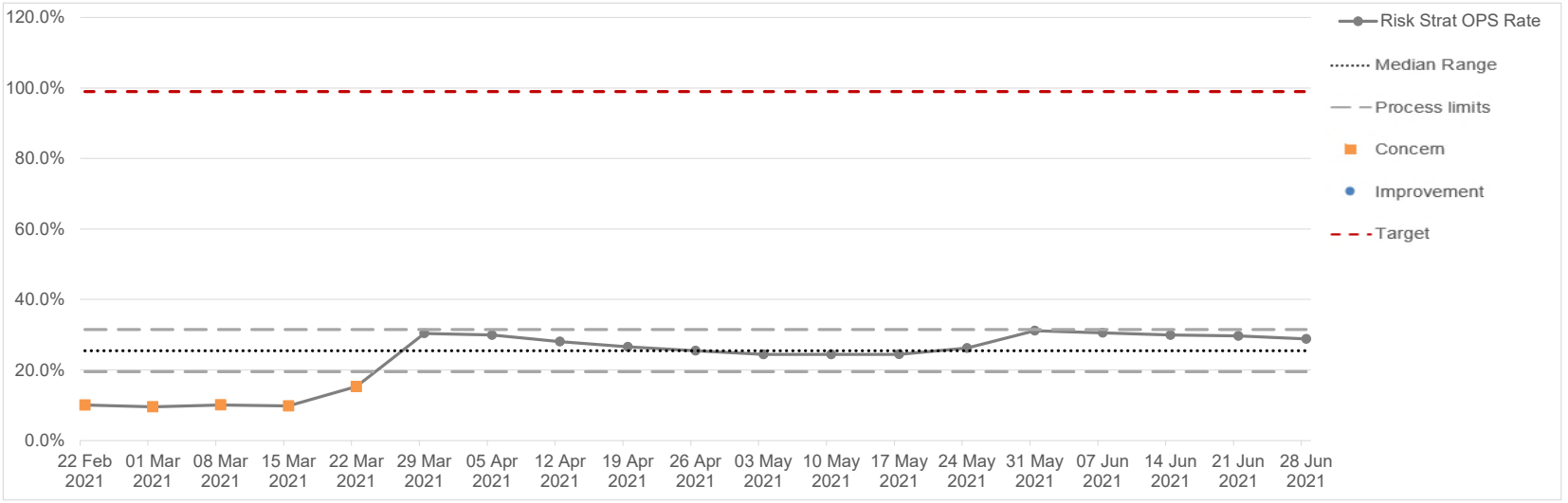
Period	Lower CL
Jun 2021	19.5%
Value	**Median**
28.8%	25.5%
Target	**Upper CL**
99.0%	31.5%

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
	S&CC monitor all overdue follow-ups closely. Division has developed a risk stratification plan - surgical categorisation underway and DCF forms for OP have been reviewed and will be updated by Patient Access to enable coding in patient appointments. S&CC are currently on track with their trajectory for the follow-up backlog and are working with Patient Access Team to formulate a plan for the entirety of the Outpatient PTL.

Issues And Risks	Mitigations
Carry over of annual leave - clinician availability Inability to resource additional sessions as lockdown lifts	Locum staff in place

Indicator: AF048 Number of 40-51 Week Waits - Latest month represents the unvalidated snapshot

Period	Lower CL
Jun 2021	284

Value	Median
1,433	838

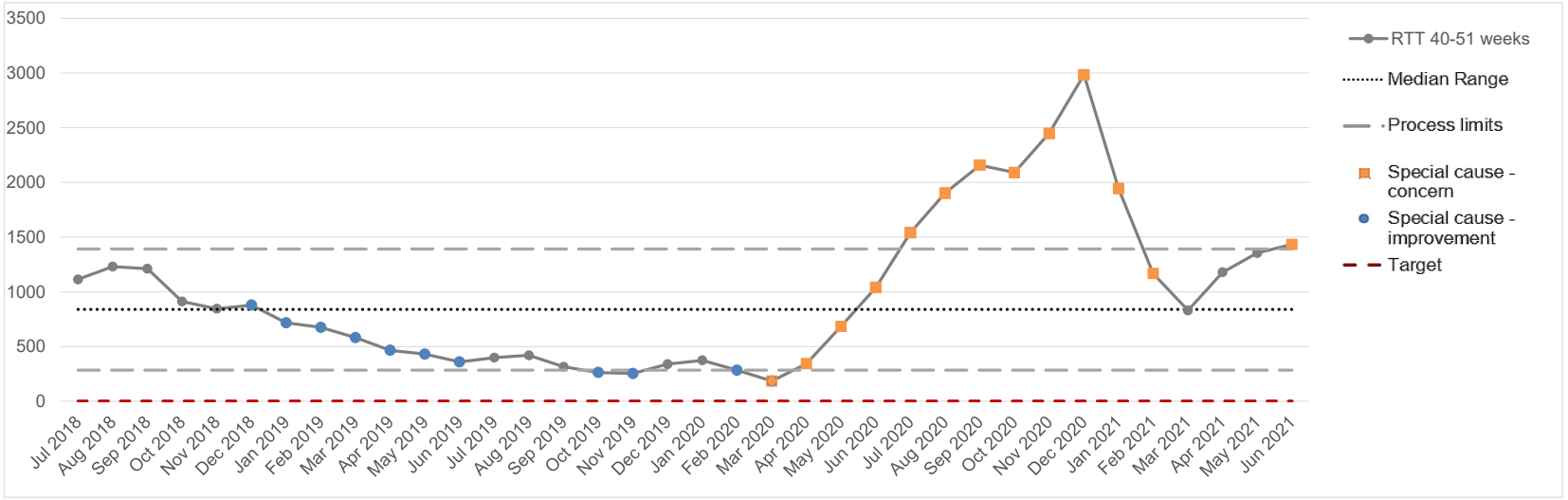
Target	Upper CL
0	1,392

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
	S&CC apply close scrutiny to the over 40 week patients and ensure valid pre assessments are in place to maximise capacity for theatres. Some specialties are now validating from 34 weeks. Theatre productivity programme currently in place to increase the productivity in theatres to maximise on available capacity, the programme is made up of 4 workstreams looking at pre-assessment, productive theatres, workforce and culture and data and reporting.

Issues And Risks	Mitigations
Potential further COVID waves	Locum staff in place
Carry over of annual leave - clinician availability	Blocking booking of agency and bank
Inability to resource additional sessions as lockdown lifts	Theatre productivity programme has commenced

Indicator: AF047 Patients in Hospital with an Inpatient Stay of 7+ Days

Period	Lower CL
Jun 2021	187

Value	Median
238	275

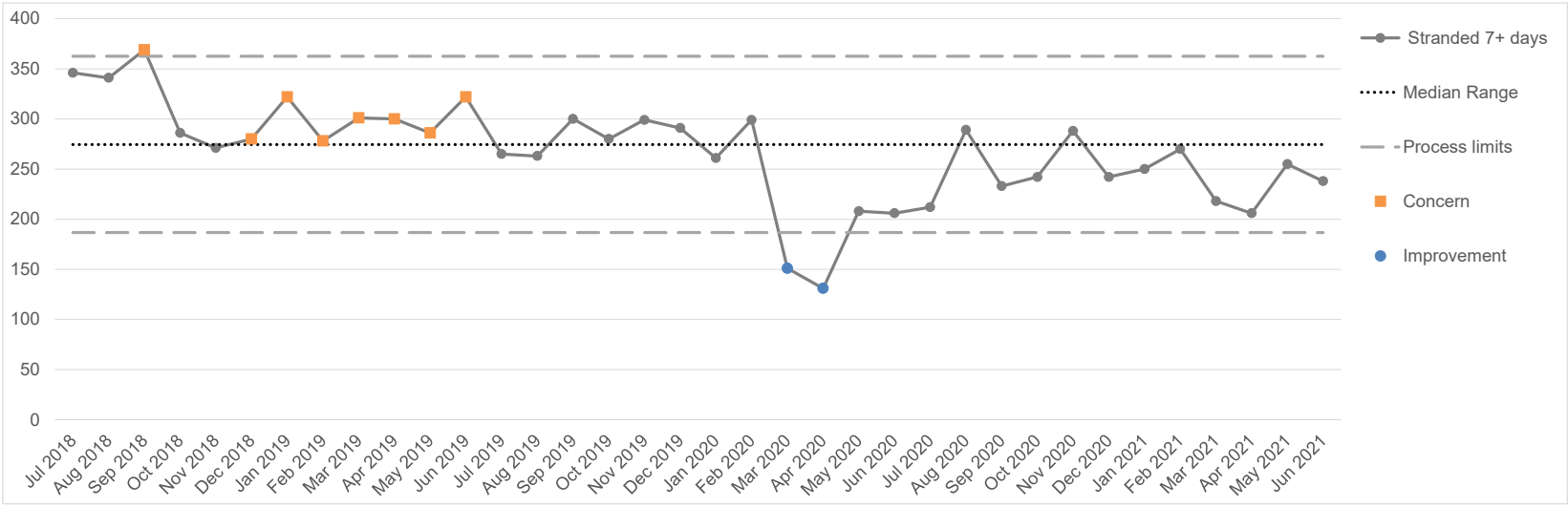
Target	Upper CL
No Target	362

Variance

Common cause - no significant change

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions
The chart shows that there has been an improvement in patients with a length of stay over 7 days, although there have been some peaks in 2020 due to COVID peaks the LOS has shown improvement, there has been a significant amount of improvement work take place around the discharge process.	Discussed at S&CC M&M speciality meetings. S&CC attend daily Discharge to Assess meeting to discuss any stranded patients. Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement in 7 day length of stay are: * Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning * Working with the ward MDT to carry out effective board rounds * Patients requiring support on discharge leave following a discharge to assess pathway on the same day * Escalation process in place to ensure any delays in patient pathways are highlighted and actioned * Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

Issues And Risks	Mitigations
Lack of dedicated specialty wards cause issues and has increased length of stay. Ongoing issues around workforce shortages and consistency of board rounds and decision making.	The Trust are part of a NHS E/I Ward/board round collaborative with external support and guidance around best practice board/ward rounds and decision making.

Indicator: AF057 Patients in Hospital with an Inpatient Stay of 14+ Days

Period	Lower CL
Jun 2021	70

Value	Median
103	124

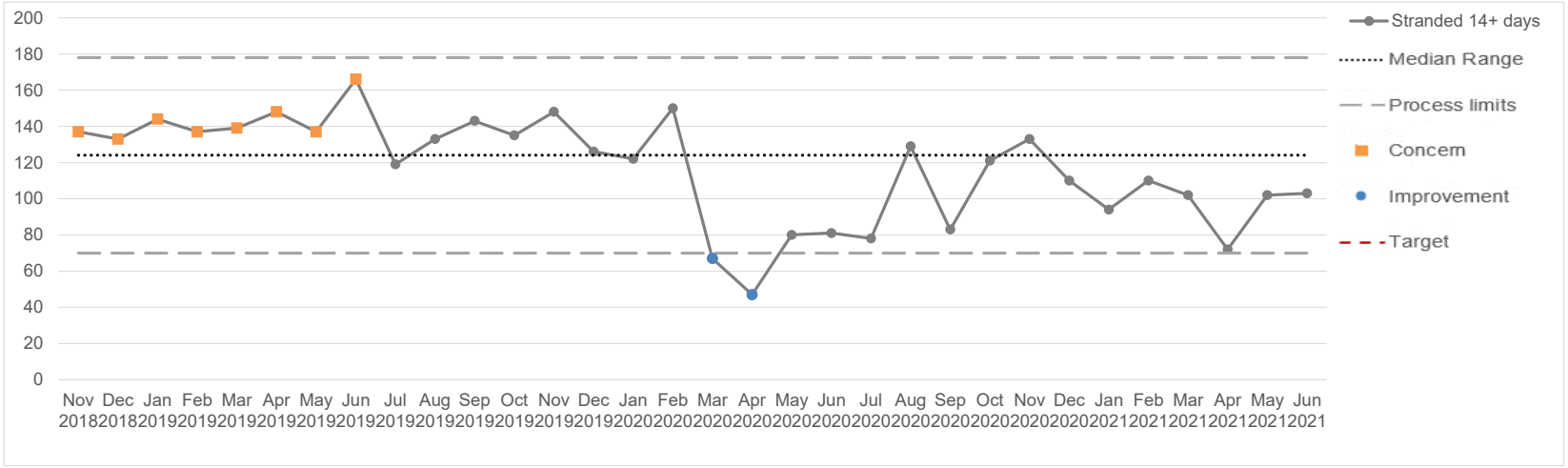
Target	Upper CL
No Target	178

Variance

Common cause - no significant change

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions
We have seen a drop in patients with a LOS over 14 days, a huge amount of work has taken place around board rounds, early discharge planning and reviewing of patient management plans.	Discussed at S&CC M&M speciality meetings. S&CC attend daily Discharge to Assess meeting to discuss any stranded patients. Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement in 7 day length of stay are: * Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning * Working with the ward MDT to carry out effective board rounds * Patients requiring support on discharge leave following a discharge to assess pathway on the same day * Escalation process in place to ensure any delays in patient pathways are highlighted and actioned * Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

Issues And Risks	Mitigations

Indicator: AF048 Patients in Hospital with an Inpatient Stay of 21+ Days

Period	Lower CL
Jun 2021	40

Value	Median
49	70

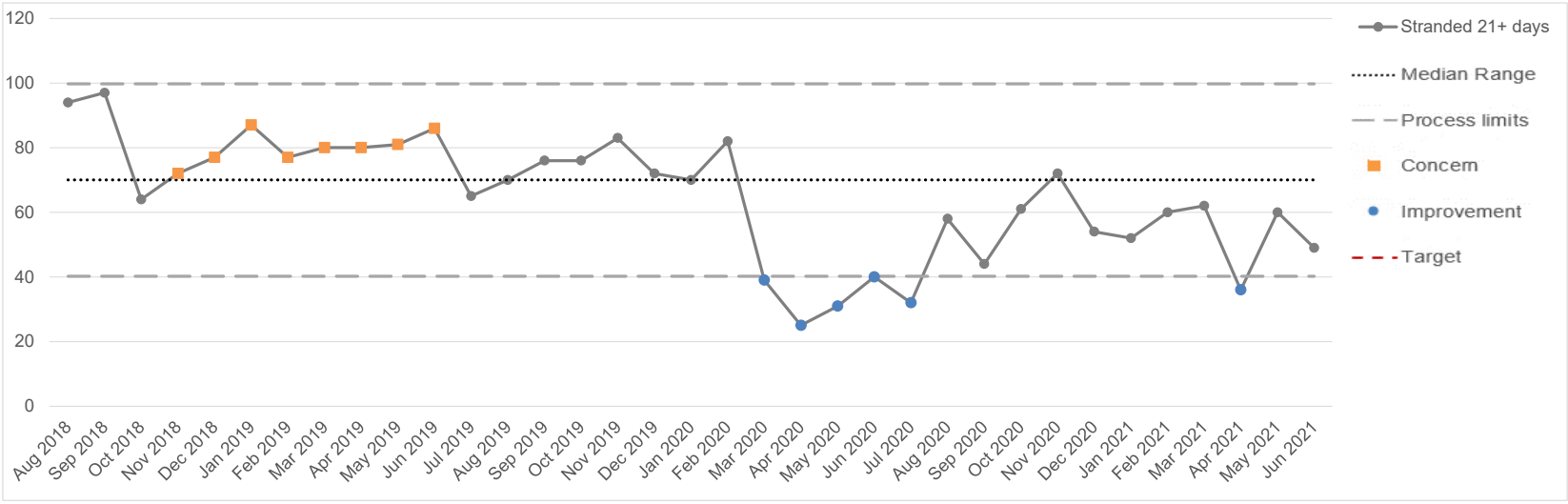
Target	Upper CL
No Target	100

Variance

Common cause - no significant change

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions
The chart shows that there has been an improvement in patients with a length of stay over 21 days, although there have been some peaks in 2020 due to COVID peaks the LOS has shown improvement, there has been a significant amount of improvement work take place around the discharge process which has resulted in the trust sitting below the national average of 12%.	Discussed at S&CC M&M speciality meetings. S&CC attend daily Discharge to Assess meeting to discuss any stranded patients. There are less than 10 over 21 days, two of whicha re intensive care who are reviewed twice weekly by the matrons and escalated to clinical teams as required. Through the discharge to assess implementation there has been significant improvement work carried out around the discharge process, actions agreed to ensure continuous improvement in 21 day length of stay are: * Ensuring all wards have daily board rounds before 10am to help facilitate early discharge & planning * Working with the ward MDT to carry out effective board rounds * Patients requiring support on discharge leave following a discharge to assess pathway on the same day * Escalation process in place to ensure any delays in patient pathways are highlighted and actioned * Working with clinical leads to highlight patients with a length of stay over 7 days to ensure patient plans are in place and any pathway delays are escalated

Issues And Risks	Mitigations
Lack of dedicated specialty wards cause issues and has increased length of stay. Ongoing issues around workforce shortages and consistency of board rounds and decision making.	The Trust are part of a NHS E/I Ward/board round collaborative with external support and guidance around best practice board/ward rounds and decision making.

Indicator: AF047 COVID Related Staff Absences

Period	Lower CL
Jun 2021	22.30%

Value	Median
7.27%	29.30%

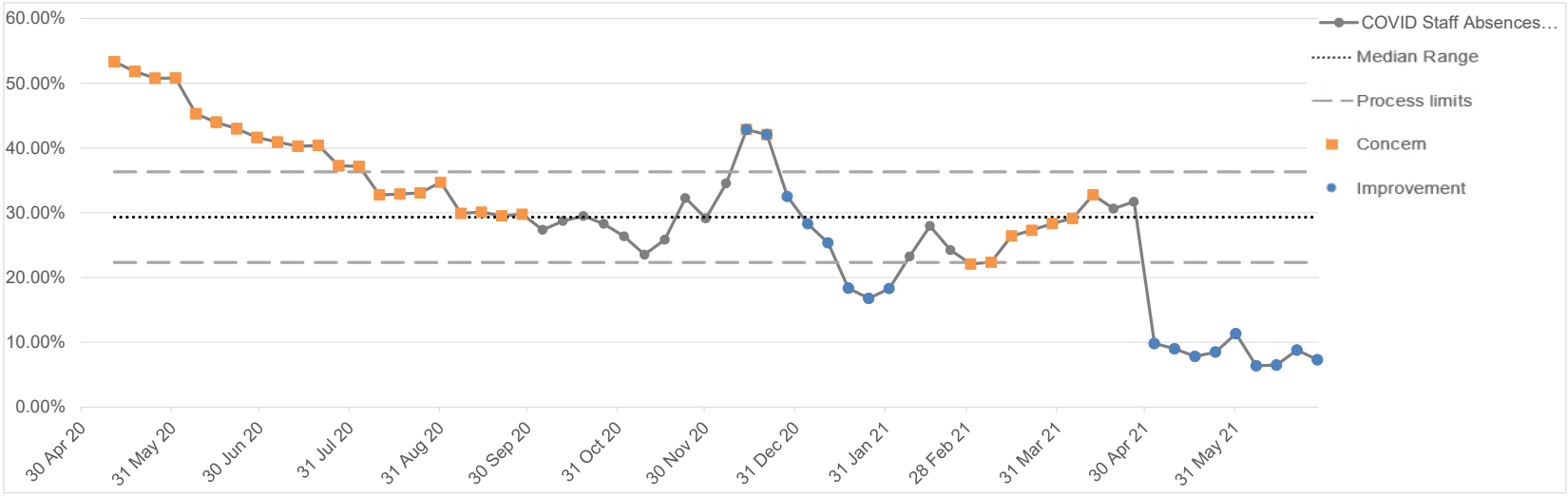
Target	Upper CL
No Target	36.31%

Variance

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

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Indicator: AF049 COVID ICU Beds

Local Target

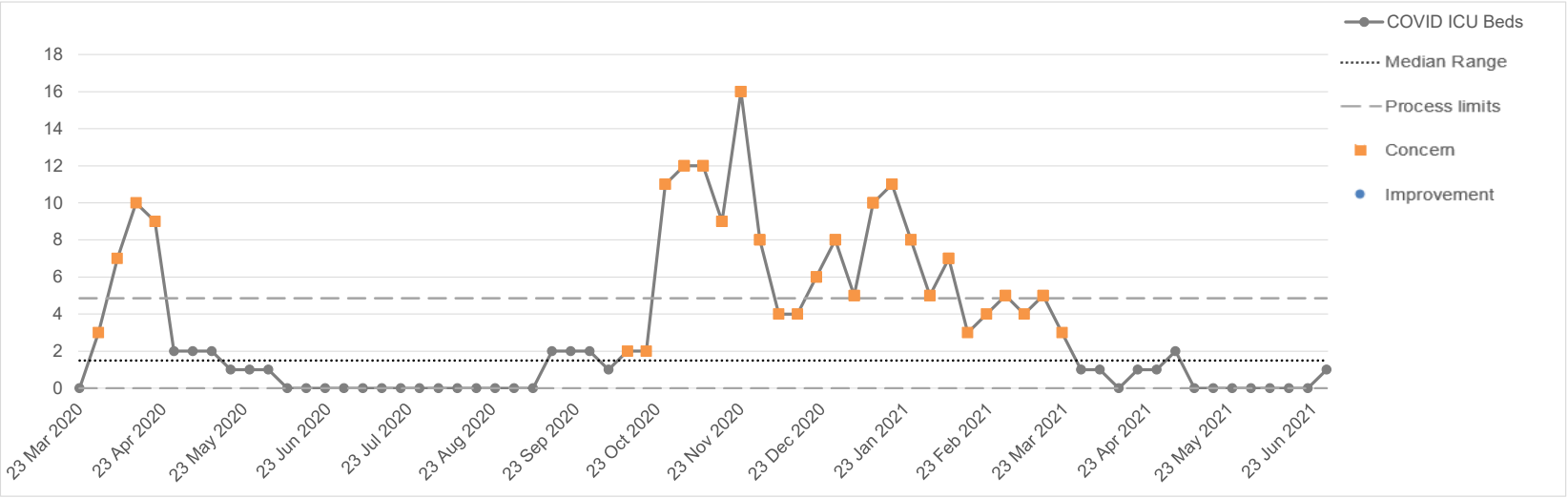
Period	Lower CL
Jun 2021	0.0
Value	**Median**
1	1.5
Target	**Upper CL**
No Target	4.8

Variance

Common cause - no significant change

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions
	Sharp increase in the number of COVID ITU admissions. The strategic meetings have all been reintroduced focussing on workforce, equipment, ventilation and oxygen with a view all elective activity should be maintained.

Issues And Risks	Mitigations

Indicator: AF046 COVID patients in other Beds — Local Target

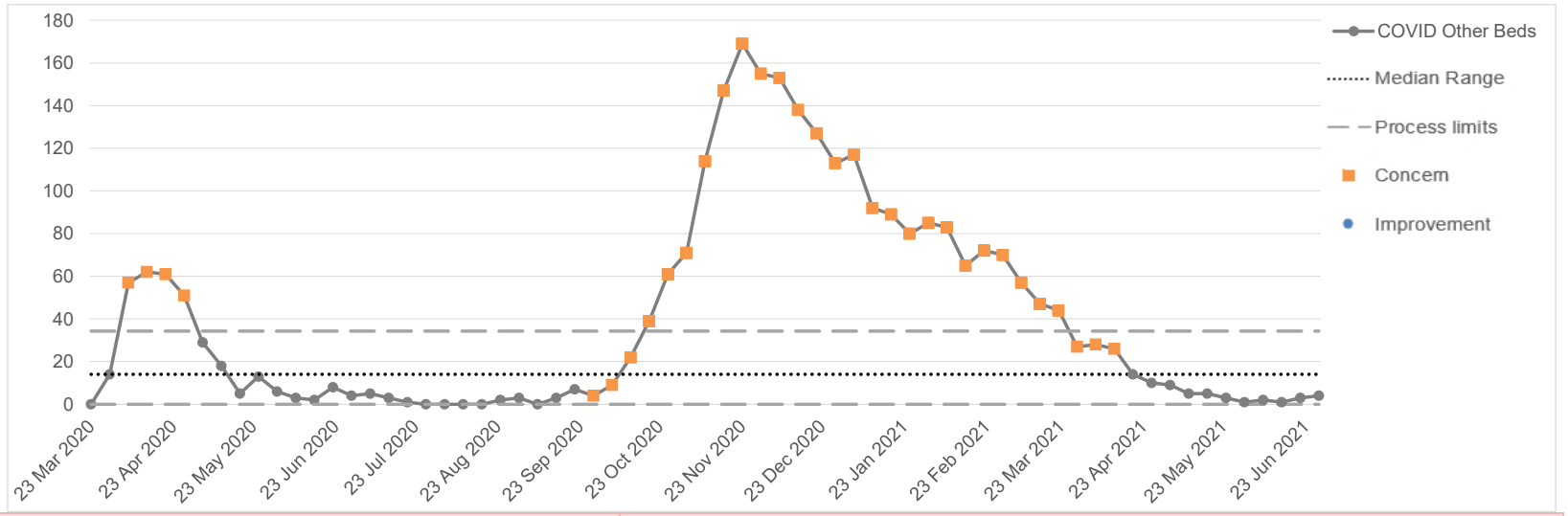
Period	Lower CL
Jun 2021	0.0
Value	**Median**
4	14.0
Target	**Upper CL**
No Target	34.3

Variance

Common cause - no significant change

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions

Issues And Risks	Mitigations

Trust Priorities Update – Quarter 1

1. Pandemic Response		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
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 (IPC).	Chief Operating Officer	In line with the NHS England (NHSE) changes to the pandemic level the Trust has continued to fulfil its role within the pandemic. The Incident Coordination Centre (ICC) and structured meetings have been stood down although arrangements remain in place to support requests and actions through the emergency preparedness, resilience and response (EPRR) Team. A revision of the Trusts surge, escalation and full hospital protocol has been provided following a wave two debrief and learning event. Trust Management has signed this document off and it is now in place to manage any further changes in the position. A ward bed and staffing review is underway to ensure we can contain any outbreak or surge in infections within our hospital sites. This will provide further details to the surge plan and ensure that ward teams can plan in advance for their role should any outbreaks of COVID-19, Flu, or other infections become a challenge within our communities. North East Lincolnshire remains the fourth highest area within the UK for COVID-19 with a positive prevalence rate of 643 cases per 100,000 and North Lincolnshire a rate of 155 cases per 100,000. Vigilance in monitoring the position within the hospitals remains a priority as does ensuring compliance with infection control practice throughout the next quarter. Staff absence related to COVID-19 remains a significant concern for the next period as we proceed into the summer holiday period. As a system we continue to make excellent progress with the local vaccination program.
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 three);	Chief Operating Officer	We continue to progress and deliver our recovery plan for the H1[1] period. We are meeting the 85% required position in all areas other than 'inpatient' electives which is at 83%. Primarily this is due to the access to operating theatres which are being phased to return to pre March 2020 capacity. The volume of patients waiting longer than 104 days in Cancer is 33 (June 2021) and has been improving since our July 2020 position of 66 patients.

[1] H1 relates to the for the six-month period from 1 April 2021 to 30 September 2021 of the Finance and Contracting Arrangements 2021-22

		The Independent Sector continues to support the Trust with additional capacity within CT, MRI, Gynaecology, Orthopaedics and General Surgery. This capacity is targeted to support long waiter backlog patients and has reduced the six week plus diagnostics waiters from 67.3% of the waiting list in April 2020 to 33.3% in June 2021. Referral to Treatment (RTT) performance continues to be low (68.8% unvalidated June 2021) driven by the Trust delivery of the backlog, however the number of RTT 52 plus week waiters has dropped from 1,287 in February 2021 to 511 in June 2021 (unvalidated). The largest risk for the H1 plan remains the workforce as there are significant vacancy gaps and carried over annual leave. Whilst the plans have taken this into consideration by increasing the use of the independent sector it remains a challenging position. The potential wave three of COVID-19 continues to be a risk to the capacity available to deliver the plan, although the surge and escalation plan addresses this by detailing the beds to be flipped to red as the numbers increase. There remains a risk to the delivery of the risk stratification for follow up outpatients with high volumes of patients not risk stratified, although these are slowly decreasing with the current number outstanding circa 63,000 (19 July 2021).
An emergency response through our Emergency Departments (ED) of 80% of patients managed within four hours;	Chief Operating Officer	**Link to Key Performance Indicator (KPI):** 80% Accident and Emergency (A&E) maximum waiting time of four hours from arrival to admission/transfer/discharge (four hour target). **Update Quarter One:** The Trust continues to see a high volume of attenders through its two emergency departments. Both Grimsby (DPOWH) and Scunthorpe (SGH) Hospitals are being challenged by the significant increase in overall ED attendances over the past few months, with an average of 455 patients per day in June 2021 compared to 344 patients per day in June 2020. This is a 32% increase in overall ED attendances compared to last year, but also a significant increase compared to the pre-COVID-19 attendances, with June 2019 averaging 416 patients per day. In context, this is 1,170 more ED attendances during June 2021 than pre-COVID-19 levels of June 2019. Trust performance against the four hour target for April 2021 was 72.34%, with May at 72.67% and June 74.63%

		(DPOWH 69.6%, SGH 79.2%). In conjunction with the system partners, two audits at the front door have being undertaken, the outcome of which is helping to focus on areas of improvement. The Trust has introduced a three tier oversight arrangement in both EDs to address fragility due to an increasing number of attendances. The impact of COVID-19 on ED is still providing additional challenge for waiting room capacity due to social distancing, delays in diagnostics due to increased cleaning regimes, additional Personal Protective Equipment (PPE) requirements, and delays to admission. Staffing numbers remain a challenge as COVID-19 heavily impacted the appointed recruitment pipeline. Ambulance handovers have been a targeted focus throughout 2020/21, with a direct correlation between high bed occupancy levels and 60 minute plus ambulance handovers delays. The Ambulance Handover Task and Finish group has been recreated and has seen 60 minute plus handovers drop from 9% of all ambulance arrivals in November 2020 to 4% in June 2021. Staffing experience, skill mix and reliance on agency staff is an issue in ED especially on overnight shifts although it has now been agreed to fund an Additional Specialty Doctor 00:00-08:00 seven days a week to provide patient care and allow the overnight Equal Partners in Care (EPIC) system to have capacity to oversee the full department. There continues to be a risk of overcrowding in and fragility in both EDs due to increase in attendances and reduced capacity from both physical and workforce perspectives. High bed occupancy levels leading to a lack of patient flow and exit block in ED will result in delays for patients in ED and drop in four hour performance and delays in offloading patients from ambulances and risk 60 minutes plus handover breaches. The Discharge To Assess (D2A) programme has been rolled out to support prompt discharges to improve bed occupancy levels by reducing unnecessary Length of Stay (LOS) to improve patient flow and prevent ED exit block. Currently the Trust's performance for 21 days plus, is reported at 8.73% (as at 19 July), and remains under the national average of 12%. This is the second lowest within the North East and Yorkshire region.

Community Single Point of Access (SPA) with 70% of patients receiving a crisis response within two hours;	Chief Operating Officer	**Link to Key Performance Indicator (KPI):** % of patients receiving crisis response within two hours of contact with SPA. **Update Quarter 1:** The Trust has recently implemented a new East Midlands Ambulance Service (EMAS) direct streaming to same day emergency care (SDEC) service at both sites and the trust is an early adopter in the region to go live with direct bookable arrival slots in ED at Grimsby for the SPA as part of the "NHS111 First" initiative programme to try and increase performance. A frailty service pilot at DPOWH commenced on 12 May 2021 for four weeks providing improved patient experience for frail patients on SDEC instead of ED. Pathways for EMAS to access advice and guidance through SPA to avoid acute attendances where possible will be implemented. In February 2021 and to support that national COVID-19 response to avoid unnecessary hospital admissions, NHS England and NHS Improvement published 'Increasing referrals to two-hour crisis response services from NHS111 and 999 - Information and actions for community providers, Directory of Services leads, Integrated Urgent Care including NHS111 and ambulance services'. The purpose of the guidance document and actions is to respond to the evidence indicating that visibility is low within NHS 111 and 999 clinicians of Urgent Community Response (UCR) two-hour crisis response services and consequently leads to unnecessary ambulance attendance, conveyance, hospital attendance and hospital admissions. The guidance document contains some specific actions for community providers and therefore the Community and Therapies Division within Northern Lincolnshire and Goole NHS Foundation Trust has prepared a 'Position Statement' in order to provide assurance regarding the status of implementation of these actions. The Trust meets all of the actions required to support delivery of the two hour response, the remaining risk to address is workforce. The Division are working through this risk as part of their contract delivery proposals.
A reduction to zero by 31.3.22 of patients waiting over 52 weeks for elective treatment,	Chief Operating Officer	**Link to Key Performance Indicator (KPI):** Zero patients waiting in excess of 52 weeks from referral to Treatment. **Update Q1:** The number of RTT 52 week plus waiters continues to decrease. There were 1,285 patients that have waited in excess of 52 weeks at our peak at the end of February 2021; this has

		since reduced to 667 in May 2021 (612 as of 14 June 2021).
And those waiting over 104 days for cancer treatment;	Chief Operating Officer	**Link to Key Performance Indicator (KPI):** Cancer waiting times – over 104 day backlog. **Update Q1:** Volume of patients waiting longer than 104 days in Cancer is 30 (trust wide – all tumour sites except Breast & Gynaecology). Cancer two week wait (2ww) standard continues to be achieved at 97.1% in May 2021 (98% as at 22 June 2021) though there are some pressures in achieving the 31 day first treatment standard which fell short at 92.9% for May 2021 (96.3% as at 22 June 2021) and the 62 day standard was 61.03% for May 2021 (62% as at 22 June 2021), again this is as a result of capacity, primarily within the diagnostic modalities.
Full risk stratification of those whose elective or out-patient care is delayed.	Chief Operating Officer	**Link to Key Performance Indicator (KPI):** Risk Stratification – Outpatients and Inpatients **Update Q1:** Processes in place to record, track and monitor risk stratification for all patients at all points in the pathway. The inpatients Live Risk Stratification remains at 99.8%. The outpatient risk stratification remains at 28% with all specialities undertake work to deliver this by end of March 2022. Ophthalmology out patients risk stratification continues to be reviewed weekly with a view to returning this speciality to its June 2020 position by September 2021.

Indicator: QS002 Methicillin - Susceptible Staphylococcus Aureus (MSSA) bacteraemias

Period	Lower CL
May 2021	0.00

Value	Median
1.00	1.00

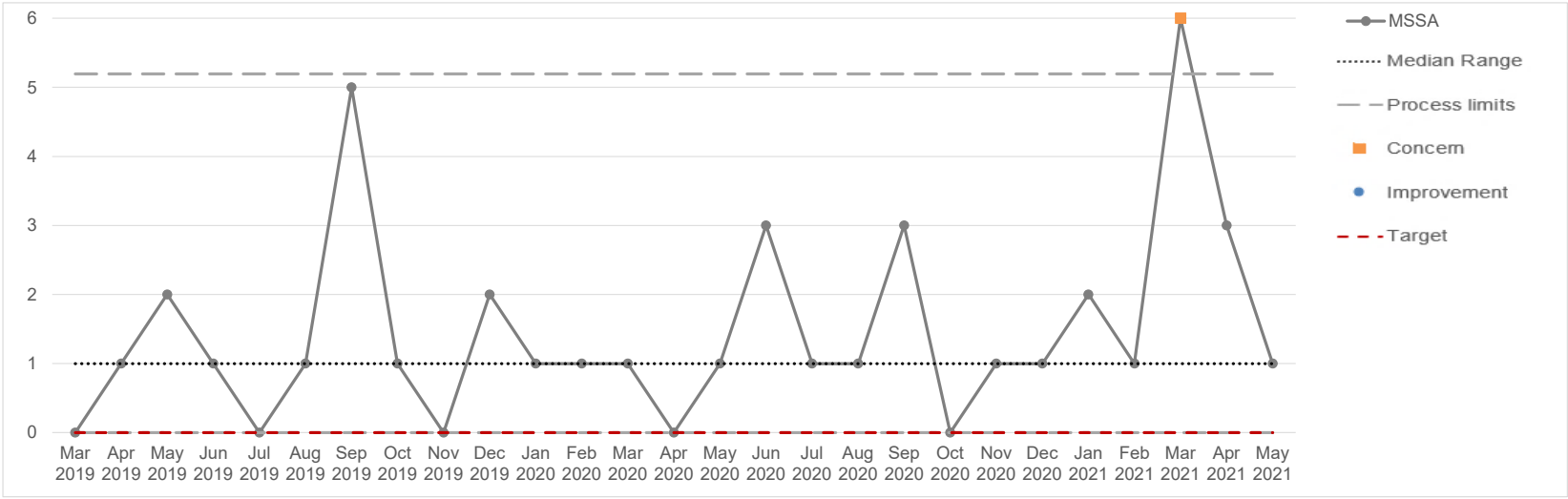
Target	Upper CL
0.00	5.19

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
There has been 1 MSSA bacteraemia during May 2021, this is in line with the median average for the period. During March a spike in the number of cases was identified, the main issue were patients being admitted with skin & soft tissue, urinary or no obvious source. 5 of the 6 cases were detected within 4 days of admission so this could have been a delay in detection or incubating on admission. 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.	Trust performance is reported against peer on a monthly basis within the 'Mandatory Healthcare Associated Infection Monthly Surveillance Report Yorkshire and Humber PHE Centre

Issues And Risks	Mitigations
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.	N/A

Indicator: QS003 Escherichia coli (E.coli) bacteraemia bloodstream infection (BSI)

Period	Lower CL
May 2021	0.00

Value	Median
1.00	4.00

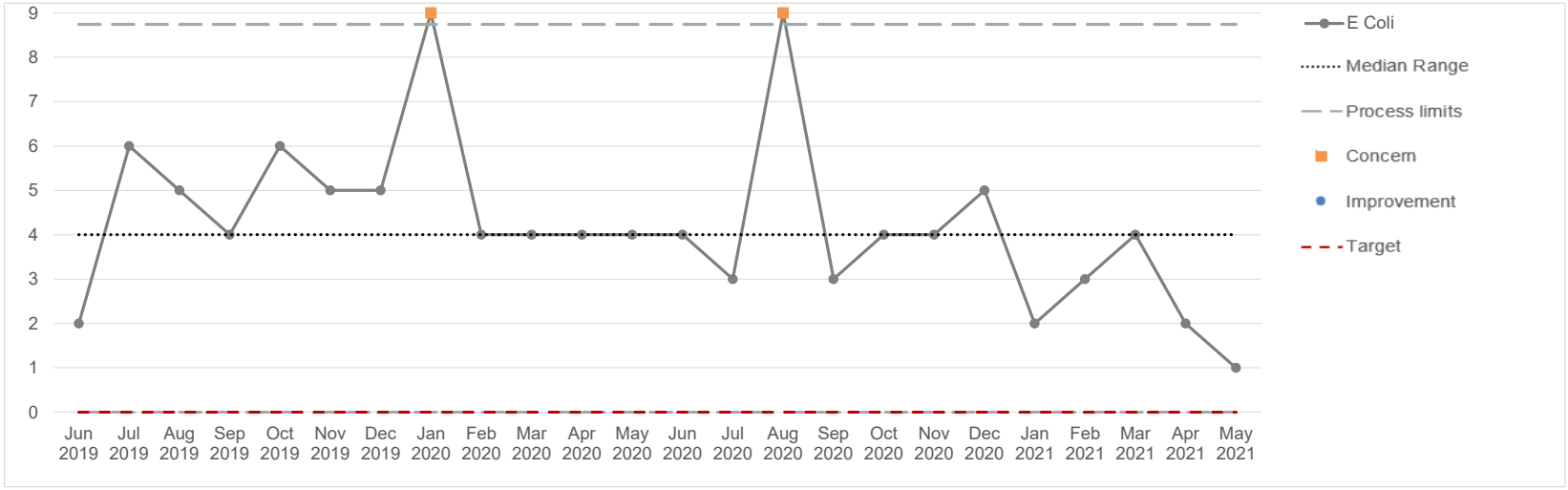
Target	Upper CL
0.00	8.74

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 chart is telling us that the median number of E.coli bloodstream infections is 4 per month. In May 1 was reported. There is no discernable trends from the SPC and no assurance outcome can be derived. 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 complicated rules determined by PHE which vary by organism.	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'. The Trust has a Gram negative reduction plan that has been in place for the last 2 years.

Issues And Risks	Mitigations
80% plus of E.coli bacteraemias are detected pre 2 days and most of the others are provbably related to underlying issues e.g. cholecystitis etc. This is a system wide issue and not just a hospital issue. There is no current target set by Public Health England for this indicator.	N/A

Indicator: QS004 Trust Attributed C-Diff

Period	Lower CL
May 2021	0.00

Value	Median
3.00	2.00

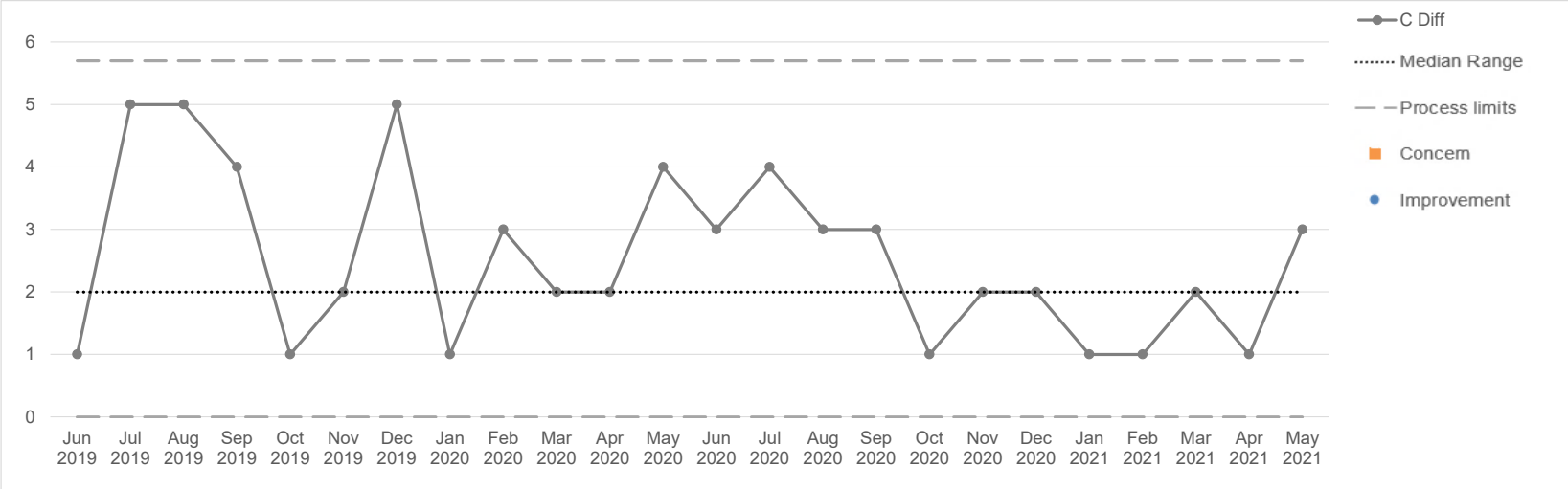
Target	Upper CL
No Target	5.70

Variance

Common cause - no significant change

Assurance Inconsistency

There is no target for this metric, therefore target assurance is not relevant.



Background And What Is The Chart Telling Us?	Actions
The chart tells us that the median each month from historic data is 2 per month. For the month of May, the Trust reported 3. There are no trends discernable from the data. For the F/Y 2020/21 the Trust reported 28 C-Diff cases which was below the Trust ambition of 36 cases. 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 is a national requirement. There has been a significant reduction in cases despite the operational issues which is great news.	Trust performance is reported against peer on a monthly basis within the 'Mandatory Healthcare Associated Infection Monthly Surveillance Report Yorkshire and Humber PHE Centre'.

Issues And Risks	Mitigations
No target set by PHE this year. Trust ambition of 36 cases - 3 per month	N/A

Indicator: QS005 Number of gram-negative bloodstream infections

Period	Lower CL
May 2021	0.00

Value	Median
3.00	5.00

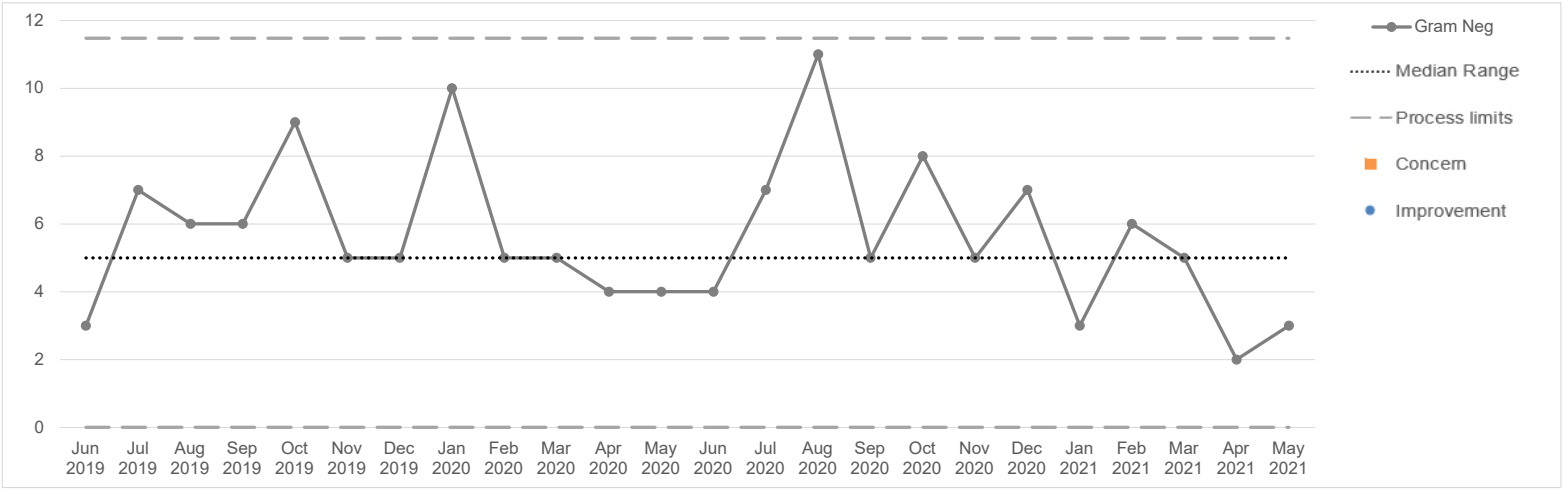
Target	Upper CL
No Target	11.48

Variance

Common cause - no significant change

Assurance Inconsistency

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



E Coli
1

Kleb
2

Pseudom
0

Background And What Is The Chart Telling Us?	Actions
The chart tells us that during May 2021 the Trust reported 3 Gram negative bloodstream infections. There is no target or ambition set by Public Health England for this area. The Trust continues to monitor. 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 is a national requirement.	No target or ambition set by PHE.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS006 Venous Thromboembolism (VTE) risk assessment

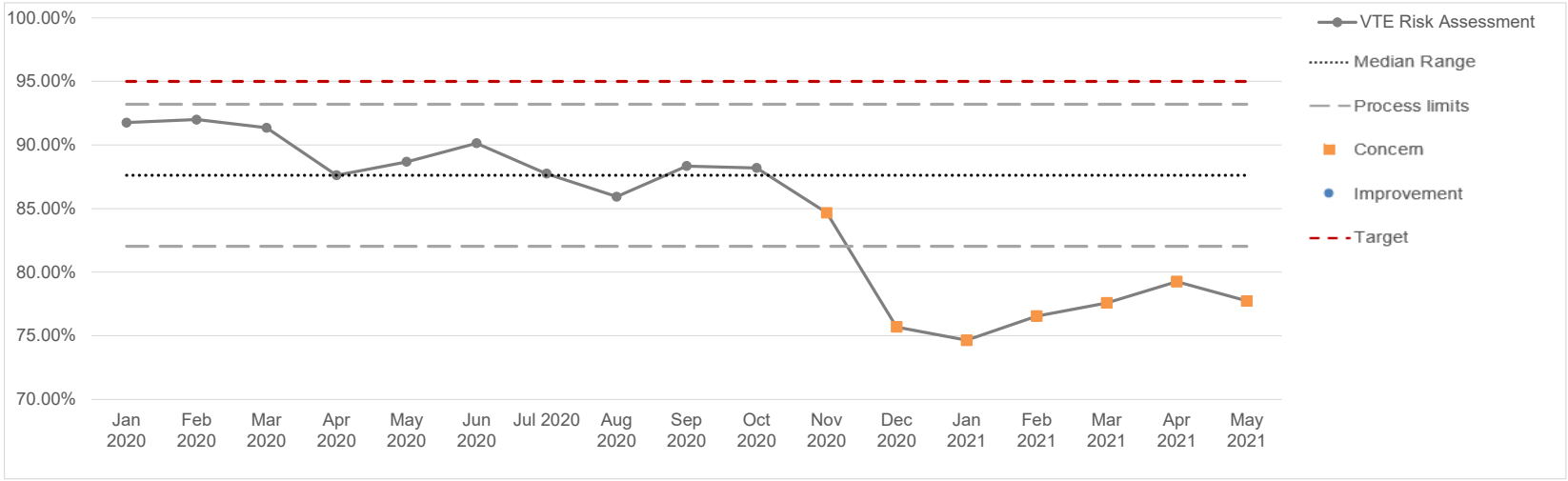
Period	Lower CL
May 2021	82.03%
Value	**Median**
77.73%	87.62%
Target	**Upper CL**
95.00%	93.21%

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?	Actions
This chart demonstrates the number of patients who have been admitted to hospital and that have had a VTE risk assessment. This the numerator in the calculation against the denominator which is the number of patients admitted to hospital. This is a nationally mandated indicator in the 2021/22 performance oversight framework, with the target of 95% in the national contract. Within the Trust the number of patients who have been screened for VTE is determined for reporting purposes using the WebV system to record when a VTE risk assessment has been completed and coding reviews of the same. Established pre-determined 'cohorts' of patients who are at low risk (i.e. day case procedures), in line with previous DH guidance also form part of the numerator. The chart is telling us that we are outside the control limit causing a special cause concern. Latest data demonstrates an improving picture which is a positive sign of recovery. May 2021 monthly data is 78% which represents a slight fall on the previous months data.	The Trust's improvement plan in relation to VTE has been reviewed and refreshed with specific clinical leads being identified to support this area. The Trust's policy and documentation used to risk assess patients is being refreshed in line with latest NICE guidance. Work is underway with the Trust's Pharmacy team to determine if VTE risk assessment can be linked to the Electronic Prescribing and Medicines Administration system (EPMA) to enable initiaial VTE risk assessments to be completed more consistently as well as to support further evaluation of VTE risk throughout the patient's admission, reflecting any changes. The Pharmacy team are in discussions with the EPMA software provider to scope this out. An electronic version of the VTE risk assessment form has been previously been developed and will be refreshed alongside the Trust's policy. Engagement work has been undertaken with front line clinical staff to understand some of the barriers and challenges and to seek their input into the design of future improvement intitiatives. A compreshenive update on the plans in place for VTE was reviewed by the Quality Governance Group in July. 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. Performance with VTE and the improvement plan is being monitored in the Trust's Performance Review meetings.

Issues And Risks	Mitigations
VTE risk assessment performance was impacted adversely during the Trust's response to the 2nd wave of COVID19 during November and December and the ongoing management of patients with or at risk of Covid19. 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 Covid19 areas to cope with the increasing demand of Covid19-related (or Covid19-suspected) acute admissions have likely impacted on performance. The Trust's policy is being updated in line with the latest NICE guidance.	Clinical leads identified and actively working to review and update VTE related policy and documentation. Working to link prescribing and VTE risk assessments to improve the recording of VTE risk assessment on admission and subsequently throiughout their admission in line with NICE guidance. Ongoing education work with clinical staff. Engagement with trainee grades of medical staff to understand and overcome identified barriers.

Indicator: QS007 Duty of Candour

Period	Lower CL
May 2021	94.78%

Value	Median
100.00%	100.00%

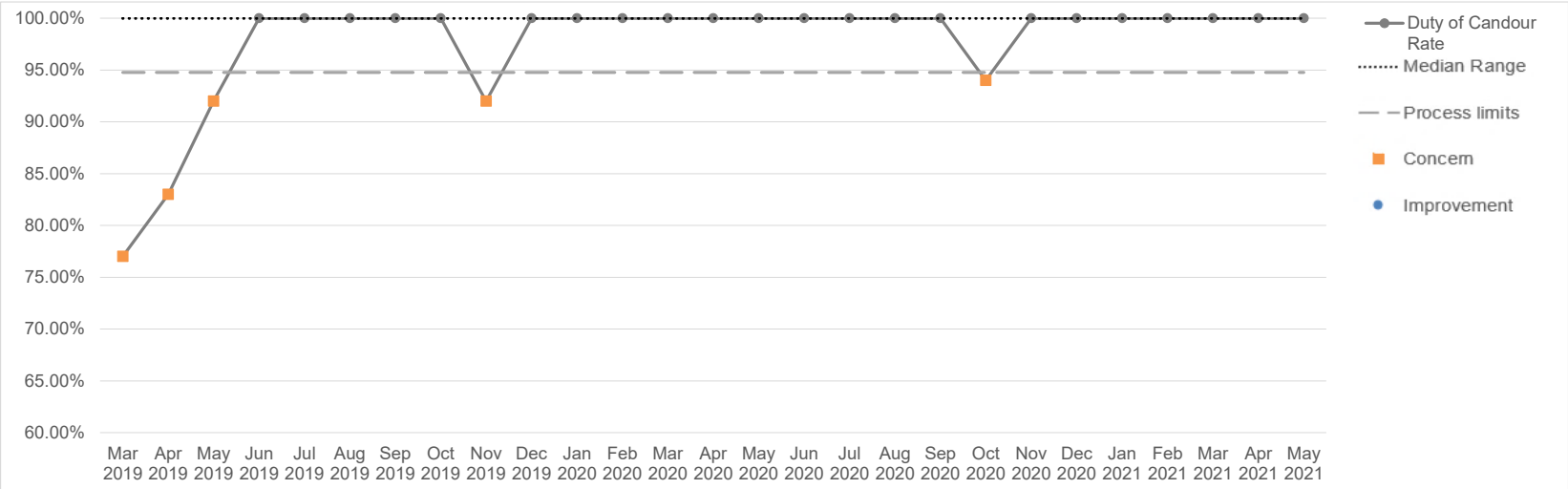
Target	Upper CL
No Target	105.22%

Variance

Common cause - no significant change

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
The Duty of Candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. Incidents that require a Duty of Candour are incidents as (Unintended or unexpected) that resulted in, or appears to have resulted in the death of a service user or severe or moderate harm or prolonged psychological harm. The data source is from DATIX and shows compliance with duty of candour requirements in relation to Serious Incidents only. The Trust's target for this area is 100%. As a result, the SPC upper control limit is based on the statistical confidence 'rules' and therefore exceeds 100%. In this setting this should be deemed as not applicable in this instance.	Ongoing oversight and action. Working with Divisions to obtain assurance that all moderate (and above) harm instances have duty of candour completed.

Issues And Risks	Mitigations
There is a requirement to ensure duty of candour is completed for all instances of harm at moderate or above. There is a gap at present in relation to moderate level harm that has been hampered by the Divisions operational response to the Covid19 pandemic. This is being further focussed on now. There is therefore a risk that the Trust may not be capturing this robustly, therefore at risk of not complying with regulations requiring Duty of Candour to be completed for cases of moderate (or above) levels of harm. Risk of financial penalty from the Trust's regulators.	Ongoing work and focus on this with Divisions.

Indicator: QS008 Emergency C-Section rate

Period	Lower CL
May 2021	8.26%

Value	Median
16.27%	14.70%

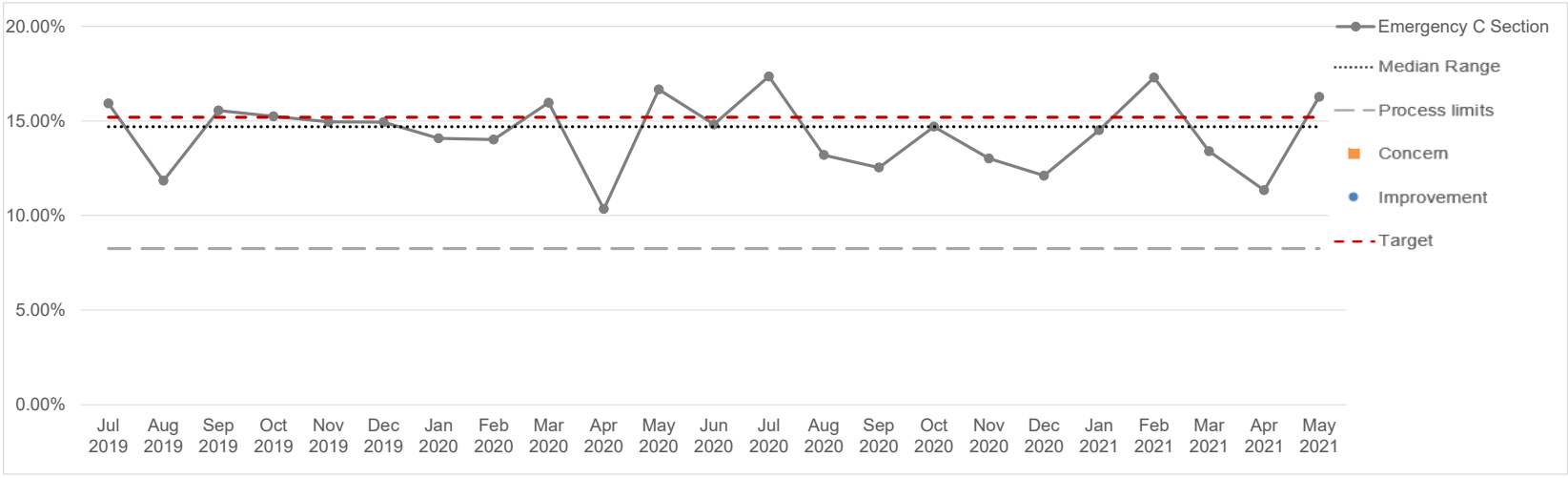
Target	Upper CL
15.20%	21.13%

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
This indicator looks at the percentage of deliveries where the mother had an emergency C-section as a proportion of all deliveries in the reported month. This is submitted as part of the Maternity Services Dataset (MSDS) and the rates are also published on the Yorkshire and Humber Maternity Dashboard. The data comes from the Trust Maternity Information System (CMIS). Indicator from the Single Oversight Framework (SOF).	Ongoing monitoring.

Issues And Risks	Mitigations
None.	N/A

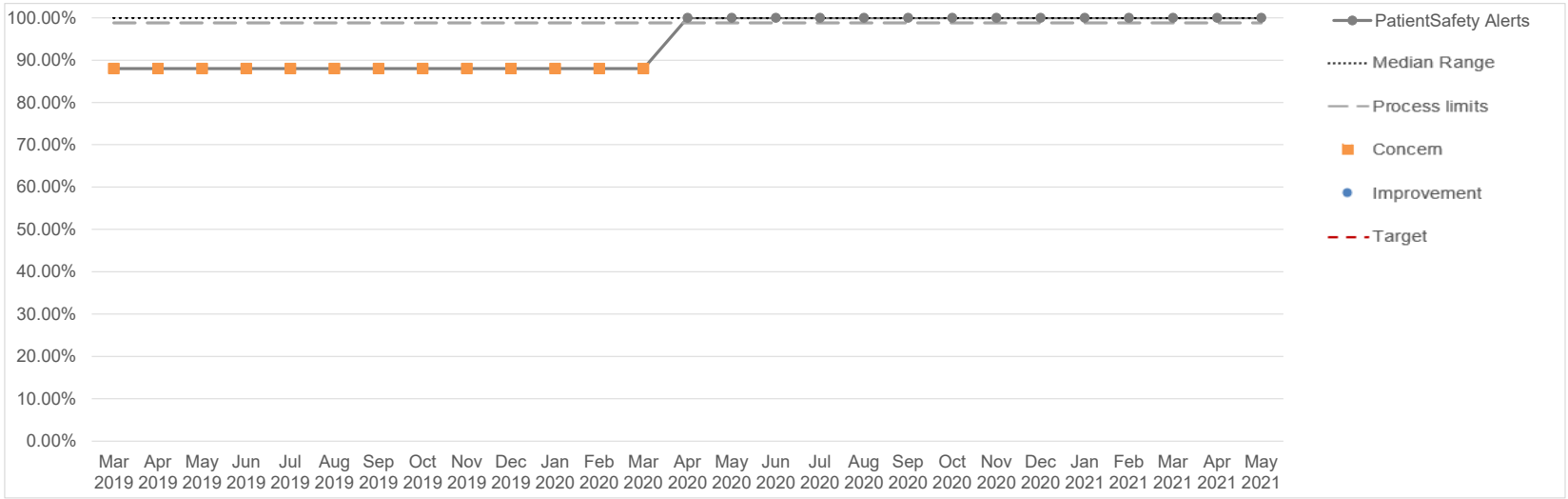
Indicator: QS009 Patient Safety Alerts to be actioned by specified deadlines

May 2021	98.77%
100.00%	100.00%
0.00%	101.23%

Common cause - no significant change

Assurance Inconsistency

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



Background And What Is The Chart Telling Us?	Actions
The Trust's indicator is based on National Patient Safety Alerts, a type of aler received via the Central Alerting System (CAS). There are no National Patient Safety alerts open past the specificed deadline. The CQC insights report also shows data on a related indicator, the number of open alerts (wider than just National Patient Safety Alerts) overdue past the nominated deadline. This presentation of Trust data shows 1 alert overdue. This overdue alert is an Estates and Facilities Alert (EFA) that relates to ligature risk. The Trust left this open whilst agreed building work within its Emergency Departments was completed to improve anti-ligature free mental health rooms. This buildling work is now complete and a refreshed gap analysis against this EFA alert is being presented to Quality Governance Group in July to determine if this overdue alert can be now closed.	Ongoing monitoring and oversight. Quality Governance Group receives a monthly update.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS027 Reduction in the number of patients dying within 24 hours of admission to hospital

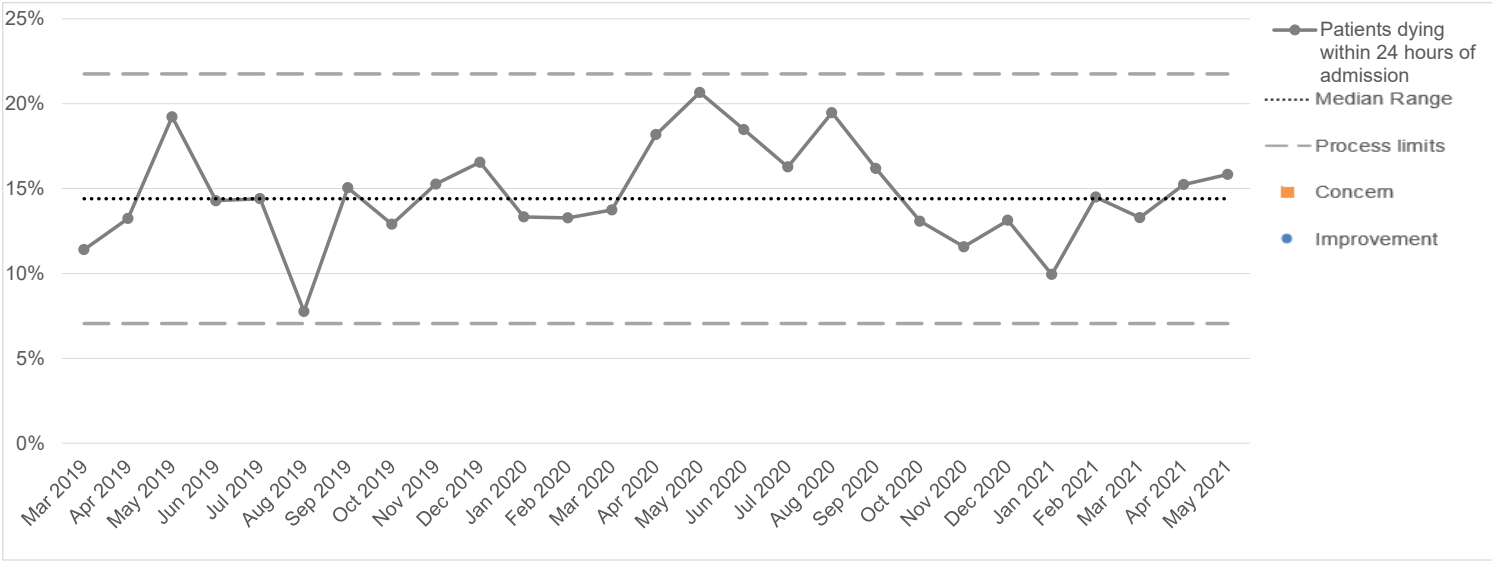
Period	Lower CL
May 2021	7.06%

Value	Median
15.83%	14.41%

Target	Upper CL
Not set	21.75%

Variance
Common cause - no significant change

Assurance Inconsistency
Target not yet set



SGH
11.48%

DPoW
19.64%

Goole
33.33%

Background And What Is The Chart Telling Us?	Actions
To support the Trust's quality priority for 2021/22, this indicator is intended to support a focus on patients at end of life being admitted to the acute hospital and dying soon after admission. Admissions at end of life sometimes signal a breakdown of advanced care plans. In such occurances, the patient's experience is adversely affected alongside relatives and carers. It is not possible to focus solely on patients at EOL who die within 24 hours, hence this data represents all deaths within 24 hours of admission. The data demonstrates that the median % of patients who die within 24 hours is 14%.	During 2021/22, a review of some of these patients will be undertaken to ascertain further understanding of patient pathways and these reviews will be included in the Trust's ongoing work, alongside commissioners and other System partners. In future months this data will be presented as a number to better support this focus on improvement.

Issues And Risks	Mitigations
The issue is that some patients admitted to hospital during their end of life phase may represent a failure in advanced care plans resulting in an unplanned admission to an acute hospital, for end of life care. It is acknowledged that an unplanned admission to the acute hospital and the admissions process via ED does not represent good care for patients who are actively at end of life. The Trust's SHMI is now normalised, but the out of hospital SHMI remains high. Patients admitted at EOL due to a breakdown in advanced care plans, even if they are fastracked home / community care, will feature within the Trust's SHMI.	EOL is one of the Trust's priorities and reports into the Mortality Improvement Group. The Trust also work closely with community partners to review System themes for sharing and learning. This indicator will support this continued focus.

Indicator: QS029 Out of hosptial SHMI

Period	Lower CL
Jan 2021	131.61

Value	Median
129.91	137.00

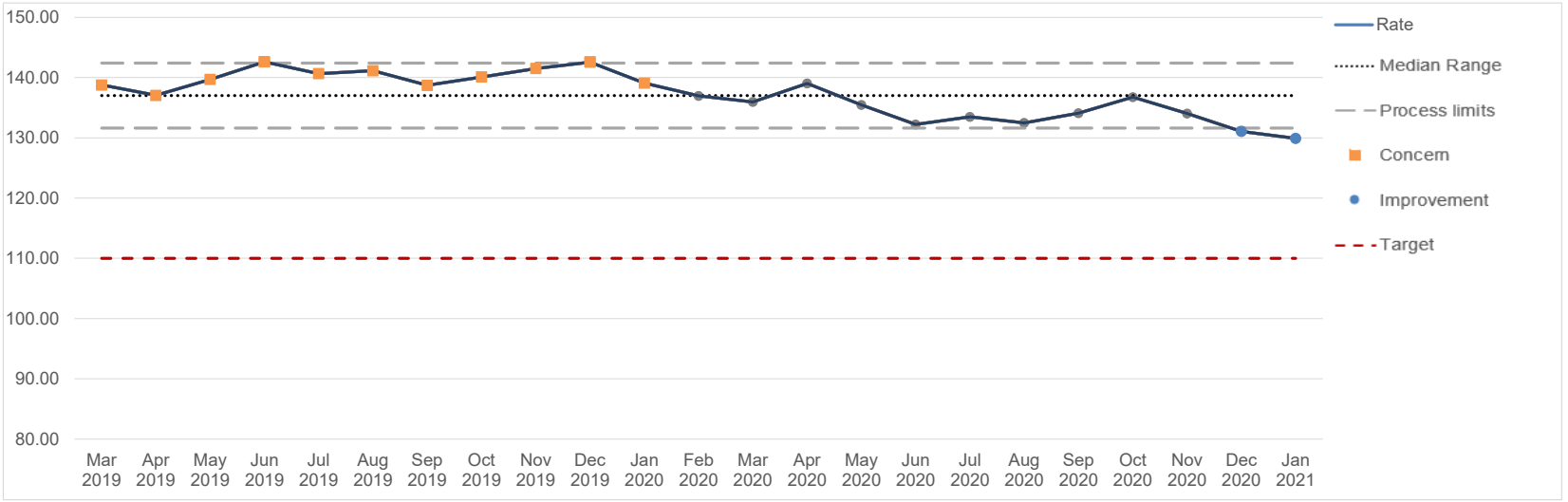
Target	Upper CL
110.00	142.38

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target

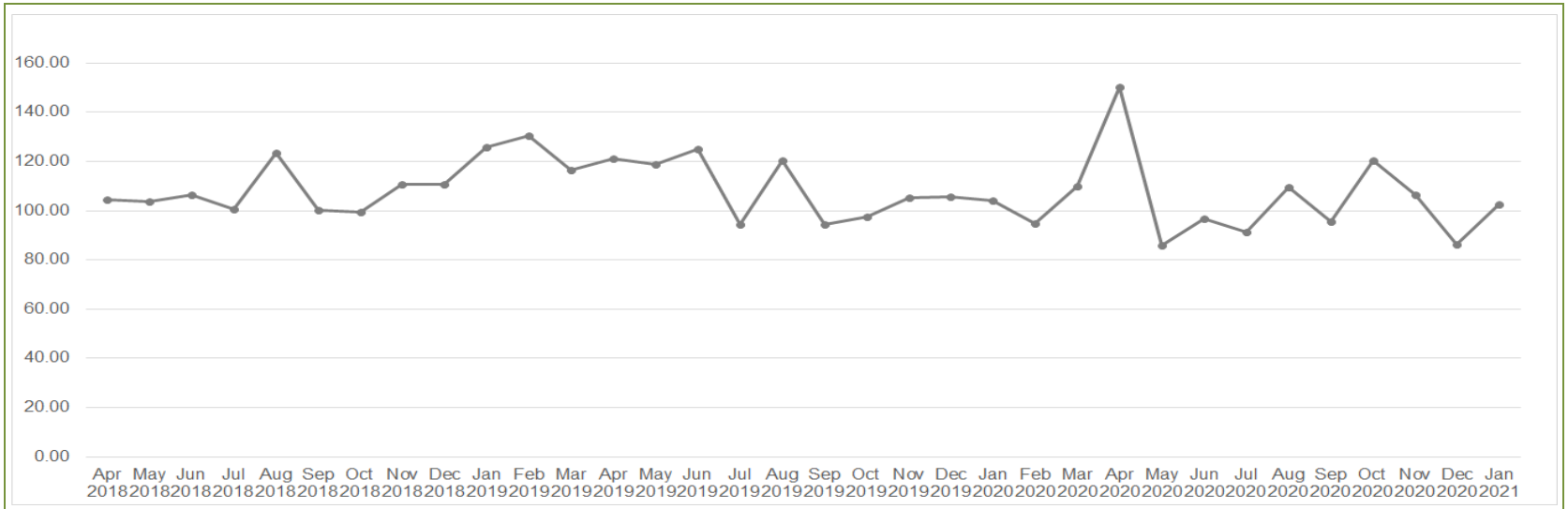


Background And What Is The Chart Telling Us?	Actions
The SHMI is made up of the in-hospital and out-of-hospital component parts. The Trust's SHMI has reduced significantly but this has been driven largely by the in-hospital SHMI reduction, out-of-hospital (<30 days of discharge) SHMI remains high with the median ~138. The January 2021 data shows the OOH SHMI at 130.91 which is the lowest recorded since February 2019.	Local CCGs have set up and established an out of hospital oversight group. The Trust collaborates with the CCGs to undertake end to end mortality reviews to identify learning when patients are felt to have been admitted to hospital when this could have been avoided. NHSE/I have been reviewing care at EOL and have reported their findings to MIG and the Strategic EOL group. It is likely this will support greater articulation of the issues that need further work/action. Action plans in response are being developed by System partners and will be overseen by the Strategic EOL group.

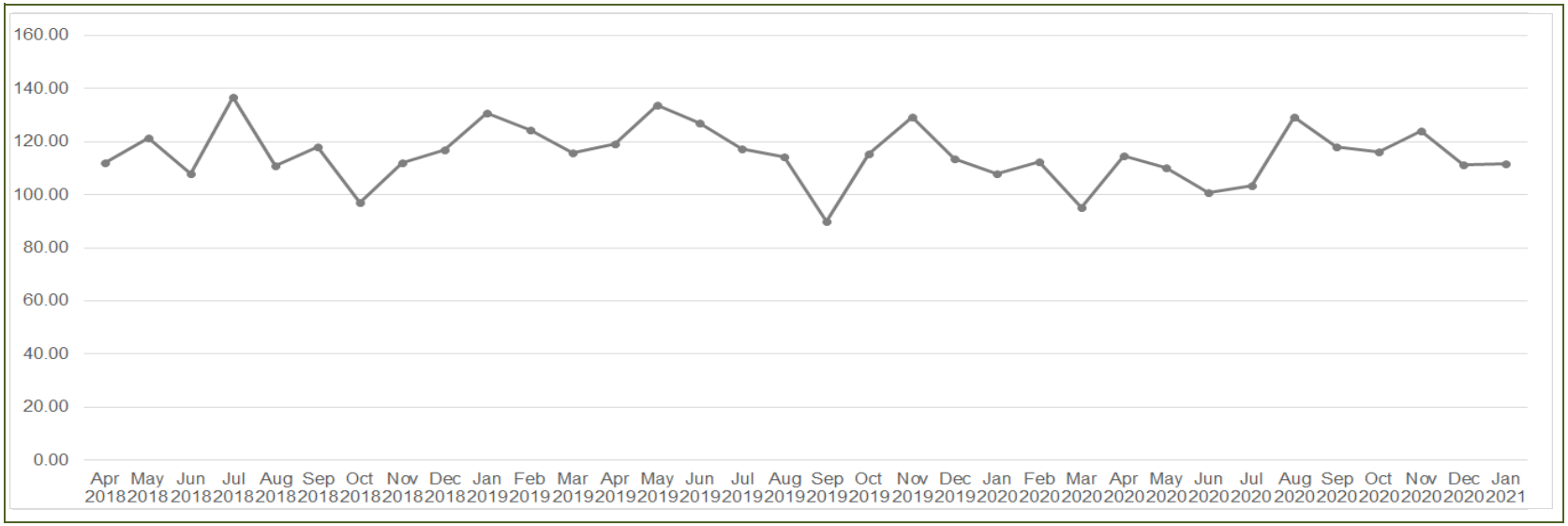
Issues And Risks	Mitigations
The Trust's OOH SHMI is high and could negatively impact the Trust's headline SHMI figure. Benchmarking with local peers identifies the Trust as having a higher OOH SHMI rate.	Ongoing review work to understand and share themes for improvement.

Quality & Safety

QS029 Site specific out of hospital SHMI - SGH



QS029 Site specific out of hospital SHMI - DPoW



Indicator: QS030 Structured Judgement Review (SJR) in 100% of those requiring a review

Period	Lower CL
May 2021	65.38%

Value	Median
50.00%	93.00%

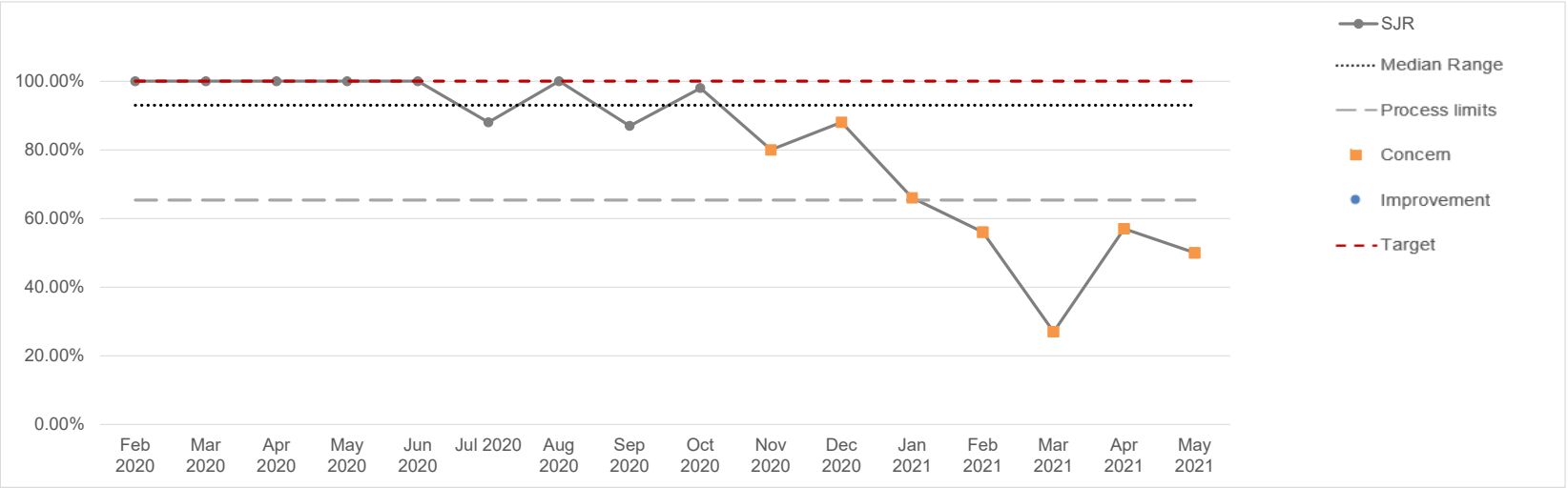
Target	Upper CL
100.00%	120.62%

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



Background And What Is The Chart Telling Us?	Actions
The chart tells us that cases requiring more detailed review using SJR are currently not being completed in a timely manner which has resulted in a backlog back to August 2020. The Trust is ensuring these cases are reviewed, but at present this is not within agreed timescales. It should be noted that the most recent months reported data should be interpreted with caution as reviewers are provided with 6-weeks to undertake a review so the latest available data may not reflect cases still being reviewed in line with these timescales.	The Trust's Mortality Improvement Group oversees this alongside other mortality performance indicators. Work is underway within Medicine to review the number of staff who have been trained in SJR reviews and determine if additional reviewers can be identified to support ensuring more timely review of cases. Specific gaps have been identified in some medicine sub-specialties at DPoW which have been escalated to the DCDs in Medicine for support in resolving. This has resulted in a focussed review of older cases still outstanding to good effect.

Issues And Risks	Mitigations
This has been added to the Trust's Risk Register.	Mitigation is that these reviews will be completed, although behind the timescales that have been set as ideal. Medicine are the primary group concerned who are reviewing internal processes.

Indicator: QS046 Blood glucose taken in ECC if NEWS over 1 for adults

Period	Lower CL
May 2021	83.40%

Value	Median
97.50%	95.00%

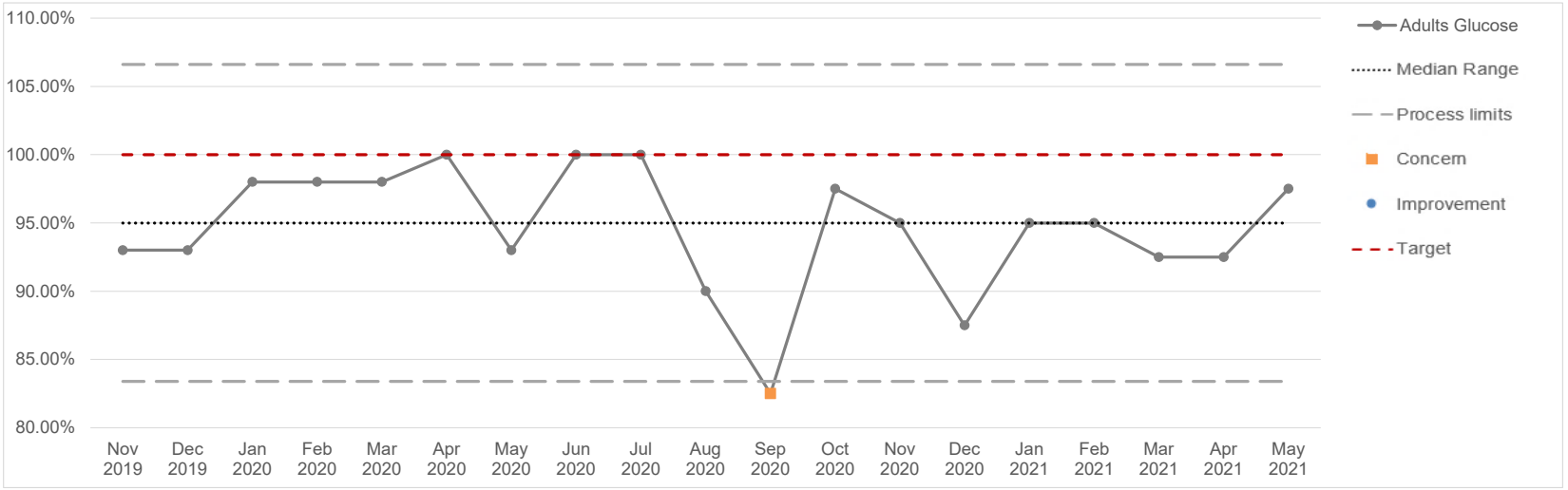
Target	Upper CL
100.00%	106.60%

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
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. The chart is telling us that for adults, on average for this period, 95% of patients with a NEWS score indicating the need for blood glucose to be recorded have had this recorded within the Trust's Emergency Department.	Ongoing oversight by the Diabetes Task and Finish group.

Issues And Risks	Mitigations
None.	N/A

Indicator: QS047 Blood glucose taken in ECC if PEWS over 1 for children

Period	Lower CL
May 2021	65.23%

Value	Median
90.00%	83.00%

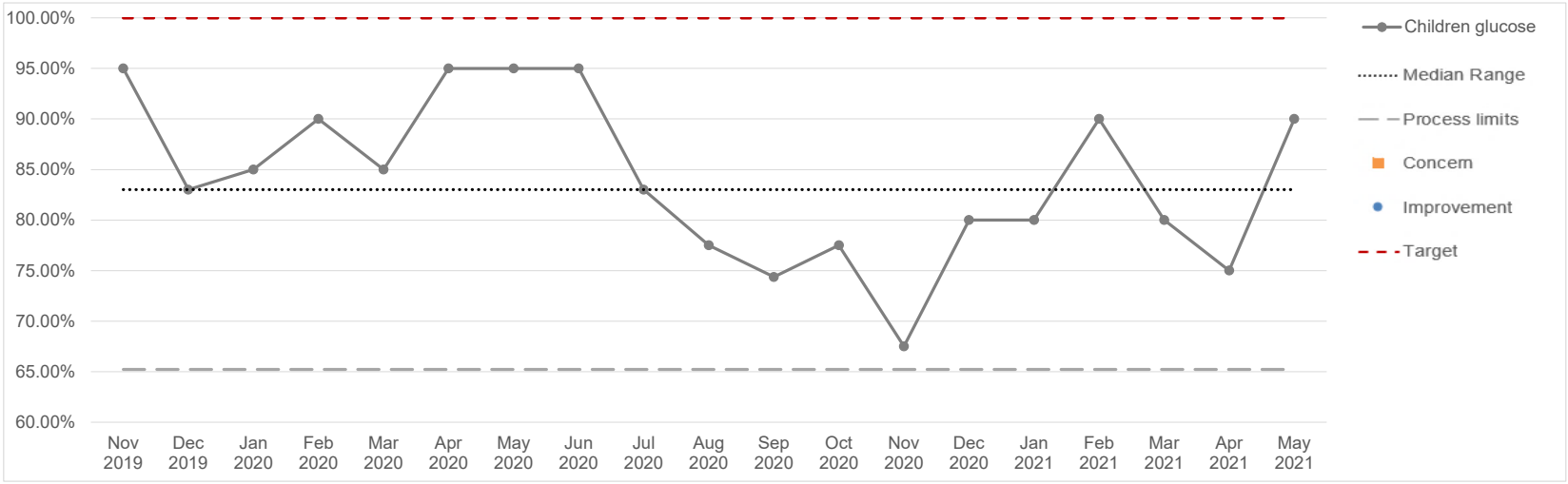
Target	Upper CL
100.00%	100.77%

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
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. The chart tells us that for children with a PEWS score that indicates a blood glucose recording this is being taken on average in 83% of cases. Performance in May increases to 90%.	The BM taken in ECC has fluctuated. The addition of the PEN team has led to a change to be set down in protocol, to allow for clinical judgement from a Paediatric expert. Paediatric cases are being reviewed in more detail with the Paediatric team each month to understand the involvement in the case of the Paediatric Nursing Team and whether there is evidence that not undertaking Blood Glucose investigations was as a result of a clinical judgement.

Issues And Risks	Mitigations
Blood glucose recording in ED linked to PEWS has fallen below 78% for 4 consecutive months. From an investigation into this it appears that the Paediatric Emergency Nursing Team has been working to PEWS of 6 or more to trigger blood glucose monitoring. Since this intervention will be monitored. Performance remains variable.	Ongoing oversight and monitoring by paediatric and ED teams. Quality Governance Group (QGG) supported a proposal in June for the standards in this audit to change to reflect the input of the PEN team removing the need for a blood sugar in all cases, and allows senior clinical judgement to be taken into account. This has been reflected in the SOP. Ongoing validation of the data each month with the Paediatric team.

Indicator: QS048 Diabetes role specific training compliance

Period	Lower CL
May 2021	77.10%

Value	Median
86.14%	81.70%

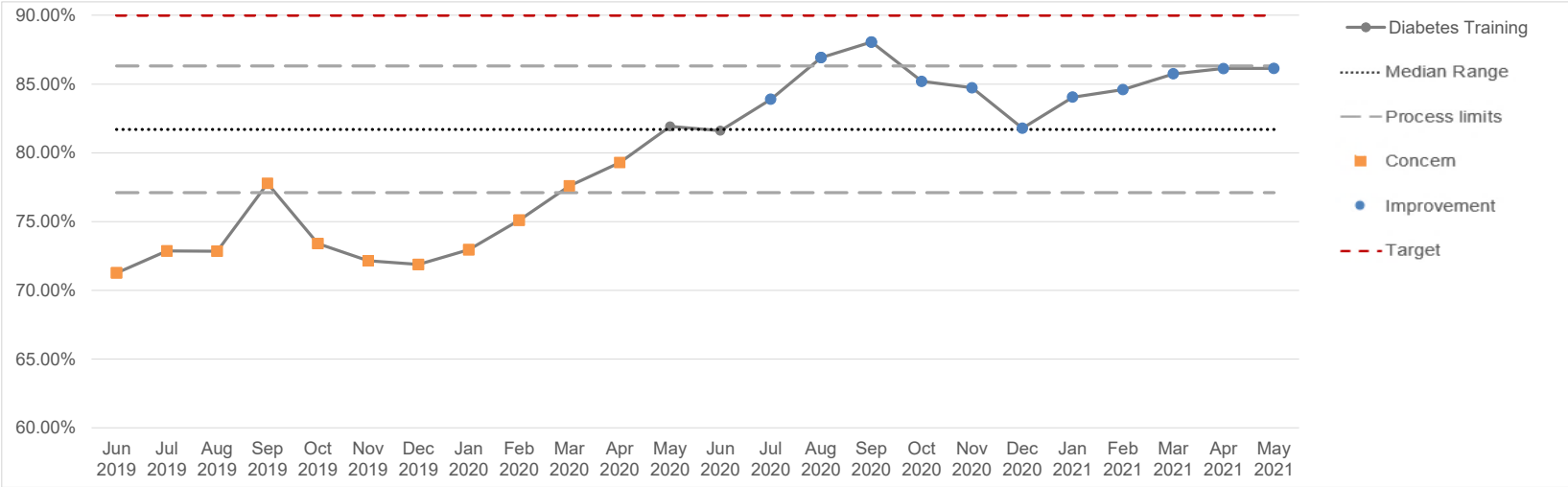
Target	Upper CL
90.00%	86.31%

Variance

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

Assurance Inconsistency

Variation indicates consistently failing short of the target



Background And What Is The Chart Telling Us?	Actions
This KPI is linked the Glucose testing for adults and children. All medical/nursing staff have undertaken the safe use of insulin training. The chart tells us that for April more than 86% of applicable staff have completed mandatory training regarding the safe use of insulin.	This is overseen by the task and finish group established to support a focus on the diabetes quality priority and at Safer Medication Group.

Issues And Risks	Mitigations
While the overall training figures are good, there are areas where there is lower compliance, particularly Medical staff (Breast Surgery, ECC SGH at 50%, General Surgery at 26% for DPoWH and 30% for SGH, Cardiology SGH at 40%, Gastroenterology at SGH at 50%, Respiratory Medicine at SGH at 38%).	N/A

3. Quality and Safety		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1 (Q1)**
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.	Chief Nurse	**Link to Key Performance Indicator (KPI):** TBC **Update Q1:** Update provided to the board on 6 July 2021 on the future plans for QI. Associate Director of QI in post, with interviews taking place for other members of the team, these team members will be in place towards the end of the year. Until this point the team will have limited capacity in the development of new improvements. Piloting a QI platform called LifeQI. Trust Framework for improvement developed. First collaborative Event, which has demonstrated improvement. First refreshed training and QI projects delivered.
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	Medical Director	In July, one action (diagnostics capacity) has changed from red to amber with a robust monitoring plan in place to support sustainability. The remaining red actions relate to community nurse staffing, mandatory training and appraisals. It has been requested that all HR leads for each division attend the regular divisional Care Quality Commission (CQC) update meetings to ensure regular compliance figures are shared. These will be collated into run charts to allow a visual representation of the progress of each staff group and easily highlight any areas of concern or downward trends. When compliance is sustained for at least three months the action can be signed off but the quarterly sustainability process will ensure quality remains high.
We will focus on the following five **quality priorities:** End of Life care and related mortality indicators	Medical Director	**Link to Key Performance Indicator (KPI):** Reduction in the number of patients dying within 24 hours of admission to hospital / Reduction in the number of emergency admissions for people in the last three months of life and Reduction in the out of hospital Summary Hospital-level Mortality Indicator (SHMI) to 110, by March 2022. **Update Q1:** The first indicator is reporting and being monitored. It is too early to assess. The second indicator is in development. The third indicator requires the support of community partners. Work is ongoing with NHSE/I support. Local

		Clinical Commissioning Groups (CCGs) have established an out of hospital oversight group. Further review work is required using a sample of these cases to distil key themes and share with community partners. To link to North East Lincolnshire CCG Collaborative Mortality Review meeting.
The Deteriorating Patient and sepsis	Medical Director	**Link to Key Performance Indicator (KPI):** Adults: Timeliness of observations within 30 minutes of due time >90%. Children: Timeliness of observations within 30 minutes of due time >90%. Improve frequency of sepsis screening and robustness of reporting; Escalation of neonatal early warning score (NEWS) in line with policy {*Manual audit occurring every two months}.* Sepsis screen in 90% of patients with a sepsis six indicator *{WebV / Manual audit occurring every two months}.* **Update Q1:** Adults and Children's: Timeliness of observations is currently on track. Data for improve frequency of sepsis screen and sepsis screen in 90% of patients is anticipated by August 2021. Sepsis remains as a gap with regard to assurance data available. No data is currently available to determine the rate of sepsis screening either via e-screening (using WebV) or paper based processes still in use throughout the Trust (as measured through audit). Plans are in place to undertake an audit and improve the process for accessing the e-screening tool.
Reduction of medication errors	Medical Director	**Link to Key Performance Indicator (KPI):** Improvements in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward *{Manual audit}.* Insulin administered on time in 85% within wards using electronic prescribing and medicines administration (EPMA). Reduction in medication omissions without a valid reason for ward areas using EPMA. **Update Q1:** Awaiting reporting from EPMA.
Safety of Discharge	Chief Operating Officer	**Link to Key Performance Indicator (KPI):** Improve the proportion of patients discharged before 12 noon (target: 30% / 70% before 5pm).

		Improve the proportion of patients discharged before 5pm Improving trend showing a reduction in length of hospital stay above seven, 14 and 21 days. Improve the timeliness of discharge letters linked to **Orthopaedic** and **Ophthalmology** Specialties. **Update Q1:** The Trust's performance for patients staying in a trust bed for over 21 days is currently reported at 8.73% (as at 19 July); this remains under the national average of 12% and is the second lowest within the North East and Yorkshire region. 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. All wards now have senior consultant presence at board rounds before 10am with a discharge rate before 10am at 4.39% (June 2021) and discharge before 12 noon at 17.33% (June 2021). Average Length of Stay has also reduced to 3.78 days (June 2021) from 4.83 days (March 2020). All wards are now able to report if and when a patient no longer has a criteria to reside in an acute hospital bed by completing WebV. A vast amount of work has been carried out on the WebV System to enable wards to record which patients no longer meet the criteria to reside this enables national daily reporting. 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. Reduction in long length of stay continues to be recognised at a national level with further recognition by the beneficial change programme. The trust are carrying out a frailty pilot on the Grimsby site this has already seen significant improvements in the patient pathway with over 85% of patients assessed by the frailty team discharged on the same day. The Trust has been accepted onto the ward/board round collaborative with NHS E/I a medical ward from the Scunthorpe & Grimsby site have been nominated. 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 IT system & reporting improvements required to ensure all data is captured and reported accurately.
Diabetes Mellitus management	Medical Director	**Link to Key Performance Indicator (KPI):** Diabetes Audit findings *{Manual audit};- Currently 75%* 100% of BM taken in ECC in adults and paediatrics when NEWS/paediatric early warning scores (PEWS) of >1 – Currently 86.4%. Diabetes role specific training compliance >90% - Slightly below target. Blood glucose taken in ECC if NEWS over one for adults and Blood glucose taken in ECC if PEWS over one for children – Paediatrics has improved but slightly below target. Work ongoing to understand reason.

Indicator: W001 Unregistered Nursing Vacancy Rate

Period	Lower CL
May 2021	1.59%

Value	Median
6.20%	6.47%

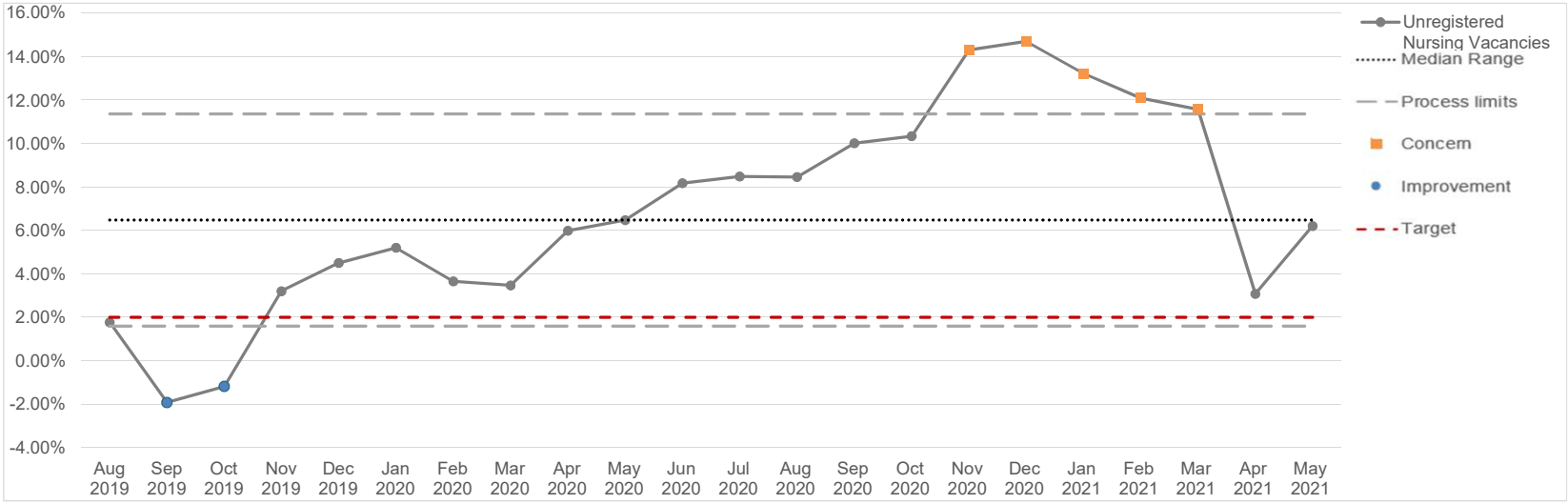
Target	Upper CL
2.00%	11.35%

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 unregistered nursing (HCA) vacancy rate has dropped considerably since the implementation of a recruitment project aiming to achieve an operational zero vacancy rate (operational zero accounts for normal levels of turnover). This was achieved through collaboration with Indeed aiming to source candidates without prior formal healthcare experience and a review of recruitment processes. This includes the formation of a pool of HCAs appointed ready for allocation to vacancies as they arise. The vacancy rate has risen in month due to a large number of leavers, some of which are relatively new starters.	Continue advertising to maintain the pool of HCA appointments ready for allocation. Implement changes for the recruitment of new HCAs, including webinars and talks on the role in detail and a "day in the life" to manage expectations.

Issues And Risks	Mitigations
Retention of HCAs, particularly new starters. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave.	Large pool of HCAs appointed awaiting allocation and continued recruitment to this pool. Implementation of information regarding the HCA role to new starters without prior healthcare experience. A project group led by the Chief Nurse's office to oversee activity. June update position: The adjusted vacancy report shows equates to 31.05 WTE vacancies: Allocated awaiting start date is 7.44 WTE The current pipeline is 49 WTE in the pool currently to be allocated.

Indicator: W002 Registered Nursing Vacancy Rate

Period	Lower CL
May 2021	8.04%

Value	Median
9.70%	10.07%

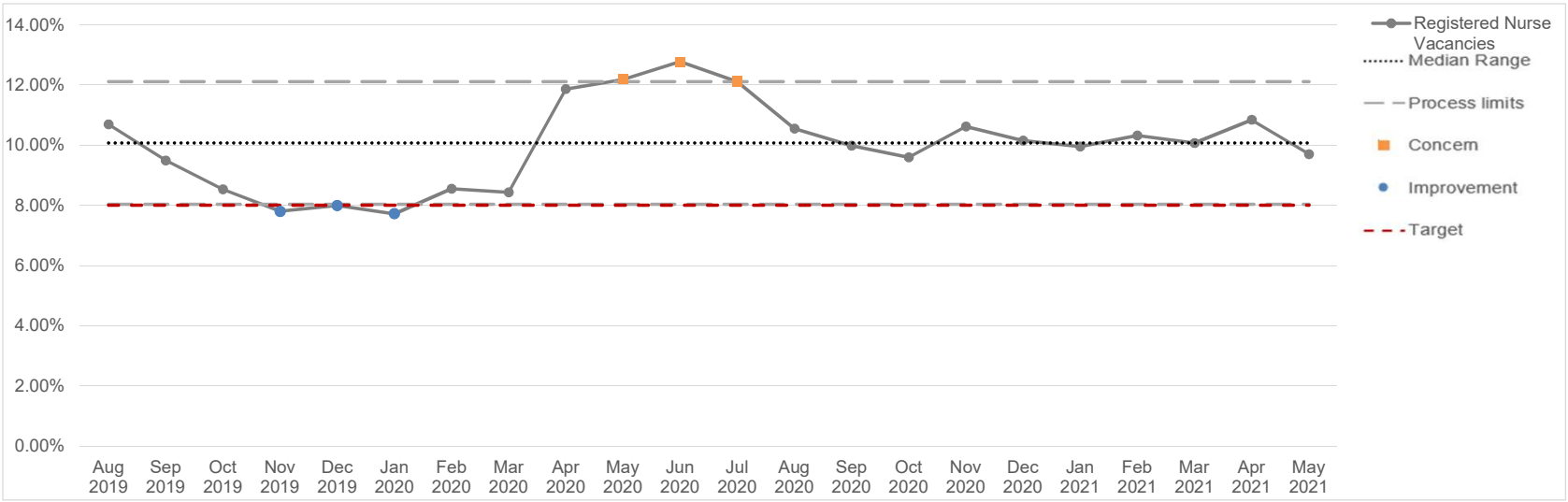
Target	Upper CL
8.00%	12.10%

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
The vacancy rate saw an increase in April 2021 due to an increase in establishment, the rate has since dropped due to pre-registered nurses starting in post. Regular recruitment activity is underway sourcing candidates from overseas via the internal Talent Acquisition Team, 20 nurses are being sourced via an agreement with Yeovil NHS Trust, and regular ongoing activity has resulted in circa 80 Newly Qualified Nurses appointed due to start in Quarter three .	Newly qualified nurse (NQN) r ecruitment with circa 80 in the pipeline due to commence between August and October. Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices. Development of a three year Nurse Recruitment Strategy as part of the Nursing Strategy inclusive of all pipelines including apprenticeship development and a strengthened domestic presence in the existing market place.

Issues And Risks	Mitigations
Travel difficulties are impacting upon start dates for international nursing cohorts. Issues with identifying and allocating appropriately skilled candidates to wards/specialties in a timely manner is impacting upon the withdrawal rate of candidates sourced via Yeovil and delays in the timesclaes initially agreed with NHSE/I. A large number of candidates sourced by the Talent Acquisition Team are currently on hold as additional candidates with the required skills and experience are sourced, the shortlisting, recruitment and allocation process are revised, and onboarding and pastoral support are strengthened. This will impact on reducing the overall vacancy rate as initally planned and continued high spend on temporary staffing.	Ongoing recruitment activity for pre-registered nurses with a very large pool of candidates available. Circa 80 NQNs appointed due to start. A project group led by the Chief Nurses office to oversee all activities.

Indicator: W003 Medical Vacancy Rate

Period	Lower CL
May 2021	11.35%

Value	Median
15.80%	13.94%

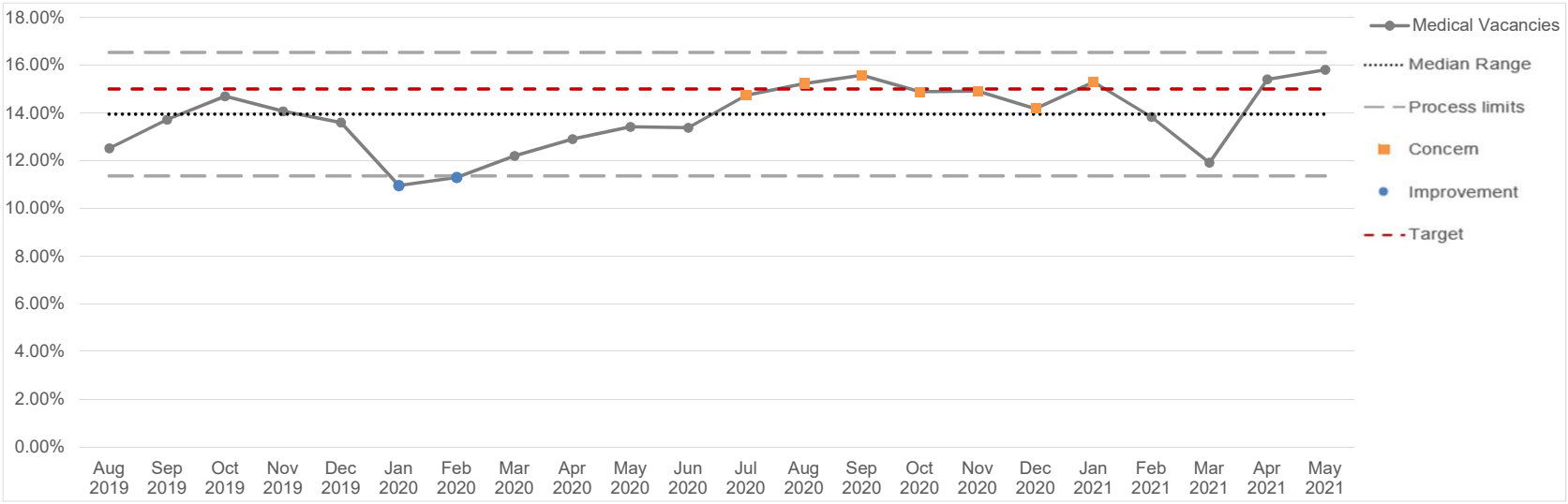
Target	Upper CL
15.00%	16.53%

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 vacancy rate saw an increase in April 2021 due to an increase in establishment of 27.37 WTE. The vacancy rate has continued to rise slightly in May 2021 due to an increase in vacancies of 2.72 WTE. Ongoing recruitment activity is underway across all grades.	Continue recruitment to all medical vacancies, including MTI scheme. Talent Acquisition Team to source senior hard to fill medical posts via innovative pathways. Divisional workforce meetings to inform recruitment activity in relation to medics and review on-going recruitment processes to reduce delays.

Issues And Risks	Mitigations
Travel restrictions are impacting upon start dates. Available accomodation can delay recruitment processes.	Recruitment team continuing to engage with candidates. Introduction of Talent Acquisition Team support in sourcing senior hard to fill medical staff posts will be introduced in July 2021 following a pilot within medicine to explore this methodology for medical staff. A large pipeline of 76 medical staff appointed and awaiting start between June and October has been established. A network of private landlords has been established to support accomodation needs where the Trust is unable to accomodate locally.

Indicator: W004 Turnover Rate

Period	Lower CL
May 2021	9.02%

Value	Median
9.50%	9.34%

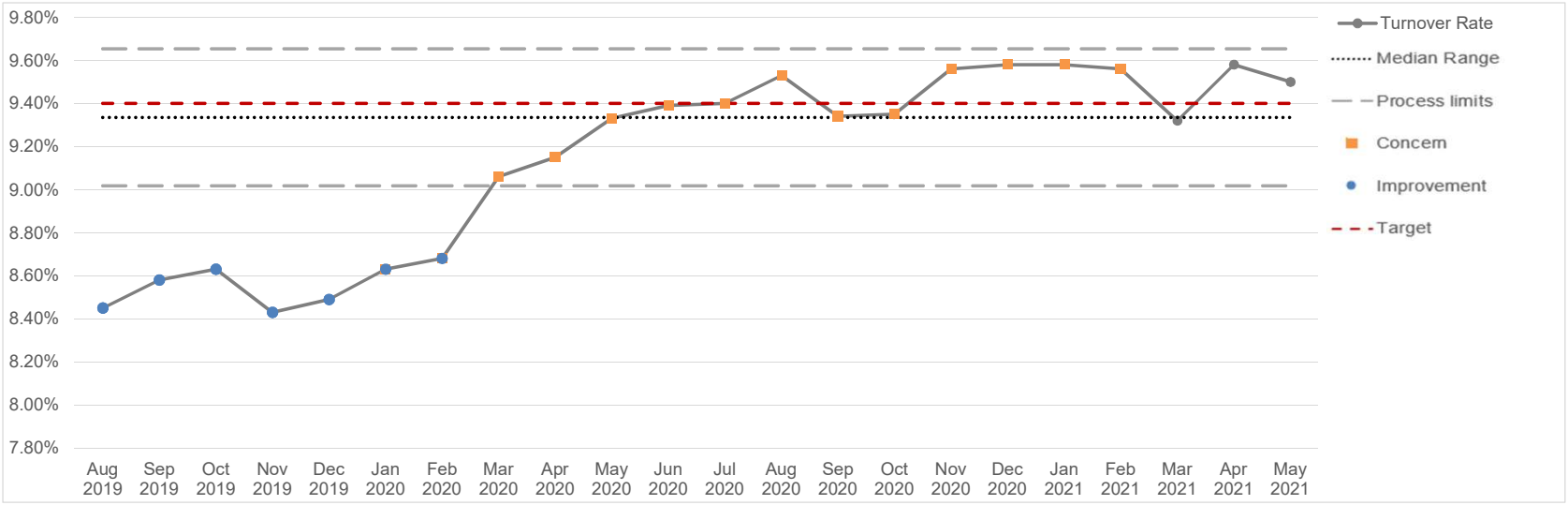
Target	Upper CL
9.40%	9.65%

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
During August 2019 to April 2020 the Turnover Rate significantly improved. This has gradually deteriorated over time since the start of the pandemic in April 2020 to present. The latest turnover data point (9.5%) is just over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%.	Greater understanding of leavers data via ESR data and exit questionnaires to understand any trends to form an appropriate response. An increased emphasis on prevention of avoidable leaders by improving cultures and strengthening leadership where appropriate. Creation of talent pools for high frequency leaver areas to ensure a quicker recruitment turnaround.

Issues And Risks	Mitigations
The risk of increase turnover ahead of recruitment is increased bank and agency costs and potential decrease in quality of patient care.	Planned earlier intervention in relation to known leavers. Creation of talent pools.

Indicator: W005 PADR Rate

Period	Lower CL
May 2021	76.58%

Value	Median
79.00%	80.00%

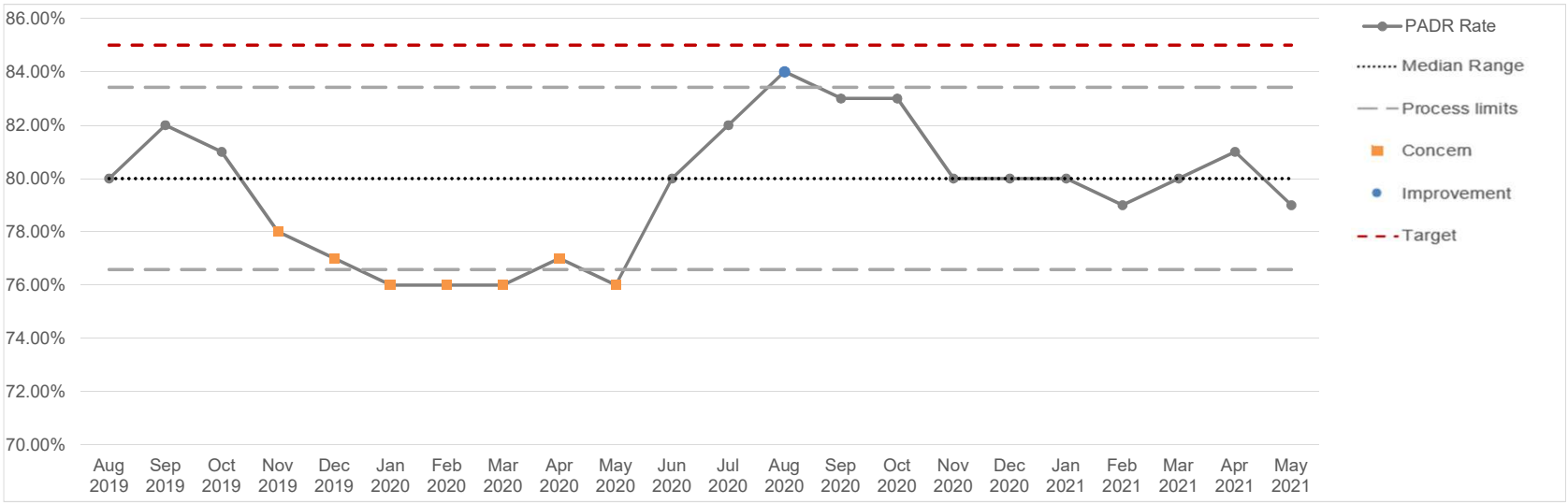
Target	Upper CL
85.00%	83.42%

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
The Trust wide PADR compliance position currently stands at 79% (May 2021). Please note that this figure does not include Medical Staff this is due to Medical Staff PADR's being extended for a six month period due to COVID19 which ESR does not reflect. This is not within the Trust target of 90%	The Training and Development Department will continue targeting Managers with low compliance by sending out reminders, and guidance for completion. We will continue to target and consider an escalation process for those areas not complying.

Issues And Risks	Mitigations
Low PADR compliance will result in the risks moral, performance and demotivation.	Historically the trend data shows that the Trust's PADR compliance has risen for this time of year at as of May 2020 the PADR Position was at 76% . It is predicted that the PADR compliance will continue to rise over the next few months.

Indicator: W006 Sickness

Period	Lower CL
Apr 2021	3.30%

Value	Median
4.87%	4.94%

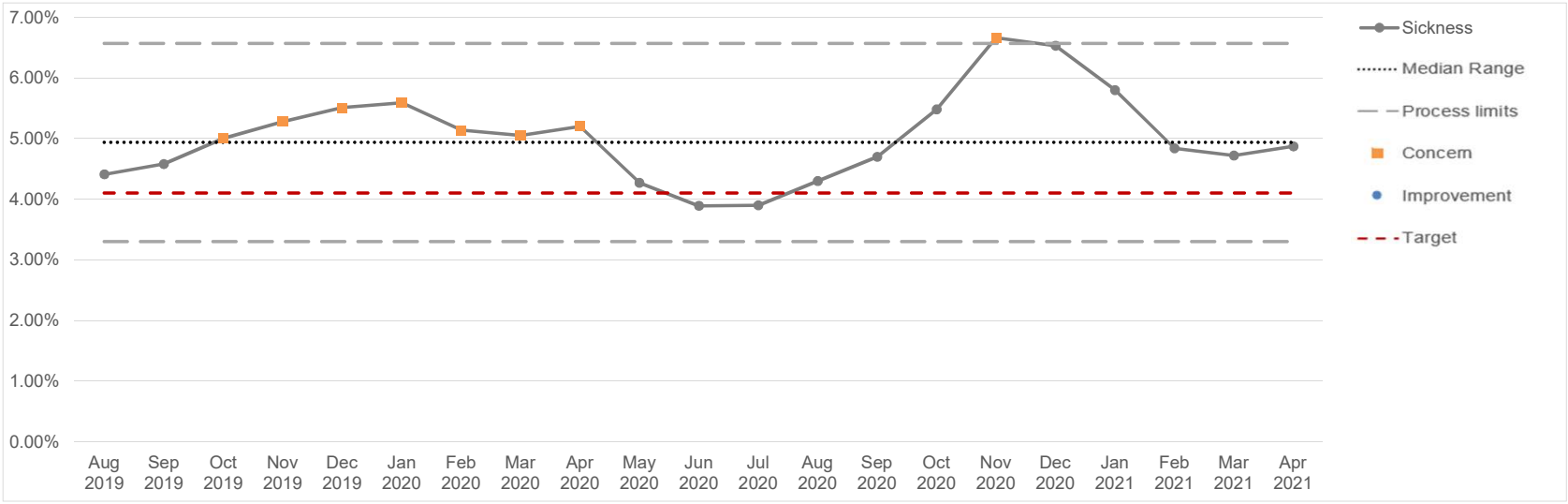
Target	Upper CL
4.10%	6.57%

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 recent variation seen is common cause which shows no significant change and is within the control limits. Sickness rates have been dropping since December 2020.A slight increase can be seen in April 2021, it is anticipated that sickness and wider absence rates will rise following the relaxation of restrictions.	The Trust has now employed a new Health and Wellbeing business partner to specifically drive the Health and Wellbeing agenda due to commence on the 31st August. Daily monitoring has recommenced with ICC and Infection Control lead to monitor specifically COVID absences. The Trust are reviewing newly released guidance from NHS employers in the relation to long term COVID related sickness with the view to implementation which will support the management of some longer term sickness cases. A revised operational dashboard will be available in August that will allow managers to have a greater level of access to data in relation to sickness which will support the wider management.

Issues And Risks	Mitigations
Staff who are shielding due to Post Travel, Household Member with Symptoms and Track and Trace are not reflected on the chart above, however this impacts staffing levels as the special leave type is starting to increase. High portion of NLAG staff are double vacciated,the end to test and trace self isolation from the **16th August**, those employees that have come to contact with a positive case of coronavirus will be except from quarantining at home for up to 10 days.	The absence rate has fallen dramatically since the start of the year. Monitoring continues with an anticipated increase in COVID related absence following the relaxing of restrictions.

Indicator: W007 Trustwide Vacancy Rate

Period	Lower CL
May 2021	8.18%

Value	Median
9.50%	9.19%

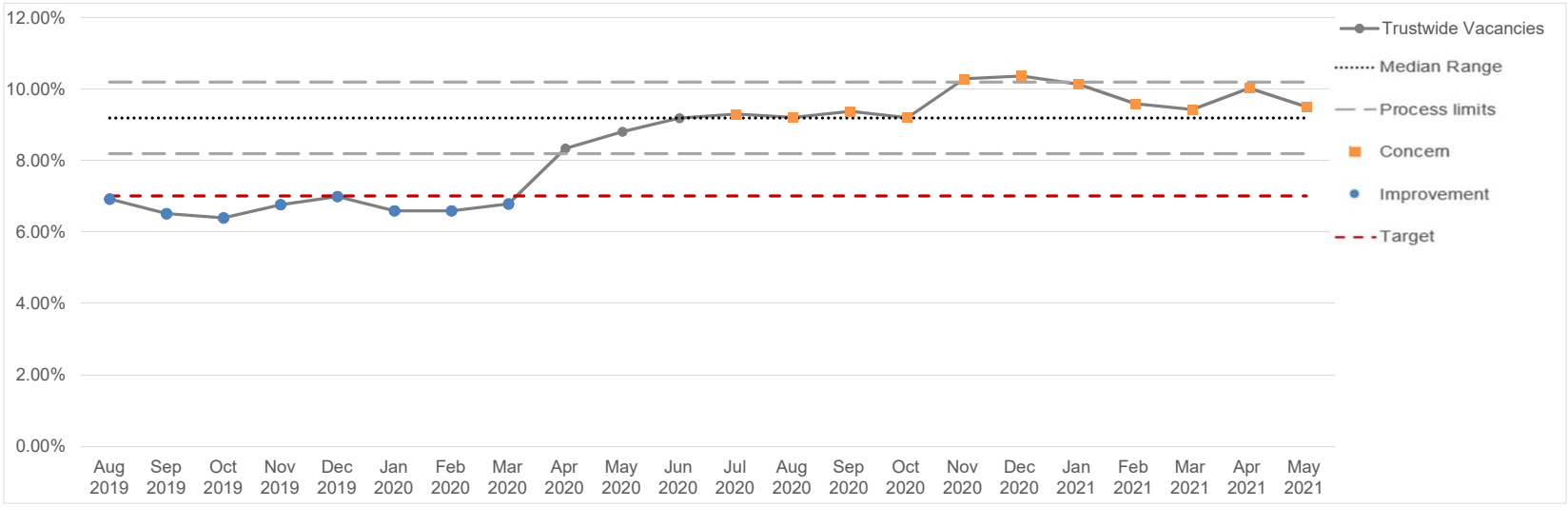
Target	Upper CL
7.00%	10.19%

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 overall vacancy rate saw an increase in April 2021 due to an increase in budgeted establishment of 86.31 WTE, and has since reduced due to recruitment activity sourcing and starting new employees across all staff groups. Recruitment at an increased rate is ongoing, with recruitment activity increasing by 25% over the last 12 months, sourcing candidates locally, nationally, and internationally.	Ongoing recruitment activity across various workstreams, engagement with candidates to reduce withdrawal rates, a full review of the recruitment processes scheduled for August 2021.

Issues And Risks	Mitigations
Travel difficulties are delaying starts for new employees coming from overseas.	Various projects for different staff groups, including international nursing and HCAs. Introduction of Talent Acquisition for senior hard to fill medical staff roles.

Indicator: W008 Core Mandatory Training Compliance

Period	Lower CL
May 2021	88.35%

Value	Median
91.00%	90.00%

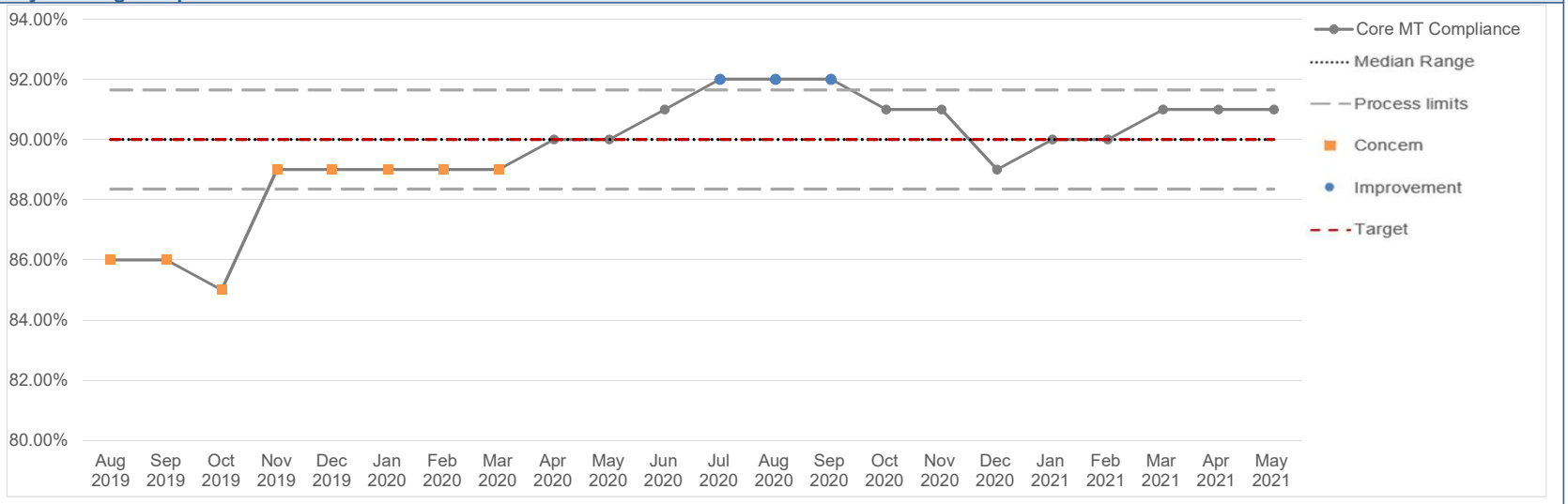
Target	Upper CL
90.00%	91.65%

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 Core Mandatory Training position currently stands at 91% (May 2021). This is within the Trust target of 90%, historically the trend data shows that the Core Mandatory Training compliance is around the same for this time of year, as of May 2020 the Core Mandatory Training Position was also at 90%.	The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. We will continue to target and consider an escalation process for those areas not complying. The Training and Development Department will ensure all data is processed and support class administrators are supported with data collections. Auto enrolment has now been switched on in ESR making this easier for staff to complete eLearning modules.

Issues And Risks	Mitigations
Low MT compliance will result in the risks around safe and effective care.	It is predicted that the Mandatory Training compliance will continue to rise over the next few months due to the Actions that will take place. Over the last three months Core Mandatory Training compliance has increased and is now close to pre-COVID19 levels for this time of year. The Core Mandatory Training compliance position has been static for the last three months.

Indicator: W009 Role Specific Mandatory Training Compliance

Period	Lower CL
May 2021	77.09%

Value	Median
80.00%	79.50%

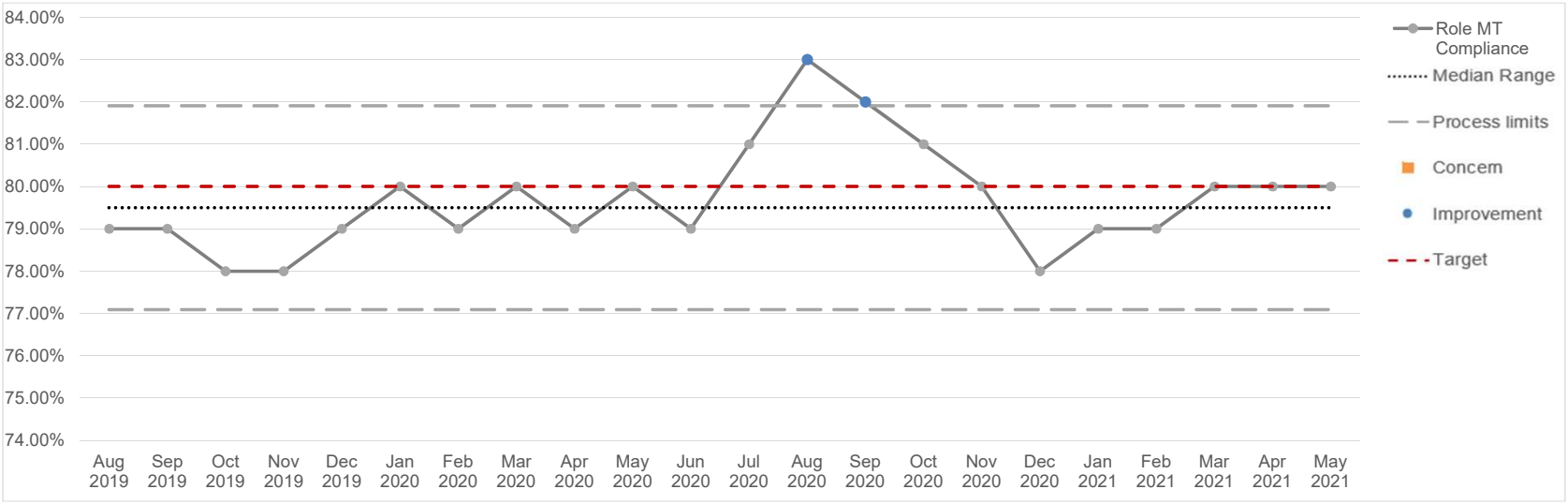
Target	Upper CL
80.00%	81.91%

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 Role Specific Mandatory Training position currently stands at 80% (May 2021). This is within the Trust target of 80%, historically the trend data shows that the Role Specific Mandatory Training compliance is around the same for this time of year, as of May 2020 the Role Specific Mandatory Training Position was also at 80%.	The Training and Development Department will continue targeting employees with low compliance by sending out reminders, guidance and workbooks for completion. We will continue to target and consider an escalation process for those areas not complying. The Training and Development Department will ensure all data is processed and support class administrators are supported with data collections. Auto enrolment has now been switched on in ESR making this easier for staff to complete eLearning modules.

Issues And Risks	Mitigations
Low MT compliance will result in the risks around safe and effective care.	It is predicted that the Mandatory Training compliance will continue to rise over the next few months due to the Actions that will take place. Role Specific Mandatory Training saw a rise in August and September last year, over the last three months the compliance position has been static. A new target has been made for Role specific which is 80% by end of December 2021 and 85% by end of March 2022 , this is a slight change from the previous target which was 80% by September 2021.

Trust Priorities Update – Quarter 1

2. Workforce and Leadership		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1 (Q1)**
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	Director of People and Organisational Effectiveness	**Link to Key Performance Indicator (KPI):** Medical Vacancy Rate, Nurse Vacancy Rate, Staff Fill rate, Registered Nurse Vacancies and Unregistered Nurse Vacancies **Update Q1:** The Trust met NHS Improvement (NHSI) targets in Q1 with NHSI sign off for filling all of its Health Care Support Workers (HCSW) vacancies. The effectiveness of a HCSW pipeline has already been utilised responding to increased HCSW turnover in Q1. This will be reviewed via KPI submission to Workforce Committee and via integrated performance report (IPR) reporting to the Board. Recruitment continues with regards to both medical and nursing vacancies. The last report position in May 2021: Consultants – 16.2% (target 16%) Specialty Doctors – 18.67% Junior Doctors – 15.32% Current pipeline of individuals awaiting start stands at 17 Consultants, 33 Specialty and Associate Specialist (SAS), 27 juniors with further recruitment ongoing. The majority of junior doctor vacancies consists of training Doctors. Rotation fill in August is currently standing at circa 80%. Increases in establishment have Impacted fill against targets. SAS Establishment increased by 18.9WTE in April 2021.
We will **Improve Culture** by developing overall plans to further implement and embed our values, improve working practices, and support new ways of working	Director of People and Organisational Effectiveness	Timescale for delivery: Quarter 4 (Q4) • Associate Director – Culture and Organisational Development (OD) has been appointed and will commence in post on 9 August. • Culture Task and Finish group to be established in Quarter 2 (Q2) • Relaunch of staff network groups for BAME, Disability and LGTBQ+ with drop in sessions for staff to find out more about how the groups operate - July • Workforce Race Equality Standard (WRES) / Disability Equality Standard (DES) data for 2021/22 currently being collated and will be reported in draft form to Workforce Committee in July 2021 • Champion role to support Health and Wellbeing (HWB), Freedom to Speak Up (FTSU) and culture change will be

		developed • Board Development Programme for 2021/22 in development alongside Executive leadership development.
We will design and implement a **Health and Wellbeing plan** which sets out our offer for all staff the next two years.	Director of People and Organisational Effectiveness	Timescale for delivery of HWB Plan – Quarter 3 (Q3) – October 2021: • Health and Wellbeing Guardian has been appointed – Michael Whitworth as Non-Executive Director (NED) on the Board • Appointment made to the HWB Co-ordinator role who will commence in post at the end of August • Health and Wellbeing Group has now been re-established • Awaiting relaunch of HWB NHSI/E self-assessment tool and then a stakeholder event, to include some managers and staff will be arranged to undertake self-assessment/diagnostic so that a HWB plan can be developed for next two years • This will also link in with wider HWB plans with the Integrated Care System (ICS).
We will scope our **Leadership Development** Framework to enhance the capabilities of clinical and non-clinical leaders at all levels.	Director of People and Organisational Effectiveness	Timescale for scoping options – Q3 – December 2021: • Associate Director – Culture and OD has been appointed and will commence in post on 9 August. This will be a key priority of the post holder • Exercise will be undertaken to design a Leadership programme for all Leaders within the Trust and will encompass HWB, Diversity and Inclusion and conflict management. Work will be undertaken to gain valuable insights from leaders across the organisation so that the programme is co-designed. In addition, we will also review current leadership development models underway to establish “what works”.
We will enhance and invest in the **People Directorate capability** to support the Trust to deliver the NHS People Plan and Trust People Strategy	Director of People and Organisational Effectiveness	Timescale for full implementation – Q2 -November 2021. • Business case submitted and approved to Executives, Business Review Group - May 2021 • Four senior posts (including Deputy role) have now been appointed • Investment has been made to the Directorate to strengthen OD and Human Resource (HR) capacity and capability • Formal consultation commenced with staff and trade unions 6 July 2021and will run until mid-August • Any vacant posts arising from the restructure will be appointed during and following consultation

4. Strategic Development and Improvement		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
With Hull University Teaching Hospitals (HUTH), 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 ear, nose and throat (ENT), ophthalmology, cardiology and urology under a single service leadership by March 2022; • Improved access and treatment pathways, including a redesigned community approach by March 2022.	Director of Strategic Development	• Revised leadership and clinical delivery approach - agreed between the organisations and currently going through Humber Acute Service Review (HASR) governance structure for approval for all 10 specialities • Cardiology Clinical Lead in post and all Transformation leads in post, timelines approved • Process mapping commenced in all specialities ensuring linkages with cancer, recover, out of hospital and diagnostics
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	Director of Strategic Development	**Programme 2:** • Moved from review to design phase • Options developed for urgent and emergency centre (U&EC), Maternity Neonates and Paediatrics, Planned Care • Evaluation progressing (data frameworks and assumptions including Out of Hospital integration and impact) • Development with the system for Community Diagnostic Hubs • Engagement activities: • Urgent & Emergency Care/Maternity, Neonates and Paediatrics and Planned Care Workshops /Focus Groups/joint pathway mapping • HUTH/NLAG Joint NEDs

		• Three Councillor Workshops “What matters to you” • “What matters to you” survey closed 3,883 responses received • Q&A sessions / briefings launched • Secured independent reviews through Regional Clinical Advisors – Midwifery complete, U&EC commenced • Engaging with Public Health, Ambulance (EMAS/YAS), Voluntary Sector to support options development and evaluation • Capital PMO appointed • Workforce planning commenced as a system, including education/training design **All Programmes**: • NHSE/I Assurance stocktake meeting with Richard Barker held on 22 April 21 – reviewed progress / plans and milestones – formal positive response to proceed • Pre-Consultation Business Case framework established and commenced populating in line with timescales (shell PCBC due end Sept, final end Dec) • Lincolnshire and Doncaster system engagement • NHSE/I pilot training complete for Delivering Service Change – creating bespoke NLAG/HUTH training package for all staff. Committees in Common to support increased collaboration and delivery agreed and launched.

5. Estates, Equipment and Capital Investment		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
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.	Director of Estates and Facilities	Full Planning Permission has been granted. Minor material change being asked at SGH car park by Planners. **Key enabling works (enables space for new Emergency Department (ED) building);** • Works to Coronation Block at SGH completed week commencing 5 July new offices for Surgery & Family Services open • At SGH, new relocated multi-faith room, private patients, patients' library open • At SGH new doctors accommodation open • At SGH circa 100 relocated offsite in collaboration with local college freeing up space for new Executive Offices open. **ED Buildings & supporting infrastructure** • At DPoW ED building works are fully underway & temporary ambulance route/station operational & works to the ED foundations complete and steelwork erection has progressed well • At both sites key infrastructure works underway with substations • All satellite car parks complete and operational • Works to the new car park decks commenced and are expected to be completed during August/September 2021 with part of the car park at SGH closed for groundworks • Independent costs analysis undertaken demonstrates NLaG EDs when in comparison with other trusts illustrates that both DPoW and SGH are more cost efficient per square metre. This analysis was undertaken 16 June 2021. All has been adjusted to the Scarborough location and 1Q21 price date. **Acute Assessment Unit (AAU) Final Business Case (FBC)** • Staffing models updated for medical and nursing • Bed base agreed with phasing plans developed with further work ongoing between nursing establishment • Three systems workshops undertaken with CCGs, Local Authorities, ambulance trusts and third sector undertaken with output for economic analysis being developed • NHSE/I requirements on standards for the AAU scheme to meet Modern Methods of Construction highlights NLaG meets the target of 50% by achieving 57%.

		MRI DPoW • This project is now complete with the facility opened for clinical use on 21 April 2021. Initial feedback from patients and staff is very positive. The official opening is taking place on 7 July. **MRI SGH** • Construction works started on site on 25 January 2021, with the facility scheduled to complete in December 2021.
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**	Director of Estates and Facilities	NLAG has worked actively with both of our local councils in North and North East Lincolnshire on the potential options for new hospital developments. Each of the local authorities is an active member of the Strategic Capital Programme Advisory Group for Humber Acute Services and have engaged in one to one discussions, workshops and focus groups. These groups have also involved wider system partners including local engagement partners (LEPs). The Trust has monthly meetings with each authority and is actively engaged in discussion about our role including: • Anchor Organisation • Workforce Development • Regeneration and urban development • Towns Centre Deals • Health and Well Being Strategies. The discussions are focussed on how to optimise and share infrastructure as appropriate and to ensure that our pans reflect not only wider development and regeneration activities but also partnerships to develop a more local workforce.

6. Digital		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
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 Electronic Patient Record (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 in-house 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.	Chief Information Officer	**Link to Key Performance Indicator (KPI):** The Digital Transformation Programme that support the Digital Strategy is tracked across its various projects via a programme tracker which provides a RAG rating framework for the schemes. National reporting rated the programme at Amber+. Delivery target is Fiscal 2021/22. Some of the initiatives will be started, not completed in year (i.e. Document management, Command Centre). **Update Q1:** • Digital Aspirant award at April 2021 Baseline has been re-ported as Amber+, successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into major issues threatening delivery • Development of PMO resources within Digital Services is underway with a permanent Programme Manager commencing in post in October 2021. Currently filling roles with interims • £2.27m of 2021/22 capital and £196k of 2021/22 revenue is reliant on having a Funding Evidence Report (FER) completed and approved by NHSX in September 2021 • 2020/21 funding for devices and infrastructure was spent successfully before 31 March 2021. Kit deliveries were received and are continuing to be rolled out across all areas • Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS Foundation Trust (HUTH/NLG) have been working closely on Lorenzo/WebV click through access. Development of Lorenzo->WebV viewer is complete and testing is under way and completion scheduled by end of August 2021 • Lorenzo patient administration system (PAS) technical proposal currently being assessed by both Trusts with Business Case/options paper to be provided to the executive team (ET) and Trust Management Board (TMB) in August 2021 • Data Warehouse project outline understood and procurement options assessed. Discussion underway with Hull University Teaching Hospitals data warehouse supplier around shared proposal that would link into support the preferred PAS option. Otherwise a separate

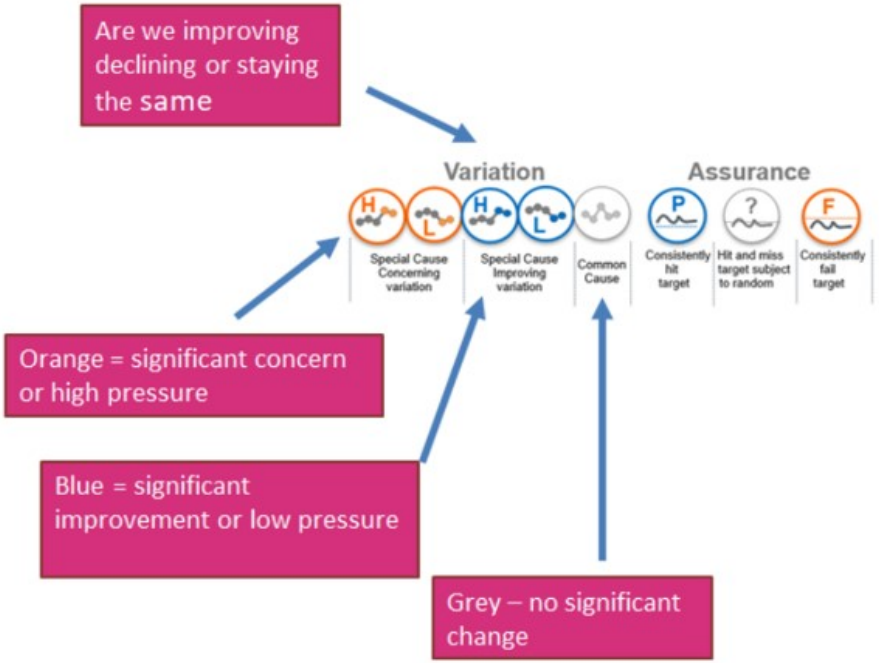
		procurement exercise would be undertaken in September • Clinical system upgrades have been purchased from suppliers and form part of the schedule of planned work across the Digital Teams. Priorities around Cardiotocograph (CTG) archiving, Cardiology and Obstetric ultrasound systems. July /August with new PM starting in July. RPA ‘envision’ workshop held with Patient Admin teams at both Trust and Northampton General (Automation Accelerator). Feedback on priority processes by end of July. Productive discussion with NHSEI to support shared robotic process automation (RPA) infrastructure for Initial pilots.

7. Finance		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
We will achieve the **Trust's 21/22 Financial Plan.**	Director of Finance	The Trust is plan compliant at the end of Q1 reporting a £0.42 million surplus against a planned surplus of £0.18 million, £0.24 million favourable to plan. The Trust reported delivery of £0.8 million of savings for the Q1 period against a plan of £0.6 million, £0.18 million favourable to plan. The current forecast is £4.08 million marginally behind the plan of £4.17 million. The Trust is forecasting to be plan compliant for the H1 period.
We will achieve the 21/22 Humber Coast and Vale HCP **system financial control total.**	Director of Finance	The HC&V ICS reported a year to date (YTD) £13.1 million surplus, which is a favourable variance to plan of £11.1 million and is forecast to deliver a £0.2 million surplus for the H1 period.
We will leave **Financial Special Measures.**	Director of Finance	The Trust received formal notification from NHSE/I on the 18 June regarding the final steps of assurance required from The Trust throughout Q2 with a view for potential exit from Financial Special Measures in Q3. The key components being: • An assessment of the impact of pandemic on recurrent run rate and a planned exit from non-recurrent costs • A H2 plan demonstrating step improvement in efficiency delivery and run rate reduction • A refreshed long term financial plan (LTFP), focused on expenditure to demonstrate Trust future financial improvement trajectory • Strengthened finance team structure approval and implementation • Embedding and effectiveness of new financial governance arrangements aligned with wider governance improvements • Trust Board and Executive leadership demonstrating management and delivery of financial improvement is a shared portfolio • Trust and system H1/H2 financial plans and delivery within envelopes • Cost improvement plan (CIP) plan development and delivery that is not significantly back-weighted • Trust governance arrangements supporting alignment of financial and quality improvement planning and implementation

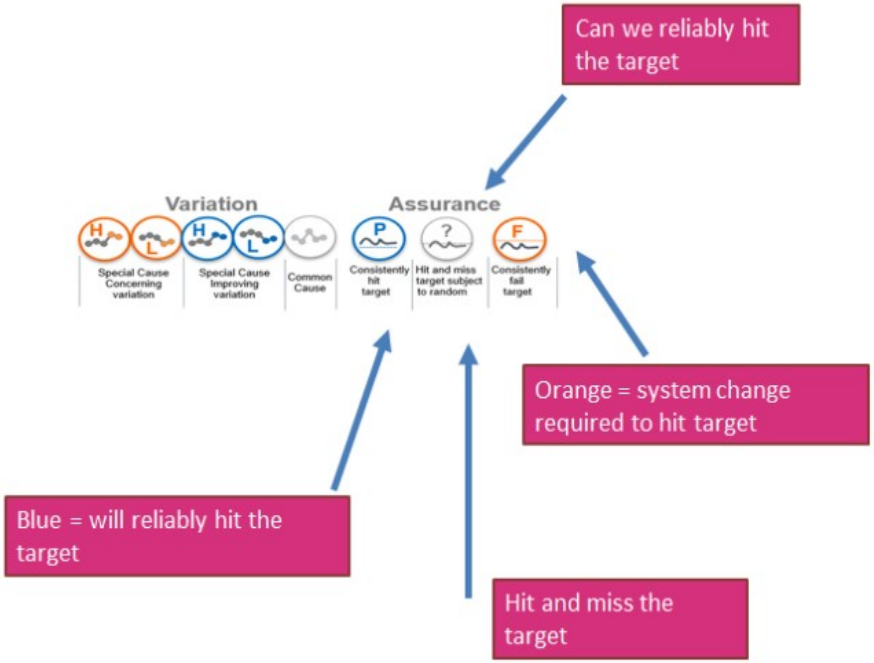
8. The NHS Green Agenda		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
We will promote, develop and embed the **NHS Green agenda** into the Trust, specifically: procurement policies; staff energy champions; travel, waste and energy reduction.	Director of Estates and Facilities	The Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) Green Plan has been developed, approved at Trust Board. This document is supported by a working group delivering objectives and strategies within the Plan. The working group are working on the next phases of the plan to update with the Trust Travel Plan and the creation of a decarbonisation strategy, paving the way for an NLAG Net Carbon Zero plan.
We will invest £40.3 million from the **Public Sector Decarbonisation Fund** (joint Department of Health and Social Care (DHSC) and Department for Business Energy and Industrial Strategy (BEIS) in Green schemes across all three hospitals, including replacing the coal fired boiler at Goole	Director of Estates and Facilities	**Goole/BEIS** The Goole decarbonisation works are well underway with Centrica now at delivery phase. The cavity wall insulation has been completed and already more than 50% of the old inefficient lighting has been with the new energy saving light emitting diode (LED) fittings. The Trust is currently working on switching off the Coal boilers ahead of the refurbishment of Energy Centre. Centrica are preparing this area for the new low carbon combined heat and power (CHP) and boiler system due to be operational in 2021. Other aspects of the Project such as building management system (BMS) upgrades, Plate Heat Exchangers and Loft insulation have all been approved and programmed in. **PSDS – SGH and DPoW** NLaG were successful in their Salix PSDS bid and have appointed Breathe Energy to complete the survey and design works for all the elements of this major decarbonisation programme for SGH and DPOWH. The key focus of Breathe Energy's design works cover the following technologies: • De-steam and renewable heat pump heating system at SGH • Trust wide BMS upgrade • Heating, ventilation and air conditioning (HVAC) upgrades and metering • LED lighting upgrades at DPOWH and SGH • Building fabric upgrades at DPOWH and SGH. There are also key enabling works that are required including a new electricity supply for SGH.

9. Partnership and System Working		
2021/22 Priority	**Senior Responsible Officer**	**Update – Quarter 1**
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.	Chief Executive	The Trust plays its full part at executive and clinical leadership level in the multiple streams developing the HCV Health and Care Partnership.
We will play a full part in other **national and regional networks**, including professional, service delivery and improvement (e.g. get it right first time (GIRFT), and operational.	Chief Executive	The Trust continues to play a full part in multiple national and regional networks.

High level key - Variation



High level key - Assurance



Northern Lincolnshire and Goole NHS Foundation Trust

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

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

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-	CAS	Central Alerting System
	CCG	Clinical Commissioning Groups
	CT	Computerised Tomography
D-	DEXA	Dual Energy X-ray Absorptiometry
	DCA	Data Capture System
	DCD	Divisional Clinical Director
	DPOW	Diana Princess of Wales Hospital
	DTA	Decision to Admit
E-	ECC	Emergency Care Centre
	ED	Emergency Department
	EMAS	East Midlands Ambulance Service
	ESR	Electronic Staff Record
	EFA	Estates and Facilities Alert
	ERF	Elective Recovery Fund
	EOL	End of Life
F-	FFT	Friend and Family Test
	FIT	Faecal Immunochemical Test
	F2F	Face to Face
G-		
H-	HCA	Healthcare Assistant
	HCAI	Healthcare Associated Infections
	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 Coordination Centre
	ICS	Integrated Care System
	IPC	Integrated Personal Commissioning
	IPR	Integrated Performance Report
	IT	Information Technology
	IV	Intravenous
J-		
K-	KPI	Key Performance Indicator
L-	LoS	Length of Stay
	LTR	Labour Turnover
M-	MRI	Magnetic Resonance Imaging
	MRSA	Methicillin-resistant Staphylococcus Aureus
	MSSA	Methicillin-susceptible Staphylococcus Aureus
	MIG	Mortality Improvement Group
	MT	Mandatory Training
N-	NEL	North East Lincolnshire
	NEWS	National Early Warning Score
	NL	North Lincolnshire
	NICE	National Institute for Health and Care Excellence
	NHS	National Health Service
	NHSE/i	National Health Service England/Improvement
	NLAG	Northern Lincolnshire and Goole
	NOUS	Non-Obstetric Ultrasound
	NQN	Newly Qualified Nurse
O-	OEWS	Obstetric Early Warning Score
	OOH	Out of Hospital
P-	PAS	Patient Administration System
	PEWS	Paediatric Early Warning Score
	PIFU	Patient Initiated Follow Ups
	PIR	Post Investigation Review
	POE	People and Organisational Effectiveness
	PTL	Patient Treatment List
	PHE	Public Health England
	PPE	Personal Protective Equipment
Q-	QGG	Quality Governance Group
R-	RAG	Red-amber-green
	RTT	Referral to Treatment
S-	SDEC	Same Day Emergency Care
	SHMI	Summary Hospital-Level Mortality Indicator
	SJR	Structured Judgement Review
	S&CC	Surgery and Critical Care
	SPA	Single Point of Access
	SOF	Single Oversight Framework
	SOP	Standard Operating Procedure
	SI's	Serious Incidents
	STEIS	Strategic Executive Information System
	SGH	Scunthorpe General Hospital
	SPC	Statistical Process Control
T-		
U-		
V-	VTE	Venous Thromboembolism
W-	WTE	Whole Time Equivalent
X-		
Y-		
Z-		

NLG(21)151

DATE OF MEETING	3 August 20201
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Kate Wood, Medical Director and Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Angie Legge, Associate Director for Quality Governance with support from: Jenny Hinchliffe, Deputy Chief Nurse Mel Sharp, Deputy Chief Nurse Vicky Thersby, Head of Safeguarding Jane Warner, Head of Midwifery Maurice Madeo, Deputy Director of Infection Prevention Sara Wood, Lead Nurse for Patient Safety Jennifer Moverley, Head of Compliance Jeremy Daws, Head of Quality Assurance Kelly Burcham, Head of Risk
SUBJECT	Executive Governance Report
BACKGROUND DOCUMENT (if any)	None
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	None
EXECUTIVE SUMMARY	Staffing pressures continue, particularly with a fresh rise in Covid-19. Child Protection for those attending ED has improved with a more robust process. Full submission was declared on all 10 of the safety actions for CNST. One CQC action, diagnostics waiting list, has gone to amber from red as the work to address the issue is on track.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓				

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and		**Digital**	

Capital Investment			
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)					
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Executive Governance Report

Dr Kate Wood, MD
Ellie Monkhouse, CN

Safe Staffing

Aim: To demonstrate compliance with safe staffing standards to keep patients safe.

Current Position	Risk	Mitigation
Combined fill rate above 95% for the first time since Aug 2020. Substantive RN fill rate below 50% on 12 wards on nights in May (decrease from 13 in April), 2 wards below 20%. 7 wards had CHPPD below 6.0 in May (national median 9.3 – Model Hospital Mar 2021) RN vacancy 9.68%, 162.55 wte. HCSW vacancy 6.23%, 52.75 wte (increased turnover in March & April)	There is a risk to the quality and safety of care of patients on the wards due to availability of staff and end of bank incentive scheme	Safecare Live data reviewed daily at 10am 3 x daily staffing reviews in place Staffing red flags and supporting SOP relaunched June 2021 Accelerated recruitment and on boarding of HCSWs continues International nurse recruitment accelerated with enhanced training and support Block booking or regular agency nurses who are familiar with the wards Currently 74 newly qualified nurses to join the Trust in the autumn CNO ward establishment reviews underway
	Increased Complaints / PALS due to staffing levels	The patient contact helpline and family liaison assistants are supporting communication with families which is supporting frontline staff to prioritise bedside care.
	Staff stress due to pressures of Covid-19	Trust wellbeing offer Professional Voice email address Leadership training is being offered to equip staff with skills to lead through this challenging period
Community nurse staffing remains under pressure with 9 red flag incidents reported in May - 6 regarding staffing levels.	There is a risk to the quality and safety of patient care due to demand exceeding capacity, particular risk on evenings and nights	Work ongoing to fill vacancies Electronic allocation system being installed and will assist with capacity and demand modelling Use of bank staff to increase staffing on an evening and overnight whilst consultation completed re shift patterns Participating in national project to develop safe staffing tool for community nursing
Midwife: Birth ratio 1:23 in May (below 1:28 & in line with national guidance)		Continue to monitor monthly and review midwifery red flags.

IPC

Aim: To minimise cross infection to maintain patient safety

Current Position	Risk	Mitigation
During June the Trust reported 1 Hospital Onset COVID case possibly linked to a visitor. 26 patients were admitted with COVID-19. New IPC assurance framework released with emphasis on hierarchy of controls, with greater emphasis on mechanical ventilation Updated national IPC guidance – very little change. Reinforcing continuation of IPC precautions.	The risk of COVID is rapidly escalating across the region and now starting to see hospital admissions mostly in non vaccinated patients. Risk 2794 (ECC cross infection) Risk 2697 (Risk of staff contracting Covid)	National guidance 30 Redirooms for isolation Cubiscreen (shielding curtain) Architectural walls on B3, Ward 23, Ward 28, IAAU SGH Lateral flow testing Vaccination available for18 yrs and over Capital projects to look at replicating A1 at SGH site to enhance isolation winter capacity.
The trust is seeing more pillar 2 COVID-19 cases admitted and significant number not vaccinated	Given the rise of Delta variant and busy nature of ECC and movement to IAAU risk of cross infection if patient not swabbed or isolated as per guidance.	Redirooms All ECC patients to be rapid tested if due for admission Utilise single rooms / Pods if result unavailable or symptomatic.

Patient Experience

Aim: To ensure patients and families experience of care is everyone's priority and that that feedback is viewed as an opportunity to improve standards.

Current Position	Risk	Mitigation
Improving position of complaints responded to within timescale. Current Open complaint position 78 in timescale with 10 > 60 WD timescale = 87% on track (Med 9 , CSS 1) Closed complaints within timescale now at 79% Complaint responses now all describe learning Leadership teams are responding pro-actively to complaints management	• Culture of responding to feedback as an opportunity is slow to shift • Capacity of Lead investigators to undertake timely investigations	• Complaints improvement plan • Training across divisions for new lead investigators • Close oversight and tracking of complaints by weekly meetings • Central Complaint Team contributing to system build of new incident reporting software to ensure continued/improved oversight • Complaints position discussed at PRIMs • Monthly report to divisions for governance purposes • Actions in place for 3 key risks to timescales
Patient/family feedback mostly related to lack of communication with In-patient wards. Family liaison 6 mth fixed term roles making difference to communication , and patient experience (mental and emotional wellbeing)	• Increased in PALS/complaints • Reputation as caring • Staff morale in the face of dissatisfied families	• Family liaison Assistants business case in development • 3 Pt experience officer across 3 sites • Patient Contact helpline • Leadership development for frontline staff • Staff well being initiatives/resilience • Sage & Thyme training programme
Impact of capital builds on DpOW patient experience	• More challenging to park, way find and mobilise to appointments	• Volunteers are being recruited for wayfinding roles • Working closely with estates project team to reduce risks and improve communication • Signage review to be arranged

Patient Safety - Pressure Ulcers and Falls

Aim: To provide harm free care, ensuring that learning is shared across the organisation, that risks are identified and mitigated through robust action plans.

Current Position	Risk	Mitigation
Numbers of reported pressure ulcers remain consistent Themes from serious incidents remain consistent	• Capacity of Ward Sisters and Deputy Chief Nurse Office to scrutinise incidents • Capacity of TV Team to facilitate training reduced due to vacancy within team • Staffing shortfalls impacting upon patient care	• Focus on areas of high reporting, previous high reporting or concern identified by Nursing Metrics Panel • TVN team recruitment in progress. • Training prioritised to higher reporting areas/areas of concern. • Recruitment to HCA vacancies, use of bank and agency staff. Themes fed in to establishment reviews.
Numbers of reported falls remain consistent Ongoing roll-out of Supportive Care and the AFLOAT tool to support decision making and escalation for resource	• There is an increased risk of falls for all patients coming into hospital wihich carries the risk of serious harm • Staffing to resource additional shift requirements	• Focussed training delivered to higher reporting areas or concern identified by Nursing Metrics Panel • Learning shared to reduce risk and training delivered as required • Action plan developed from themes of huddles and serious incidents • Recruitment to HCA vacancies, use of bank . • Training delivered to Matrons, Site team and Clinical Sister to support decision making

Safeguarding and Vulnerabilities

Aim: Safeguarding is everybody's business and embedded across all Trust areas

Current Position	Risk	Mitigation
Not completing statutory Initial Health Assessment within 20 working days of becoming a looked after child (NE Lincs) due to delays in information from Social Services June 45% in 20 days	Late identification of unmet health need of child new into care	Robust oversight On risk register All assessments are completed but not within the timeframe Externally reported to CCG/ Focus Engagement meetings with LA to improve timeliness of notification to NLAG
Child Protection Information Sharing System Now meeting the requirement to alert but documentation not always robust	Missed opportunity to safeguard children and young people	NHS spine of all children and young people is accessed. Built process into Web V SOP developed Ad hoc training and support as needed CP-IS alert is immediately sent to the originating local authority
The Trust has oversight of all DoLS authorisations from NLaG in patient wards NLAG notifications from 1 July	Not following statutory requirements to inform CQC of DoLs application and outcome	The safeguarding team have oversight of where referrals are coming from and quality assure all authorisations Monitoring data and database Spreadsheet to monitor DoLs and outcome
Liberty Protection Safeguards awaiting draft Code of Practice from the Government	The Trust is not prepared to implement new system Financial implications Training	Awaiting draft Code of Practice (Summer 2021) MCA lead is linked with local networks/ nationally Lead for LPS established in NLAG Task and Finish Group to implement LPS

CQC Action Progress

Aim: The Trust can evidence completion of all CQC actions or have mitigation for those not yet achieved.

Current Position	Risk	Mitigation
Signed off: 32% (46 actions) Complete: 37% (52 actions) In Progress: 21% (30 actions) On Hold : 2% (3 actions)	There is a risk that actions may not be fully embedded	Monitoring is a part of each action A review has commence of all blue actions to ensure the monitoring is robust.
Off track actions (Red): 5.6% (8 actions)	The Trust will not be compliant with mandatory training by the CQC visit	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
	The Trust does not have sufficient capacity to meet the diagnostics action	Risk Stratification & Clinical harm reviews Additional capacity where feasible through mobile diagnostics Agreed referral priority Action now ratified as amber due to ongoing work and mitigation.
	Additional resources are needed to meet staffing levels	See Slide 1 for wider view on staffing Presentation of community staffing to CCGs on 19th July following which a further review will be undertaken to support a business case. Daily monitoring to ensure safe service.

Maternity & CNST

Aim: To be fully compliant with the Ockenden Report, CNST and Saving Babies Lives

Current Position	Risk	Mitigation
Full submission declared of all 10 Safety Actions (CNST incl Saving Babies Lives)	Failure to submit the evidence to provide assurance on safety in maternity units	n/a
Evidence submitted to NHSE/I. Action plan – 28 actions met, 22 outstanding with a number reliant on national work programmes.	Safety in maternity units	Provision of independent senior advocate role (awaiting further detail). Further develop of Safety Champions. Implementing Local Maternity System SOP with sharing of Serious Incidents. Establishing submission to Trust Board of Serious Incidents. Implementation of LMS oversight being embedded
MDT Training - Compliance >90%, HCA 79%, Anaesthetic doctors 89%	Staff training and working together in emergency situation	Comply with MDT training compliance across all staff cohorts – need to meet 90%
All 5 SBL elements met. Q3 30/21 – NLAG 6.3/1000 birth stillbirth rate. Region average 3.6.	Managing complex pregnancy and ability to escalate to regional centres	To establish National Antenatal Risk Assessment process once guidance released To develop a pathway and SOP for referral to Regional Maternal Medicine Centres once national guidance released. Review of stillbirth review completed
All 5 elements met (Safety Action 6).	Monitoring fetal wellbeing to ensure reduced risk of stillbirth. Saving Babies Lives - Multiple criteria required to be met – CO monitoring, pre-term birth clinic, uterine artery Doppler scanning.	On-going audit to ensure embedded practice
	24/7 theatre access, maternity SGH	24/7 theatre (SGH) access commenced 1/1/2021 for caesarean sections and trial of instrumental bi-the

Mortality

Aim: 90% of all deaths screened by July 2021, 100% of those where a concern is identified have an SJR within 6 weeks

Current Position	Risk	Mitigation
Q4 20/21: 90% **Q1 21/22: 87%** (Jan 21: 93%; Feb 21: 91%; Mar 21: 87%; Apr 21: 91%; May 21: 87%; Jun 21: 79%) Latest data tends to be an under-reporting due to timescales involved in undertaking reviews.	Risk of failing to meet the Trust's target of screening 90% of deaths	Ongoing work. Linked to clinical coding validation work led on by divisional lead mortality/coding leads. Assurance reporting on process from Coding report to MIG and quality screening reported to MIG in monthly mortality report.
2020/21: 90% There is a backlog of cases not yet reviewed going back to Sept 2020 [Risk 2797; risk rating 8]. There were 3 cases from this period that are overdue	Risk of not achieving the 100% of SJR on cases identified from screening, within 6 weeks. There is the risk that some older cases may require escalation for further investigation and consideration of duty of candour on the back of the SJR review.	Revising SOP in line with NHSE/I guidance and share cases with community concerns with CCGs via incident reporting instead of NLAG internal review. Escalation to and working with DCD in Medicine; Review of SJR trained staff in divisions and determination if the pool of reviewers can be expanded.
(Month ending Feb 21) In hospital SHMI 95, out of hospital is 128, broken down to NEL: 135 and NL: 121	Risk of harm reflected in a high SHMI position Out of hospital SHMI significant disparity of 36 points (41 at DPoW and 31 at SGH).	NHSE/I audit completed looking at the management of patients at EOL. Recommendations received by MIG; action plan to be developed. CCG/out of hospital improvement action plan, reporting to MIG.

Serious Incidents

Aim: To deliver quality investigations within the national timeframe by trained investigators and deliver timely actions to reduce the risk of recurrence

Current Position	Risk	Mitigation
19 out 32 investigations in progress are within timescale (From January 2021 onwards)	There is a risk of delay in investigation due to staffing pressures or complexity of the case	Key dates initiated at commencement of investigation Early booking of interviews and RCA meeting Weekly timeliness monitoring Escalation of delays to SI Panel / division Family Liaison keeping the family up to date Liaison with CCG in respect of reasons for delay
87% assurance rate by CCGs. (From January 2021 onwards)	There is a risk that the quality of the investigation will not be enough to identify the key concerns and root cause	Regular training on investigation skills Review process on Serious Incidents through divisional sign off to central Governance challenge and Executive sign off.
No measurement	There is a risk that actions will not be SMART and thereby not increase safety	Challenge to recommendations and actions at SI Panel
Currently 7overdue actions in total. 6 off track within Medicine and 1 surgery but less than 3 months over due date and verbal assurance on safety received	There is a risk that actions will not be delivered in a timely way	Action plan monitoring monthly at SI Panel Action plan delivery part of PRIM Action change process for when the context changes and action no longer applies
Risk & Learning Manager in post	Insufficient learning from 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 Strategy Learning Group commenced to devise key themes for sharing

NLG(21)152

DATE OF MEETING	3rd August 2021
REPORT FOR	Board of Directors
REPORT FROM	Quality and Safety Committee
CONTACT OFFICER	Mike Proctor – Chair QSC
SUBJECT	Highlight Report from the Quality and Safety Committee meetings held on 18th June, 12th July and 16th July
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A.
EXECUTIVE SUMMARY	The narrative in the report is an Executive Summary of QSC discussions over 3 meetings in June and July 2021

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)					
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 or state not applicable (N/A)	The Committee focusses on the identified risks in the BAF as it relates to strategic objective 1.

BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	3rd August 2021
Report From:	Mike Proctor – Chair Quality and Safety Committee

Highlight Report from QSC meetings held on 18th June, 12th July and 16th July

18th June Meeting.

Cancer

Following a referral from ARG, the Committee received detailed report on the Risk Stratification of patients on the cancer pathway whose waiting time had breached the constitutional standard. The Committee noted the complexity of the pathways and accepted that some delays were due to difficulties in diagnosis, cross referrals to other hospital and the fact that the patients themselves required further time to think before agreeing treatment regimes.

Some specific harms were identified and reported in detail to the Committee. The Committee noted that whilst the Trust struggled to meet constitutional standards (as all cancer units were experiencing) there will be ongoing quality and safety risks. However, the Committee took comfort and assurance from the existing processes for risk stratification and the identification of harms.

Overall the report received provided significant assurance

Update from July QSC meeting – The Committee noted the recent necessary changes to Oncology services and requested an update report at its September meeting

Ophthalmology

The Committee received reassurance that significant progress on the development of a risk stratification process for patient's overdue review outpatient appointments and looked forward to a further progress report in August.

Update from July QSC meeting – Concerns reported via Quality Improvement Group that the ophthalmology waiting list is growing. The Committee noted a further Never Event (the third) and was seeking further assurance on learning and prevention of recurrence from the specialty

IPR

The Committee noted an improving position on VTE assessment (although this remained a concern) and some indications that out of hospital SHMI might be starting to improve.

Update from July QSC meeting – Key areas of concern and ongoing monitoring include; Out of Hospital SHMI, Number of patients dying within 24 hours of admission, VTE, Structured Judgement Reviews, Adult observations, Duty of candor, Emergency C-Section rate and MSSA.

Safeguarding

There are ongoing concerns about delays in receipt of notifications to the Trust from social care of children who became 'looked after' which led to potential delays to the hospital provided Initial Health Assessment for the children. However, the Committee was assured that the CCG were leading work to rectify this issue.

Patient Prioritisation

Concern were expressed that patients from the South Bank were not receiving the same prioritisation as patients from the North for treatments which were delivered in Hull for both populations. It was agreed that there was no evidence beyond anecdote to support this but the Chief Executive acknowledged that the concerns were real and would discuss the perceptions with colleagues at HUTH in order to gather evidence and assurances that this was not the case.

Report from Medicine Division

The significant increase in ED attendances was causing concerns related to quality in addition to performance issues related to the constitutional standard. It was agreed that the work to reduce unnecessary patient attendances in ED was very important.

The excellent working relationships between physicians in the Trust and the ED Consultants were highlighted. The Chair noted that this was not always mirrored in other organisations

Report from the Community, Therapy Services and End of Life Division.

The Division continues to experience significant pressures with identified risks related to the redesigning of patient pathways which result in a 'left-shift' away from secondary care to primary, community, home and self-care. Staffing shortages, particular in community nursing were a major concern.

Maternity SI.

Maternity SI, STEIS 2020 15890 was reported to and considered by the Committee. Key learning identified included:

- Highlighting to all clinicians the relevance of raised urea levels in perinatal

mortality meetings.
- Ensure sonographers and a senior clinician has discussions regarding their decisions.
- Ensuring Dawes Redman criteria are used for all antenatal patients in CTG's

Extraordinary meeting 12 July.

The Committee met to review the proposed full declaration with all 10 patient safety standards required by the Clinical Negligence Scheme for Trust (CNST). The membership reviewed to declaration and heard of the 'confirm and challenge' events related to the evidence to support the declaration which included external participants. The Committee was confident that the declaration was accurate and, on behalf of the Board, signed off the declaration for submission.

Additional highlights from the 16th July meeting.

Quality Account

The Committee agreed to confirm the accuracy of the Trusts Quality Account, including stakeholder comments and approved the final version for publication, subject to Board approval.

Mental Health Act (MHA) and Mental Health in NLAG

The Committee approved the recommendations from the MHA action plan and requested, via ARG, that Audit Yorkshire re-audit the Trust with regard to the adequacy, effectiveness and compliance with its responsibilities under the Mental Health Act following a 'Limited Assurance' verdict in April 2021.

Infection Prevention and Control.

The Committee congratulated the infection control team for their magnificent efforts during the COVID crisis particularly as the challenges of meeting best infection control practice for the management of patients often run up against estate constraints including ventilation and lack of single occupancy rooms. The team has had to be, and remain incredibly flexible and is faced with difficult compromise decisions daily.

Confirm or Challenge of the Board Assurance Framework:

BAF reviewed at the July meeting.

The reduction in cancer risk assessment score was challenged and would subsequently be reviewed.

Action Required by the Trust Board:

To support the publication of the annual Quality Account.

To note the QSC's sign-off of the CNST safety standards compliance.

To note that the QSC, on behalf of the Board, has reviewed and will continue to monitor actions related to a Trust requested external quality review following a safeguarding issue in 2015.

NLG(21)153

DATE OF MEETING	2nd August
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Shaun Stacey, Chief Operating Officer
CONTACT OFFICER	Richard Peasgood, Executive Assistant
SUBJECT	Executive Report - Performance
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY	The Operational Update details the current position with ED and ambulance waits, as well as the Discharge to Assess program and Elective and Cancer position.

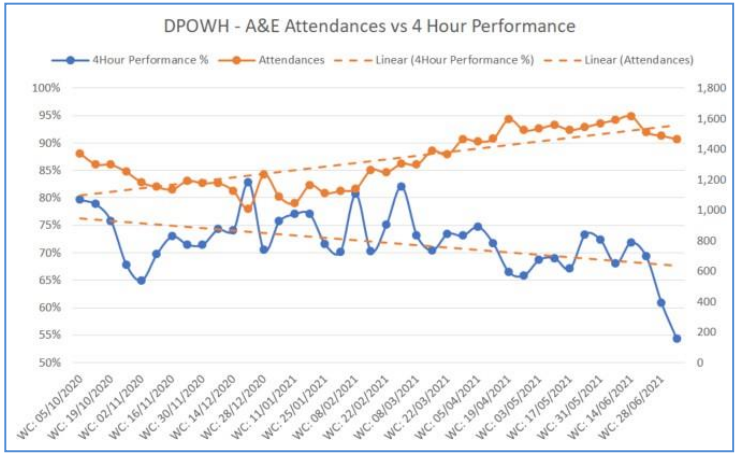
LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
1. To give great care	**2. To be a good employer**	**3. To live within our means**	**4. To work more collaboratively**	**5. To provide good leadership**
✓			✓	✓

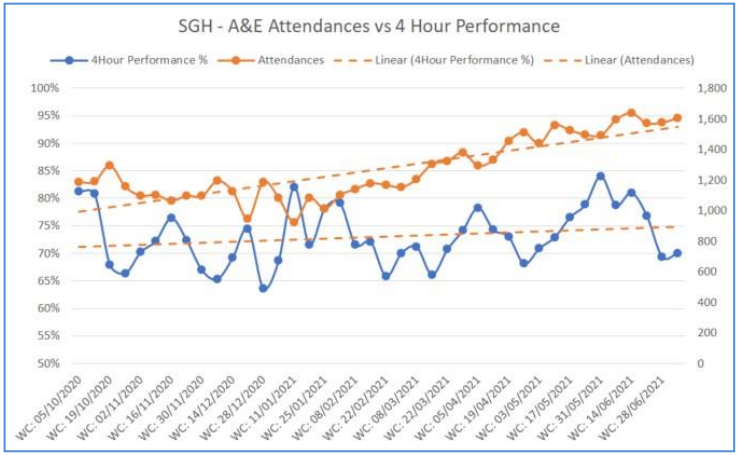
TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	✓
Quality and Safety	✓	**Strategic Service Development and Improvement**	✓
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	SO1 – 1.2 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.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Emergency Department Waits

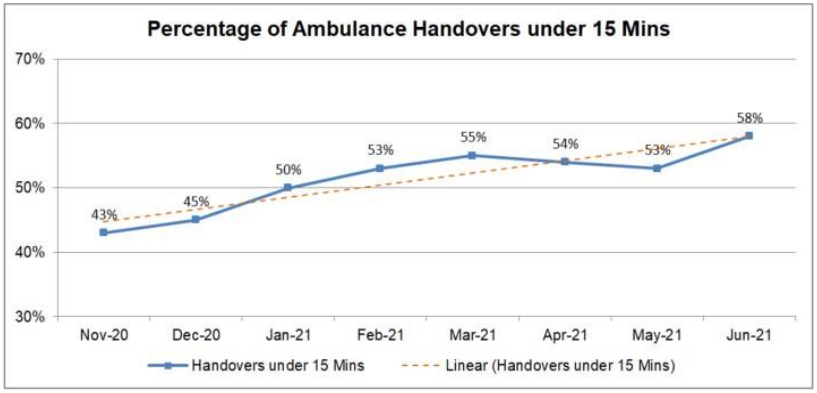
Highlights	Lowlights	Risks
• The ED's are responding to increased attendances in June 2021 that are up 32% compared to June 2020, with on average 455 patients per day compared to 344 last year • When compared to June 2019 pre-covid, average daily ED attendances are up from 416 per day to 455 per day, resulting in 1,170 more patients attending ED during June 2021 compared to June 2019 • Zero 12hr DTA breaches at either site during June 2021 • Frailty assessment service at DPOWH continued beyond pilot • Improved position for medical recruitment within ED • The new ED builds are progressing well with construction ongoing at DPOWH and the final decanting and enabling works ongoing at SGH. Detailed room specifications and digital strategy being developed • NLAG went live with direct bookable arrival slots in ED at DPOWH for the SPA using the new Any2Any interfacing as part of the NHS111 First initiative programme as the regional early adopter Trust • Additional medical staff have been injected into ED to improve patient safety throughout the department	• June 2021 performance was 74.6% (DPOWH 69.6%, SGH 79.2%) • Increase in walk-in attendances with non-ED patients due to lack of alternative service availability/accessibility • Challenges with crowding and pressures on support services turnaround times (e.g. diagnostics) due to increase in attendances • Risk of delays in booking in walk-in patients due to no capacity within ED waiting area to bring more patients into the ED (shift lead completing walk by reviews of queuing patients to identify any clinical risks) • Challenges in filling medical and nursing shifts due to vacancies/sickness • 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	• High bed occupancy levels leading to a lack of patient flow and exit block in ED will result in delays for patients in ED and drop in 4hr performance and delays in off loading patients from ambulances and risk 60min+ handover breaches • Reliance on locum bank and agency specialty doctors in ED due to delayed recruitment pipeline • Risk of crowding in ED due to increase in attendances and reduced physical capacity due to covid-19 impacts

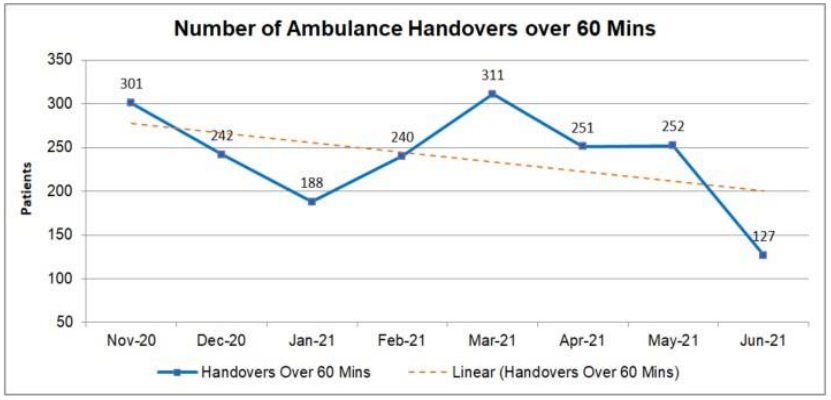




Ambulance Handovers

Performance	Quality
• Significant reduction in 60min+ ambulance handovers in June 2021 with a total of 127 compared to previous month's • Ambulance handovers completed in under 15 minutes has improved from 43% in November 2020 to 58% in June 2021 - the highest within last 12 months • The percentage of 15-30 minute handovers has improved from 35% in November 2020 to 30% in June 2021 • The percentage of 30-60 minute handovers has improved with a decrease from 14% in November 2020 to 9% in June 2021 • The percentage of over 60 minute handovers has improved from 9% in November 2020 to 4% in June 2021 • Both DPOWH and SGH have risen in the EMAS regional handover rankings across all three ranked brackets	• Reduced time between ambulance arrival and patient assessment by ED clinical staff • Implementation of the latest Manchester Triage Tool version improved patient triage • A training programme for ED nurses is improving clinical handover assessments • When patients do wait in the ambulance, an ED clinician assesses all waiting patients in the ambulances to prioritise • Paediatric patients in ambulance queue can be fast-tracked by support from the Paediatric Team





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

Highlights	Lowlights	Risks
• Work ongoing with NHSE/I to review and develop new Medicine rotas and job planning to support increasing service hours of SDEC and ED in-reach. A 2 week perfect week rota pilot at SGH is being developed for 9th August 2021 extending SDEC hours to 10pm 7 days a week • Frailty assessment service at DPOWH completed the 4 week initial pilot in May/June 2021 and has been continued going forward. The service reduces waits for frail patients within ED (bypassing direct to SEC where possible) and provides an improved pathway for the patients. Although average of small numbers through the service per day, 93% were discharged home avoiding an admission • Further developments made on IAAU dashboard linking in with the long-term phase 3 new ED/IAAU build objectives • New Medicine Management tier 3 oversight rota implemented providing improved escalation and support to ED and Acute teams • 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, high levels of vacancy still exist within the Acute Medicine team while awaiting for appointed medical staff to start • 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 • Continued embedding to improve specialty input times and remove traditional barriers from quick access to SDEC services • Specialty SDEC capacity and access not sufficient to meet patient demand – Focus on this is part of newly established Patient Flow Improvement Group • An IT solution has not yet been identified to enable electronic direct booking of patients from community (GP/SPA) into SDEC	• Reliance on sufficient daily discharges to enable flow out of IAAU is required to prevent bottleneck between ED and IAAU • Turnaround times for covid-19 swab results impacts on ability to move patients on from IAAU into green/red wards • A lack of sufficient specialty SDEC capacity impacts on the ED workforce, patient waits and crowding in ED

Response and Next Step to ECIST Audit Findings

Progress

Improved Oversight

- 3 tier system of Medicine senior oversight in ED implemented to provide support for staff, improve real-time escalation and resolve patient flow blockages
- New ambulance handover protocol with escalation triggers
- SOP introduced for walk-in patients when waiting area at full capacity for social distancing

Collaborative Working

- Established Patient Flow Improvement Meeting to drive forward cross-Divisional ECIST recommendations
- Patient Flow workshop to take place to improve patient moves
- OOH programme working group is being established with NEL/NL CCG to develop Integrated Frailty and LTC Service

Pathways

- Frailty assessment service at DPOWH
- Review of non-elective Gynae pathways, including location of services
- Direct streaming to SDEC from EMAS pathway since March 2021 – Continuing to promote within EMAS
- IAAU pilot with NHSI - extending SDEC and specialty in-reach on AAU “Today’s work today” – August 2021
- ECIST review of IAAU service

Discharge to Assess (D2A)

Highlights	Lowlights	Risks
• The Trust's performance for 21 day + currently reported at 7% remains under the national average of 12% and is the lowest within the Humber Coast and Vale • 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. • All wards now have senior consultant presence at board rounds before 10am • All wards are now able to report if and when a patient no longer has a criteria to reside in an acute hospital bed by completing web v and this is being monitored on a daily basis by matron staff • A vast amount of work has been carried out on the Web V System to enable wards to record which patients no longer meet the criteria to reside this enables national daily reporting to NHS E/I, currently further work taking place to ensure the data is alive position to help facilitate discharge and escalate appropriately • 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 • The trust have carried out a frailty pilot on the Grimsby site this has seen significant improvements in the patient pathway with over 85% of patients assessed by the frailty team discharged on the same day • The trust is taking part in the the ward/board round collaborative with NHS E/I a medical ward from the Scunthorpe & Grimsby site have been nominated • Large process mapping exercise taken place concentrating on sustainability of the discharge to assess process	• 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 • Significant pressures on partner organisations for home care, this has resulted in some discharge delays and more placements to temporary care homes	• 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. • The number of RTT 52 week plus waiters continues to decrease and the current number waiting is 497 • Overall out-patient attendances for new patients are being delivered above plan for Q1 at 103%. • Throughout Q1 the overdue follow-up position has slightly deteriorated and has reduced further during July. Each specialty is working up plans to deliver their share of the maximum 9000 waiters as at the end of March 2022, with only 7 of the 25 specialties highlighting risk of delivery. Further work will be undertaken with these specialties to work up action plans or potentially adjust the share of better performing areas. • The use of the Independent Sector continues to support the Trust and additional capacity has been agreed with St Hughs during Q2 to support long waiter backlog patients. Work is due to commence with a new provider in Scunthorpe to provide ENT & General Surgery support also. • Processes in place to record, track and monitor risk stratification for all patients at all points in the pathway • Inpatients Live Risk Stratification at 99.8%	• Volume of patients waiting longer than 104 days in Cancer is 34 (trust wide – all tumour sites except Breast & Gynaecology (22nd July 2021)) • For follow-up attendances the Trust are delivering 86% of the plan. A number of specialties are working up plans to continue and increase use of external providers to support with delivery of the plan along with ensuring all available capacity is being utilised to full utilisation. • For Q1, elective performance against plan continues to be under delivering at 85% for in-patients and 92% for daycases. A number of specialties are experiencing an increase in Priority 2 and urgent patients who are more complex. • Plans are being put in place to risk stratify all open Outpatient episodes • Risk stratification in ophthalmology at SGH.	• Workforce risk around significant vacancy gap • Workforce risk around carried over annual leave • Potential wave 3 of COVID-19 • Capacity to deliver risk stratification for Outpatients • Challenges to delivery of the elective recovery plan

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)154

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Gill Ponder, NED / Chair of Finance & Performance Committee
CONTACT OFFICERS	Lee Bond, Chief Financial Officer
SUBJECT	F&P Committee Highlight Report – June & July 2021 – **PERFORMANCE ONLY**
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY	The attached highlight report summarises key issues presented to, and discussed by the Finance & Performance Committee at its meetings on 30 June & 28 July 2021 and worthy of highlighting to the Trust Board.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	✓
Estates, Equipment and Capital Investment	✓	**Digital**	
Finance		**The NHS Green Agenda**	✓
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable	BAF Risk SO1 (1.2-1.6) & SO4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	3 August 2021
Report From:	Finance & Performance Committee – 30 June & 28 July 2021

Highlight Report:

F&P Committee – 30 June 2021

The Committee meeting was not quorate, despite the Chief Operating Officer attending the meeting whilst on leave. I would like to thank him for sacrificing his well-earned break. Other absences resulted in the lack of quoracy, due to the Terms of Reference requiring 2 Executives to be present. Deputies were in attendance but did not count towards quoracy. To prevent this situation from arising again, the Terms of Reference for the Committee would be amended to make it clear that Deputies would count for quoracy, but Executives would still be required to attend at least 75% of the meetings.

Unplanned Care

Patient numbers attending A&E were breaking previous records, due to high demand and acuity, partly due to patients delaying seeking treatment during previous waves of Covid. A number of patients could have been treated in primary care, so streaming was being used where possible, but patient education on the right place to obtain the treatment they needed was required. The high level of demand was resulting in ambulance delays, delays in being treated and poor flow through the department due to high bed occupancy and delayed discharges.

External audits of emergency care had taken place and had suggested a number of ways in which performance could be improved spanning staffing, environment and observations. They had recommended the formation of a Board to increase accountability for resolving Urgent and Emergency Care issues, with closer monitoring of recommended actions to improve performance.

A review of the bed base was also taking place and the outcome would be presented to the Committee in July.

Planned Care

Whilst the Trust was behind plan for H1 due to lack of capacity, an improvement trajectory was in place and the Trust was meeting the requirement for 85% of pre-Covid treatment levels. Patients with cancer, those with the greatest clinical need and those that had waited over 52 weeks were being prioritised by using risk stratification, but this had resulted in some minor procedures being delayed. The prioritisation of cancer patients and those waiting over 52 weeks had resulted in sustained improvements in performance on 52 week waits and the cancer 2 week wait, 31 day and 62 day targets, but Diagnostics remained a concern due to a 50% vacancy rate and the impact that delayed diagnostics had on patient pathways.

Outpatient Transformation and Reduction in Follow-up Waiting Lists

The Trust were 16,500 follow-ups behind plan to achieve the end of year target of 9,000 due to prioritisation by clinical need, but a robust recovery plan was in place. The benefits from the work on the Connected Health Network would not be seen for 6-8 months. A trial of Patient Knows Best was being carried out with Cardiology patients, which should reduce admissions by empowering patients to manage their own care by monitoring relevant health data.

CQC Progress Report

The Committee was pleased to note the appointment of Jennifer Moverley as Head of Compliance and Assurance, which would increase the level of resource available to ensure that evidence of improvements was available and that improvements had been embedded.

Estates and Facilities Deep Dive into Medical Gases

The HSIB report into the incident in November 2020 was due to be considered by the ARG Committee in July. The final SI report would be brought to the F&P Committee in September. The Committee requested the inclusion of a summary of the learning from both reports and the actions taken as a result.

Surge plans were in place which included the maximum oxygen flow capacity of each ward before internal diversion would be required. The Trust had been allocated £1.5m of funding to future proof some areas. The lack of completion of training for the Duty Nursing and Medical Officer roles had been escalated to the Medical Gases Committee and the COO and Deputy Director of Estates and Faciities were actioned to ensure it was completed.

F&P Committee – 28 July 2021

Committee Workplan, Terms of Reference and Review of Effectiveness

The Workplan was approved by the Committee, subject to bringing the annual effectiveness review earlier to align with the Board timetable and to a rotating monthly deep dive into the BAF strategic risks assigned to the Committee, to ensure that sufficient time was available to review the risk scores, controls and gaps in controls.

The draft Terms of Reference were approved, pending a further review of the TORs for all Committees. The Committee also reviewed the output of the self-assessment of effectiveness. No significant issues emerged, but an action plan would be agreed to take the opportunity to further improve the Committee's effectiveness.

CQC Progress Report

Diagnostic capacity had moved from red to amber due to new scanners. A new quarterly monitoring process had been introduced to ensure that improvements were sustained.

Unplanned Care

High levels of A&E attendance continued, leading to a 74.63% achievement of the 4 hour wait target and 127 ambulance delays exceeding 60 minutes. 34% of patients were directly streamed to IAU against a national average of 30%. Discharge to Assess was progressing well, with one of the best results in the region and 98% of ward rounds taking place before 10.00am. Length of stay also compared very favourably, with daily and weekly escalations in place for patients in hospital for 14 days or more. There had been a big increase in direct streaming to SDEC at both sites and a successful pilot of a frailty service at DPOW. Covid 19 had led to an increase in patients and workforce challenges due to sickness and self-isolation.

Improvement opportunities identified from the recent audits were being progressed through the newly established Patient Flow Improvement Group, chaired by the COO. Community responses included Single Point of Access to support people to stay safe and well in their local community without admission to hospital, Community Response Team GP to provide clinical advice and decision making in situations where acute care needs were identified in the community, 2 hour crisis Urgent Community Response to reduce avoidable hospital admissions and readmissions and Discharge 2 Assess where health, social care, care and voluntary sectors work together to enable quicker and more integrated discharges from hospital. All of these initiatives required future funding to enable them to continue.

Planned Care

The number of patients waiting over 52 weeks had reduced from 1,285 in February to 511 in June. Capacity remained a concern due to reduced elective operating capacity as a result of the response to the high acuity of Covid patients and social distancing. Additional capacity had been created at Goole and by using the Independent Sector, with an initial focus on treating clinically urgent and cancer patients.

The Cancer 2 week wait and 31 day first treatment standards were both met, but the 62 day standard was 65.9%, primarily due to lack of diagnostic capacity.

Diagnostics performance was 33.28% against a target of 1%, due to focusing on urgent and cancer patients and reduced capacity in some modalities. The new scanning facilities at DPOW would improve capacity and other options were also being explored, including use of the independent sector and community diagnostic hubs.

There was a significant risk to achieving the target of 9,000 by March 2022 for patients overdue a follow up outpatient appointment and risk stratification was taking place to prioritise patients according to clinical need.

Performance against H1 ERF was 93% due to case mix, underachieving on elective and follow-ups, offset by over-achieving on first attendances and day cases. NLAG were the only Trust below trajectory in the local system. The Committee requested data on theatre utilisation and productivity in future reports.

HASR Programme Update

The Pre-Consultation Business Case was on track for completion by December, with public consultation expected to start in May 2022. An expression of interest for capital to build one of 8 new hospitals would be submitted by 8 September, led by the ICS. Programme 1 was progressing as planned, with a meeting of the Strategic Joint Committee in Common, with delegated authority from HUTH and NLAG Boards, held on 22 June. Patient, clinical and staff engagement activities continued, but attendance by staff had been low.

Construction costs for the new ED/AAU facilities had increased by 7% since the outline business case, which still benchmarked favourably on cost per square metre, even though learning from Covid and improved ventilation had been added to the specifications. This created a cost pressure of £4.7m. The Committee endorsed a proposal to Trust Board to agree to the use of £1.7m per year for the next 2 years to fund the gap and this will provide contingency within the case.

Estates and Facilities Annual Fire Report

The Committee received the Annual Fire Report, which had also gone to ARG and would be submitted to Board in August. There had been no primary fires on any site, but 3 small fires had occurred with kitchen white goods, which had been managed locally.

Significant progress with fire compliance issues has been made in the last year, in particular with the fire alarm system upgrade at DPoW which was funded from the additional capital Critical Infrastructure Risk monies the Trust received in 2020-21. This work has reduced fire risks and aided compliance with fire safety legislation. However, further work would still be required on fire stopping, fire door inspections and repairs.

Confirm or Challenge of the Board Assurance Framework:

The BAF was not presented to the meeting on 30-6-21.

The Committee reviewed the BAF on 28-7-21 and decided to review each strategic risk on a rotational basis at monthly meetings. The intention was to ensure that the Committee did a deep dive on each risk to gain assurance on the risk score, target score, controls, mitigations and control gaps.

Action Required by the Trust Board:

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

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

NLG(21)155

DATE OF MEETING	03 August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Dr Kate Wood, Medical Director
CONTACT OFFICER	Dr Kate Wood, Medical Director
SUBJECT	Annual Quality Account 2020/21
BACKGROUND DOCUMENT (if any)	Annual Quality Account 2019/20; Monthly Quality Report (IPR)
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality Governance Group Quality & Safety Committee
EXECUTIVE SUMMARY	• Following the Quality & Safety Committee's approval of the final draft quality account, the document has been shared with stakeholders. Following this stakeholder comments have been included verbatim within the document, presented from page 71. • The 2020/21 Quality Account is presented for final approval and publication thereafter on the NHS website.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓				

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Quality Strategic Risk				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2020/21

CONTENTS

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

This year has been the most challenging the NHS has ever faced. In my long career in the health service I have never seen the levels of anxiety and stress which our staff have faced during the coronavirus. Our staff responded magnificently to the challenges put in front of them. Their care and compassion were second to none. To come to work day in and day out – particularly for those staff needing to put on and take off many layers of Personal Protective Equipment (PPE) because of the patients they were caring for – showed extraordinary levels of courage and commitment. Teams representing a variety of roles and disciplines have played an enormous part in keeping our hospitals running through the pandemic. I have said it before, but I mean it: it is humbling being their Chief Executive and a real privilege. Thank you once again to them all.

With our staff facing such unprecedented times we cannot underestimate what impact this has had, and will continue to have, on their health and wellbeing, particularly their mental health. We had already identified staff health and wellbeing as a priority for 2020/21 so in many ways we were ahead of the game and had some support already planned. During the course of the year we added to this support to put together a comprehensive package of help to support our staff and enable them to continue to deliver high quality care to our local population. This will continue to be a key priority for 2021/22.

The pandemic has affected all aspects of how we have provided healthcare. We have continuously had to make risk based decisions to keep people safe which has resulted in services being segregated and reducing the scale of services we could offer due to reduced capacity. This has been complicated further by some of the Trust's ageing estate. This impacted on our improvement ambitions for the year with regards to patient flow through our hospitals. As a consequence I'm sad to report the number of patients waiting more than 12 hours increased although our annual performance for seeing and treating patients in the ED within four hours saw a slight increase to 81% compared to last year.

Our planned care (which means operations or other procedures) numbers were less than planned, due to the national decision to cancel all planned activity. The numbers of COVID-19 patients we were caring for at times, particularly over winter in Scunthorpe, also meant we were unable to bring our theatres back into use as quickly as we would have liked. Taken together these issues have had a significant impact on our waiting lists, as they have for all trusts across England.

To all those patients waiting I send my apologies, we will do everything we can in 2021/22 to improve the position. This will be a key priority for the Trust and we have set ourselves the target of reducing both the number of patients waiting over 52 weeks for elective treatment and those waiting over 104 days for cancer treatment to zero by the end of March 2022.

Despite the challenges we faced, this annual quality account is also an opportunity to reflect on what the Trust has achieved and its progress against quality goals and to the best of my knowledge the information contained within this report is accurate. Work has continued throughout the year to achieve the 'must do' and 'should do' actions identified by the Care Quality Commission (CQC) in their report published in February 2020 following their inspection in September 2019. This is progressing well in most areas.

The Trust has seen a sustained decrease in hospital mortality over the course of the year, now being rated ‘as expected’. This is an excellent achievement especially given we were amongst the three worst trusts in England 18 months ago. The following report will provide greater details on this and other achievements.

Our challenge for 2021/22 is to look after our staff and support them as they recover from such an intense year, whilst at the same time doing everything we can to bring down our waiting lists and managing the increased demand we are experiencing for urgent care. That’s an incredibly tough balancing act and we need to do that whilst the Trust changes around them – with new buildings, new digital systems, and new ways of working. If anyone can manage to do this, our staff can; they are remarkable. Thanks to them all once again.

Dr Peter Reading,

Chief Executive

08 June 2021

About Northern Lincolnshire and Goole NHS Foundation Trust

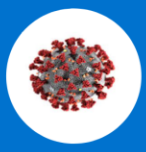
Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'The Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire and therapy services at all our sites. In summary these services are:

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

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

A year in numbers 2020/21

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust



1,500
COVID-19 positive patients treated

124,000
Attendances at our emergency departments

11,500+
Coronavirus vaccines administered (1st doses)

40,000+
Operations carried out

350,000+
Outpatient appointments

4,500+
Video consultations

240,000
Attendances at radiology

44+million
Pathology tests

3,700
Babies delivered

£130million
secured in capital funding

250,000+
tasks carried out by porters

640,000+
patient meals prepared

Figures obtained for 1 April 2020 to 31 March 2021. Please note, rounded figures used

Executive summary of key points

6 Quality Priorities for 2020/21:

As part of the Trust's annual setting of priorities, the Trust had set 6 quality priorities:

(1) Improve the Trust waiting list;
(Patient Experience)

(2) Reduce mortality rates and strengthen end of life care;
(Clinical Effectiveness)

(3) Improve the management of diabetes;
(Patient Safety)

(4) Improve the effectiveness of cancer pathways;
(Patient Experience & Clinical Effectiveness)

(5) Improve safe flow and discharge through the hospital;
(Patient Safety, Experience & Clinical Effectiveness)

(6) Improve the quality and timeliness of complaints responses using a more individualised approach.
(Patient Experience)

Performance against these quality priorities has been reported within the quality report.

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

Covid-19 Pandemic Response:

The Trust's priorities for 2020/21 were set prior to the onset of the Covid-19 pandemic that had a significant impact on the Trust and the wider NHS.

As such it should be noted:

(1) Responding to the pandemic and its many associated impacts on staff, waiting lists, facilities, etc. was not included among these priorities, and was therefore handled as additional pressure;

(2) The pandemic significantly affected Trust performance against some objectives where key personnel/organisational focus needed to be diverted to pandemic response.

Priority 1 – Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups:

- The Trust's improvement plans in this area were substantially affected by the NHS wide response to the Covid-19 pandemic which included, during wave 1, a cancellation across the country of all planned activity. This resulted in an unavoidable growth in the waiting list during the course of the pandemic.

- The Trust is currently working hard to recover performance and this is a key priority for the 2021/22 period. Recovery performance to date has shown a strong response when comparing the Trust to regional peers.

- The Trust aimed to reduce the overdue follow up waiting list to below 9,000 by 31 March 2021. This reduced from 31,323 in March 2020 to 21,969 in March 2021. Progress was

affected by COVID-19 which limited follow up patients to be reviewed. The Trust introduced patient initiated follow up during the year to support better management of follow up patients and new referrals.

- Another priority was to have zero patients waiting 52 weeks (or longer). Based on the previous two years delivery the Trust would have achieved this and maintained this performance, however the pandemics impact on elective planned activity resulted in the Trust ending the year with 1,187 patients breaching 52 weeks. Whilst not where the Trust aimed to be, recovery work has supported the Trust compare very favourably to other Trusts within the region similarly impacted.

Priority 2 – Clinical Effectiveness: Reduce mortality rates and strengthen end of life care:

- The Trust has sustained a statistically significant improvement with regards to mortality as measured using the Summary-Hospital Level Mortality Indicator (SHMI). The Trust's SHMI was 106.4 in the March 2021 release which covered the January – December 2020 timeframe. This is within the 'as expected' range and therefore achieves the priority ambition.

- The Trust also achieved its target in increasing the number of deaths that are reviewed by healthcare professionals for learning purposes to support improvement of services.

- Recording of patient observations using NEWS (National Early Warning Score) in line with timescales was also achieved against a target of 85%. This is a significant achievement given the pandemic pressures and the additional time required for Trust staff to don Personal Protective Equipment (PPE).

- The pandemic impacted upon the Trust's plans to improve its ability to report sepsis screening data for improvement and assurance purposes.

Priority 3 – Patient Safety: Improve the management of diabetes:

- Performance against the diabetes quality priority was for the most part achieved, with a monthly audit established for assurance and improvement purposes.

- There have been zero insulin errors resulting in significant harm. 85% Mandatory training for staff in diabetes management has been achieved.

- The audit data has demonstrated that further improvement work is required on ward areas in relation to diabetes. Recording of blood glucose in the Emergency Department has fluctuated for adult and paediatric patients. This therefore will remain as a quality priority for 2021/22 to embed improvements.

Priority 4 – Patient Experience & Clinical Effectiveness: Improve the effectiveness of cancer pathways focussing on time to diagnosis:

- The pandemic has had a significant impact on Trust cancer improvement priorities:
    - Faster diagnosis and patient informed by day 28 was 59.7% compared to the target of 75%.
    - Request to test report turnaround to be no more than 14 days was not achieved with the wait for most cancer diagnostic tests exceeding 14 days.

- To support improvement, the Trust has established the Humber Cancer Board which meets monthly to support the management of Cancer Services across the Humber. The

Group have progressed faster access to diagnostics and earlier treatment in a number of tumour types.

- All cancer MDTs across the Trust have now been combined and through the Humber Cancer Board, work has commenced on combining MDTs across the Humber in a number of tumour sites to improve pathways and access arrangements.

Priority 5 – Patient Safety, Experience & Clinical Effectiveness: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon:

- Despite the pandemic, the Trust has made some significant progress against this quality priority with the average length of stay reducing to below that seen during 2019/20. Complex patients with Covid-19 have prevented this from being reduced further.

- Discharges from hospital with length of stay less than 2 days was 5,953 in March 2020 and 6,578 in March 2021, demonstrating significant improvement in this approach to care.

- Reduction in elective length of stay to less than 2.4 days was achieved during 2020/21 with an elective average length of stay was 2.00, a significant improvement from previous years.

- The Trust embarked on the discharge to assess programme in April 2020. Through this programme, the number of early supported discharges has increased to an achievement of 44% of discharges happening within 7 days against a national ambition of 40%.

- Covid-19 has impacted on the Trust's priority to reduce patients on ward areas outside of the specialty they are being cared under. Percentage of ward outliers was 22.66% in March 2020, this increased to 47.44% in March 2021, however this figure is difficult to report as throughout the year wards changed their classification and clinical patient type due to the need to manage Covid-19 patients. There was also a significant impact on this position related to the overall reduction in beds due to requirements of social distancing and temporary cubicles which were used throughout the COVID-19 pandemic.

Priority 6 – Patient Experience: Improve the quality and timeliness of complaints responses using a more individualised approach:

- Significant improvements have been made with respect of the Trust's processes around the handling and response to complaints.

- All complaints open for more than 120 days have been now closed (at March 2020, there were 97 open).

- There has been a significant reduction in the number of open complaints despite only a slight reduction in the number incoming during the pandemic. There were 219 open in March 2020 compared to just 64 open in March 2021.

- There has been a Trust wide adoption of the new process, with lead investigator roles taking responsibility for investigation within the Division as opposed to central team. This has led to an improvement in both the quality of responses and learning.

Quality Priorities for 2021/22:

Setting quality priorities:

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

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

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2021/22. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

Quality priorities for 2021/22:

Five priorities for 2021/22 have been agreed, these relate to the progress made during the period covered by this quality account:

(1) End of Life and Related Mortality Indicators (n=3)

- Indictors within this area build on the progress made with mortality performance and seek to support further improvement with care planning for patients who are at end of life and require individualised and holistic plans to ensure care is provided in the right care setting.

(2) Deteriorating Patient & Sepsis (n=3)

- These indicators build on the improvements already made in connection with patient observations but aims to focus on improvements in action taken in response to recorded observations.

(3) Increasing medication safety (n=3)

- Medication safety is a new area of focus and links to the Trust's roll out of its Electronic Prescribing and Medicines Administration (EPMA) system to support an understanding of safety gains resulting from this.

(4) Safety of Discharge (n=4)

- These measures focus on the Discharge to Assess project and will enable the Trust to monitor progress with continued improvements in patient flow through the Trust's hospitals.
- Also included are measures linked to specific sub-specialties performance with issuing discharge communications to the patient's GP Practice within defined timescales. This will support and measure improvement plans.

(5) Diabetes Management (n=3)

- These indicators link back to the progress made in 2020/21 and seek to enable continued monitoring to support embedding.

How progress against 2021/22 quality priorities will be monitored and measured:

Progress will be monitored through the Trust's quality section of the Integrated Performance Report. This is a monthly report considered by the Executive-led Quality Governance Group for the oversight of management actions and also by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes.

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

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

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

Interpreting the data presented within this report:

The Trust's monthly quality report makes use of Statistical Process Control (SPC) charts wherever possible to support an understanding of what data trends show and what assurance can be gained from these data trends.

The annual quality account aims to provide an easy to digest summary of this performance during the 2020/21 period. To achieve this aim the measures used to focus on the Trust's quality priorities are presented in a table that summarises what the data trends show. This presentation will use the following icons to support interpretation of key points.

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

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

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

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

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

2.1 Priorities for improvement: overview of the quality of care against 2020/21 quality priorities & quality priorities planning for 2021/22

2.1a: Priority 1: Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups;

Summary table: Performance during 2020/21:

PATIENT EXPERIENCE:					
QP1: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
1a) Reduce delayed transfers of care to 60 (move flow and access)	**8.3**	No data			G
1b) Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021	**21,969**	27,803			R
1c) 52 week waits to be at zero	**1187.0**	1285.0			R
1d) The overall RTT waiting list to be less than it was on 31 January 2020	**28,853**	28,307			R
1e) 50% of out-patient summary letters to be with GPs within 7 days of patient's attendance	**35.00%**	40.00%			R
1f) Reduce the number of face to face follow up appointments by 10%, to support the delivery of an overall reduction by a third by March 2023	**13,657**	11,279			R

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has not met the targets set for waiting list improvements as a result of the significant impact, across the NHS, of the Covid-19 pandemic.

- **Reduce delayed transfers of care to 60:**
- The Trust has reduced the number of delayed transfers of care and is currently performing very well compared to other Trust's in the region for the number of patients with a length of stay over 14 days.

- **Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021:**
- The Covid-19 pandemic limited the number of patients who could be seen and followed up. Despite the pandemic the Trust reduced this from 31,323 in March 2020 to 21,969 in March 2021. The Trust also introduced other initiatives to mitigate the quality risks associated with this indicator by introducing patient initiated follow up during the year to support better management of follow up patients and new referrals as well as a move to virtual forms of patient reviews.

- **52 week waits to be at zero:**
- Prior to the pandemic, the Trust were on track to achieve this target, evidenced by a review of the previous two years' worth of data and the improving trend. The pandemic significantly impacted on the Trust's planned activity and limited what the Trust could achieve. As a result the Trust ended the year with 1,187 patients waiting more than 52 weeks. Whilst this is not where the Trust wanted to be, the work during the pandemic to maximise capacity available and the recovery work since the peak of the pandemic places the Trust in a strong position compared to other peer Trusts in the region. This is demonstrated in the chart that follows:

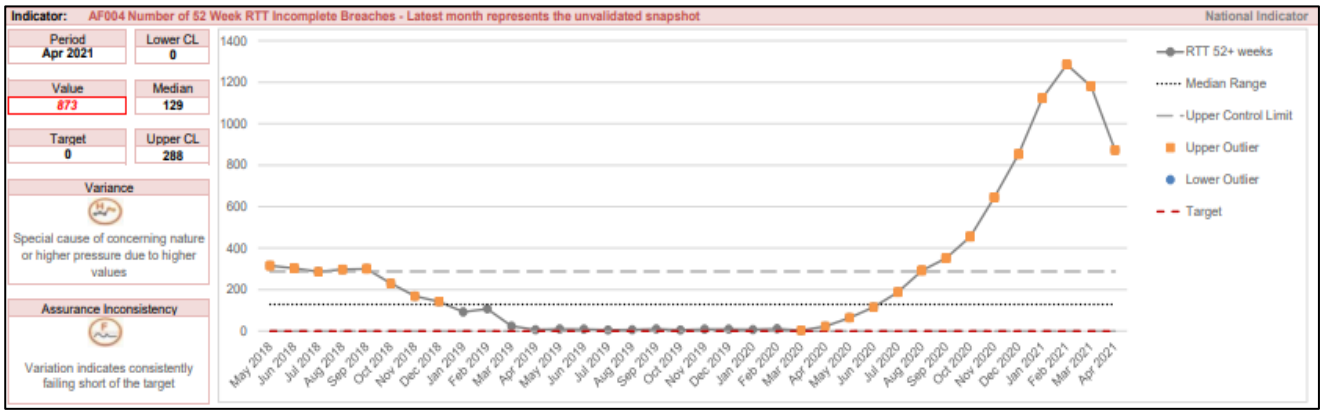


Figure 1: Impact of the Covid-19 pandemic on the Trust's performance with manging patients who are waiting 52 weeks or more

- The chart shows the improvements made in this area during 2019 and the impact of the pandemic on the waiting list position from early 2020. The chart shows the March and April 2021 data that demonstrates the Trust's recovery measures beginning to take effect and reduce the number of patients waiting.

- **The overall waiting list to be less than it was on 31 January 2020:**
- The overall referral to treatment RTT waiting list on 31st January 2020 was 25,227. As a result of the pandemic and its impact on planned activity, the Trust's waiting list grew to 28,853.

- **Reduce the number of face to face appointments:**
- The Trust priority was to move to offer outpatient clinic appointments using different formats other than purely face to face, in person. The pandemic accelerated this enabling the Trust to begin offering more online and telephone appointments. Use during the pandemic of this approach has provided the Trust a strong base to build on to develop further through 2021/22 and beyond.

The Covid-19 pandemic, with the national decision to cancel all planned activity during early 2020, local pressures faced on beds due to surges in activity and staff availability linked to the pandemic significantly impacted on the Trust's ability to focus on these priorities.

During 2021/22 the Trust has listed this as a priority to do everything possible to improve this position as part of the focus on recovery. This key priority for the Trust will include the target of reducing both the number of patients waiting over 52 weeks for elective treatment and those waiting over 104 days for cancer treatment to zero by the end of March 2022.

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

Relationship to 2021/22 Quality Improvement Priorities: This quality priority has remained the same throughout 2020/21, although significantly impacted upon by the onset of the pandemic. Waiting list indicators no longer feature as quality priorities, but are a part of the Trust's wider priorities to recover following the pandemic.

2.1b: Priority 2: Clinical Effectiveness: Reduce mortality rates and strengthen end of life care;

Summary table: Performance during 2020/21:

CLINICAL EFFECTIVENESS:					
QP2: Reduce mortality rates and strengthen end of life care;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
2a) Reduction in the Trust SHMI to within expected range	**106.4**	106.8			G
2b) Mortality screening: 50% of all deaths	**82.00%**	84.00%			G
2b) Mortality SJR: 100% for those cases identified as requiring SJR	**9.00%**	25.00%			R
2c) a) Adults: Timeliness of observations to 85% within 30 minutes of due time	**90.89%**	88.97%			G
2c) b) Children: PEWS: Observations recorded at least every 4 hours (first 12 hours) to 85%	**85.00%**	88.90%			G
2c) c) Full observations a minimum of 12 hourly & relevant observations as clinically indicated between times to 85%	**92.30%**	100.00%			G
2c) d) New admissions must have all 9 observation parameters (including temperature) recorded and scored at the first assessment to 85%	**80.00%**	80.00%			A
2d) Improve frequency of sepsis screening and robustness of reporting	**No data**	No data			R
2e) Gather patient and carer feedback for end of life care with local hospices	**No data**	No data	-	-	-
2f) 80% of inpatients (exc. maternity) screened for alcohol and tobacco use	**No data**	No data	-	-	-
2g) 90% of inpatients (exc. maternity) receive brief advice on tobacco use if smoke	**No data**	No data	-	-	-

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has met the targets set for mortality improvement metrics and partially achieved the other indicators linked to mortality.

- **Reduction of the Trust SHMI to within expected range:**
- The SHMI (Summary Hospital-Level Mortality Indicator) is a statistical calculation of a Trust's hospital associated mortality, including both in-hospital deaths and those occurring within 30 days of discharge. It is based on routine data submissions from the Trust, from hospital coding. Nationally, this data is used to perform the statistical calculation of total deaths expressed against the total number of 'expected deaths' which is derived from the Trust's data recording around admitting diagnosis and their pre-existing co-morbidities amongst other indicators.
- The Trust's performance is shown in the chart and demonstrates statistically significant reductions (improvements) in the Trust SHMI. This is now within the 'as expected' bracket.

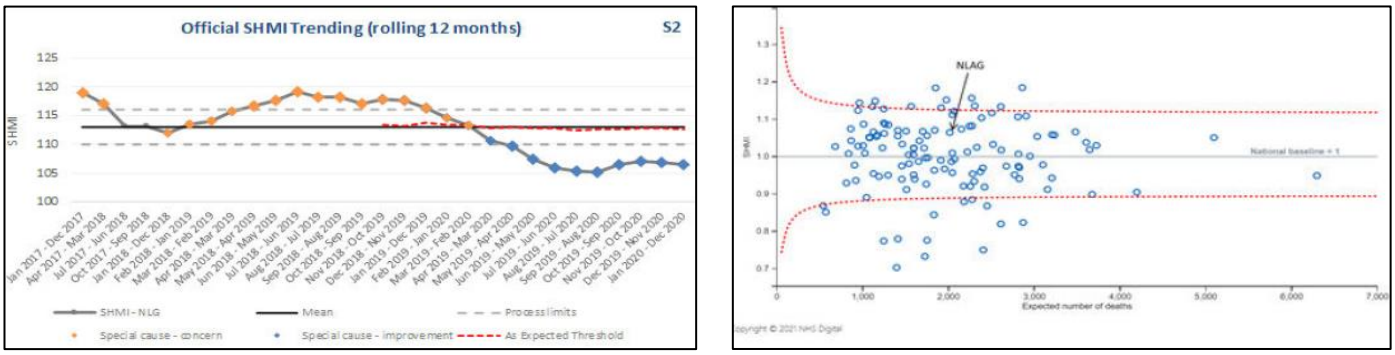


Figure 2: Statistically significant improvement of the Trust's SHMI

- **Learning from deaths – mortality review work:**
- The Trust have met the ambition to review, for learning opportunities, an increased number of deaths, this has been a gradual improvement aim over recent years and during this year the process has been improved to ensure a consistently high proportion of deaths will be 'screened' to identify learning opportunities and where further more detailed reviews are indicated. The second element of this aim was to ensure that all cases requiring more detailed review have this completed within 2 months of the death for more detailed understanding of learning points arising. Due to operational pressures linked to Covid-19 there is a backlog of cases requiring review. These cases are being prioritised as part of the Trust's recovery efforts following the pandemic.

- During 2021/22 the Trust aims to improve the processes in place to support sharing and learning for improvement following completion of mortality reviews.

- **Timeliness of observations:**
- The Trust achieved this target aiming to ensure observations for adults utilising National Early Warning Score (NEWS). This was maintained during the pandemic which is a significant achievement, given the need for staff to don and doff personal protective equipment and the zoning of clinical areas to meet the demands of Covid-19. The chart below summarises this over the year compared to the 85% target.

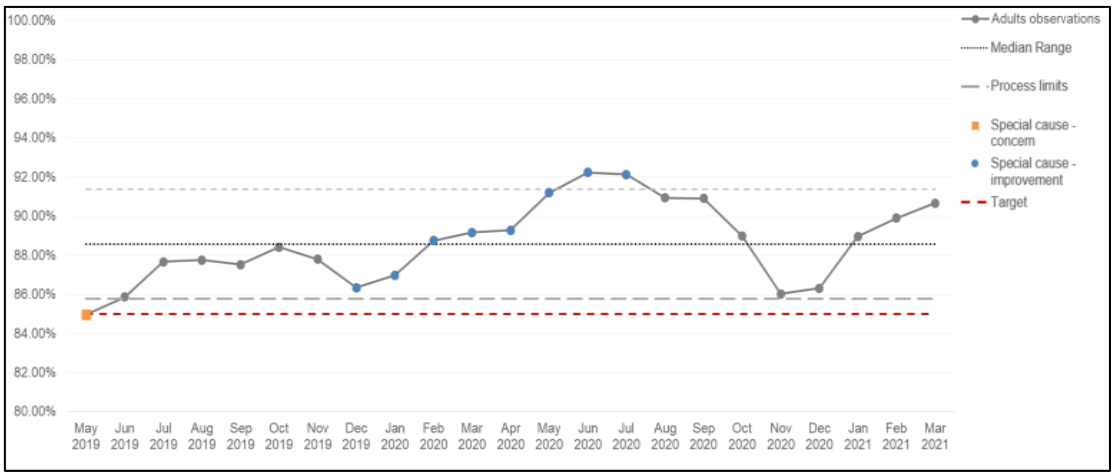


Figure 3: Achievement of the recording of NEWS observations within timescales (including 30 minutes grace)

- **Assurance in connection with Sepsis six:**
- Improvement plans linked to sepsis screening and appropriate treatment were not achieved during the year as a result of the pandemic. This is carried forward as a priority into 2021/22 alongside education and support at ward level and the use of Trust electronic systems to record sepsis screening.

- Other areas within this quality priority were unable to be progressed as a result of Covid-19.

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

Relationship to 2021/22 Quality Improvement Priorities: This quality priority has remained the same throughout 2020/21. Focus on continued improvement around mortality will continue with a focus on end of life and advanced care planning. Sepsis and the deteriorating patient will remain a priority also.

2.1c: Priority 3: Patient Safety: Improve the management of diabetes;

Summary table: Performance during 2020/21:

PATIENT SAFETY:					
QP3: Improve the management of diabetes;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
3a)i) Improvement in monitoring of blood sugar in patients with diabetes - DPOW	**81.11%**	86.51%			A
3a)ii) Improvement in monitoring of blood sugar in patients with diabetes - SGH	**66.42%**	80.95%			R
3b) Reduction in insulin errors which cause significant harm to less than 5% of overall reported insulin incidents	**0.00%**	0.00%			G
3c) Achieve 85% compliance with role specific mandatory training for diabetes	**85.00%**	85.00%			G
3d) Adults: Blood glucose taken in ECC if NEWs >1 in 95% of cases	**92.50%**	95.00%			A
3d) Children: Blood glucose taken in ECC if PEWs >1 in 95% of cases	**80.00%**	90.00%			R

Progress Made: (April 2020 – March 2021): This priority for the most part has been met.

- **Improvement monitoring of blood sugar in patients with diabetes:**
- A Monthly audit has been designed and implemented. This has helped to get an understanding of the management of diabetes across ward areas. From this the results indicate additional work still to do to attain and embed the standards. This will be retained as a quality priority for 2021/22.

- **Reduction in insulin errors which cause significant harm:**
- There have been zero insulin medication errors resulting in significant harm.

- **85% compliance with role specific training:**
- 85% compliance with mandatory training for diabetes has been achieved.

- **Blood glucose recording in Emergency Department if NEWS/PEWS >1:**
- Performance against this indicator has fluctuated and has demonstrated that practice is not embedded. This will remain as a quality priority during 2021/22. During 2020/21, the introduction of the Paediatric Emergency Nursing Team into the Emergency Department resulted in paediatric oversight negating the need for blood glucose recording in some instances. The audit is being amended but will continue to ensure there is assurance on practice.

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

Relationship to 2021/22 Quality Improvement Priorities: This quality priority has remained the same throughout 2020/21. Focus on the care of diabetes patients will be included as a quality priority during 2021/22 and expand to include a focus on the use of insulin within the dedicated medication safety quality priority.

2.1d: Priority 4: Patient Experience & Clinical Effectiveness: Improve the effectiveness of cancer pathways focusing on time to diagnosis;

Summary table: Performance during 2020/21:

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:					
QP4: Improve the effectiveness of cancer pathways focussing on time to diagnosis;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
4a) Time to diagnosis and patient informed by day 28 to be at 75%	**59.70%**	65.19%			R
4b) Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	**20.00%**	25.00%			R
4c) Request to test report turnaround to be no more than 14 days in 100% of cases	**84.77%**	84.48%			R
4d) Develop a clear service model and a Trust target to ensure that cancer services are maintained	**No data**	No data	-	-	-
4e) Number of combined site MDTs to be 100%	100.00%	100.00%			G

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has not met the targets set for cancer pathway improvements as a result of the significant impact, across the NHS, of the Covid-19 pandemic.

- **Time to diagnosis and patient informed by day 28:**
- Performance against this target was 59.7% in March 2021. This has been severely hampered by the Covid-19 pandemic throughout the year and restrictions affecting planned pathways of care and access to diagnostics.

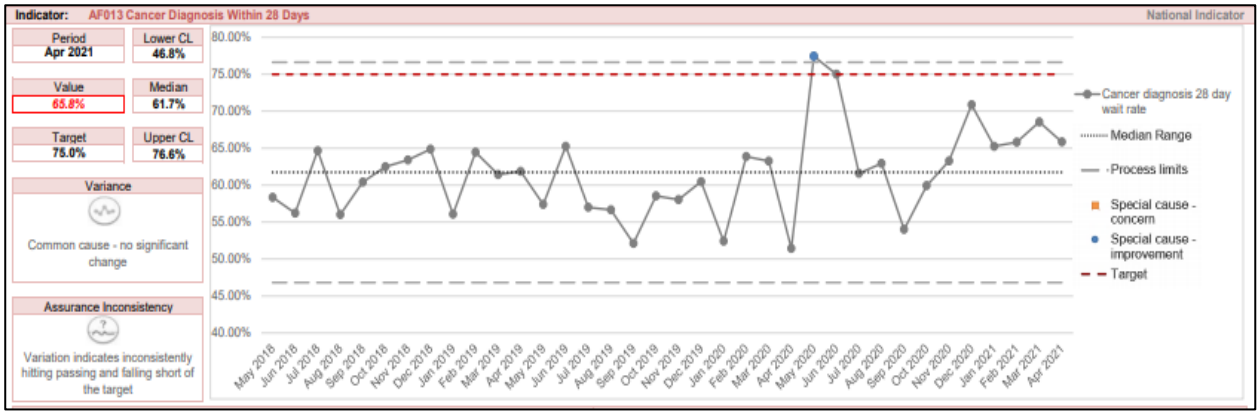


Figure 4: Cancer diagnosis within 28 days

- The chart demonstrates the performance in this area. Despite the pandemic the data for late 2020/early 2021 has been above the median average demonstrating the potential for sustained improvement, although further months data will be needed to determine if this increase is significant.

- **Care of patients with confirmed diagnosis transferred by day 38 to be at 75%:**
- For March 2021 performance was at 20%, but there were only a small number of patients ready to transfer, therefore this percentage should be interpreted with caution. As with all Cancer pathways COVID-19 has had a significant impact.

- **Request to test report turnaround to be no more than 14 days:**
- Due to Covid-19 pressures and the impact of infection prevention and control mitigation on throughput in diagnostics, this target has not been achieved and cancer diagnostic tests waits are greater than 14 days.

- **Develop clear service model and a Trust target to ensure that cancer services are maintained:**
- The Trust has established the Humber Cancer Board which meets monthly to support the management of Cancer Services across the Humber. The Group has progressed the faster access to diagnostics and earlier treatment in a number of tumour types. Unfortunately the progress of these development has been significantly delayed DTC.

- **Number of combined site multi-disciplinary teams to be 100%**
- Despite Covid-19, this target has been achieved with all Trust multidisciplinary teams (MDTs) now combined. Further work is ongoing through the Humber Cancer Board to look at further collaboration with MDTs across the Humber in a number of tumour types.

The Covid-19 pandemic, with the national decision to cancel all planned activity during early 2020, local pressures faced on beds due to surges in activity and staff availability linked to the pandemic significantly impacted on the Trust's ability to focus on these priorities.

During 2021/22 the Trust has listed this as a priority to do everything possible to improve this position as part of the focus on recovery. This key priority for the Trust will include the target of reducing both the number of patients waiting over 52 weeks for elective treatment and those waiting over 104 days for cancer treatment to zero by the end of March 2022.

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

Relationship to 2021/22 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2020/21. Cancer will feature as a priority for the Trust during 2021/22 as part of the post-pandemic recovery work.

2.1e: Priority 5: Patient Safety, Experience & Clinical Effectiveness: Improve safe flow and discharge through the hospital focusing on outliers, late night patient transfers and discharges before noon;

Summary table: Performance during 2020/21:

PATIENT SAFETY; CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE:					
QP5: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
5a) Reduction in the average length of stay to less than 4 days	**4.05**	3.99			A
5b) Increase in the zero length of stay to 32%	**28.94%**	29.03%			A
5c) Sustained improvement in the 0 – 1 day length of stay	**6578.0**	No data			G
5d) Reduction in non-elective length of stay to less than 4.1 days	**4.18**	4.18			A
5e) Reduction in elective length of stay to less than 2.4 days	**2.54**	1.91			A
5f) Reduction in the number of medical outliers					
5g) 85% of discharge letters to be completed within 24 hours post discharge	**87.62%**	88.60%			G
5h) Progressive improvement in the number of golden discharges from April 2020 (target: 35%)	**16.8%**	16.2%			R
5i) Increase in A&E performance to 83.5%	**72.2%**	73.3%			R
5j) Reduction of non-emergency patient transfers at night after 10pm by 10% (Target: 48)	**9.84%**	8.5%			R
5k) Reduction in average ward moves for non-elective patients for non-clinical reasons by 7% (Target: 4.6%)	**15.04%**	12.8%			R
5l) Number of early supported discharges to increase by 10%	**No data**	No data	-	-	-
5m) Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire	**No data**	No data	-	-	-
5n) All patients requiring mental health support in ED will be assessed within 4 hours of referral	**No data**	No data	-	-	-
5o) Patient in in-patient wards will be assessed and have a plan in place within 8 hours of referral	**No data**	No data	-	-	-

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has made significant progress against these areas, but have been impacted once more by the pandemic.

- **Reduction in the average length of stay to less than 4 days:**
- The average length of stay during the year was 4.06 which is a further reduction on performance during 2019/20. Further improvements were planned, but these were impacted upon by the pandemic and the complexity of caring for some patients affected by Covid-19.

- **Sustained improvement in the 0–1 day length of stay:**
- Patients discharged with a length of stay less than 2 days was 5,953 in March 2020 compared with 6,578 in March 2021. This demonstrates a significant improvement in this approach to care.

- **Increase in the zero length of stay to 32%:**
- The proportion of patients having a zero length of stay was 27.23% which was just short of the target being aimed for. The chart shows the Trust's performance with this:

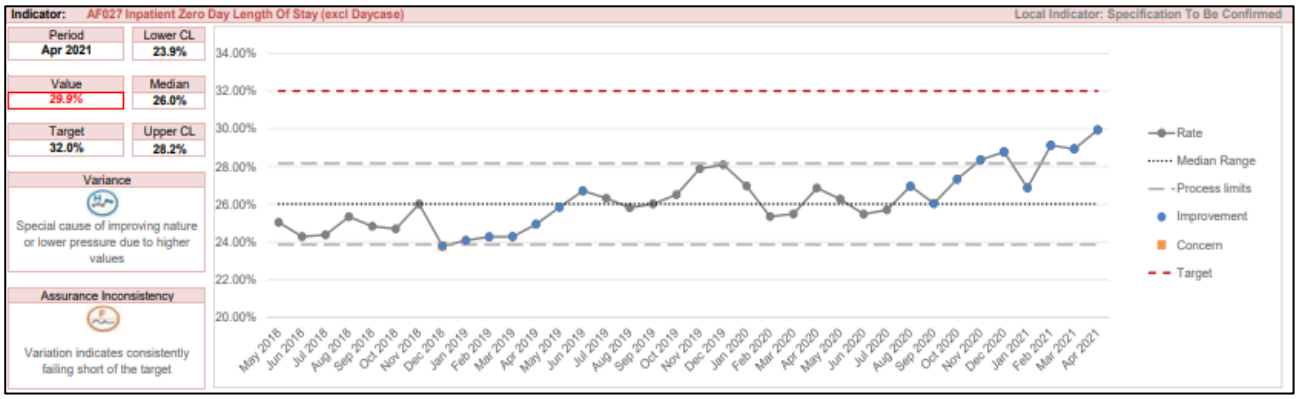


Figure 5: Increase in the zero length of stay

- The chart demonstrates an improving level of performance for patients with a zero day length of stay

- **Reduction in non-elective length of stay to less than 4.1 days:**
- During the year the Trust's non-elective (patients admitted as an emergency or unplanned) average length of stay was 4.22, which was just above the target being aimed for. This again was linked to the care and delivery of treatment to patients affected by Covid-19 requiring more complex input.

- **Reduction in elective length of stay to less than 2.4 days:**
- Patients admitted for planned care had an average length of stay of 2 days which is a significant improvement on previous years performance and has met the quality aim.

- **Reduction in the number of medical outliers:**
- The percentage of patients being cared for on wards outside of the specialty they were being treated under (i.e. a medical patient on a surgical ward) in March 2020 was 23%. This increased to 47% in March 2021. This quality priority was significantly affected by the Trust's response to the pandemic which required segregation and zoning of areas to mitigate infection spread, this has resulted, throughout the year, with wards changing their classification and clinical patient type to manage Covid-19 affected patients. Mitigating actions to support the Trust's response to the pandemic also led to a reduction in beds available due to requirements of social distancing and temporary cubicles which were used throughout the COVID-19 pandemic.

- **85% of discharge letters to be completed within 24 hours post discharge:**
- To support this action further the trust has engaged with clinicians and agreed a new category of letter 'Dictated but not Signed' to reduce the delays to letters being submitted on time.

- **Identify a robust mechanism for recording golden discharges:**
- Despite the pandemic, there was a modest improvement in the number of golden discharges rising from 1,480 in March 2020 to 1,491 in March 2021.

- **Increase in A&E performance to 83.5%:**
- In the early weeks and months of the pandemic the Trust saw a steep fall in the number of patients attending the Emergency Department (EDs), almost certainly due to anxieties related to the coronavirus. As a result, the Trust saw and treated around 25,000 fewer patients in ED compared to last year.

- Towards the end of the year, however, attendance numbers were more or less back to what we would expect and, on some days, even more than that.

- To keep people safe, the Trust made changes to the treatment and waiting areas in the Emergency Departments. This along with the mitigating actions taken on wards and the reduction in beds resulted in additional pressures and difficulties in being able to move patients out of the department resulting in longer waiting times. This is demonstrated in the chart below:

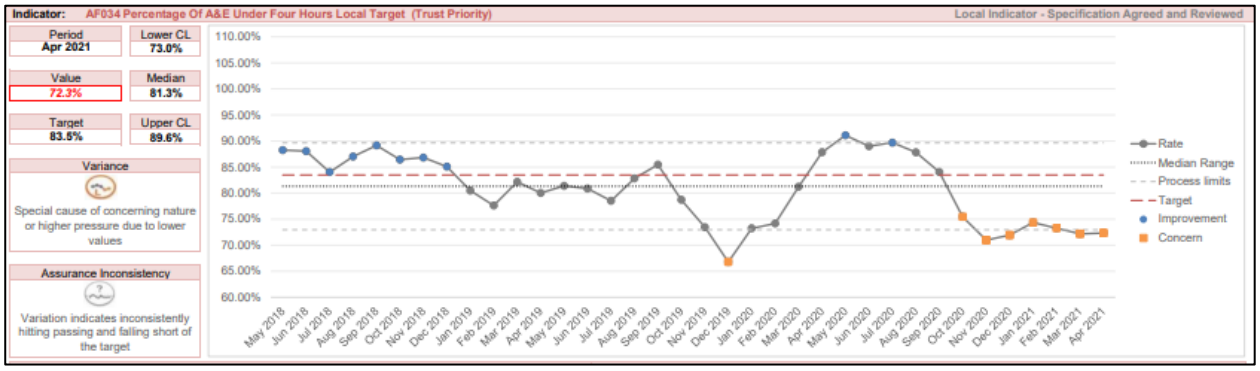


Figure 6: Emergency Department performance with 4-hour standard

- **Number of early supported discharges to increase by 10%:**
- The Trust embarked on the discharge to assess programme in April 2020. Through this programme, the number of early supported discharges has increased to 44% happening within 7 days compared against a national ambition of 40%.

- **Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire:**
- In March 2020 in response to the Covid-19 pandemic response the Community Team added a GP to the single point of access and crisis team. This has resulted in 450 patients in the North Lincolnshire locality being maintained at home rather than attending the Trust's Emergency services.

- **All patients requiring mental health support in ED will be assessed within 4 hours of referral:**
- It has not been possible during the year to collect this data from the Trust's Emergency Department system.

- **Patients admitted will be assessed and have a plan in place within 8 hours of referral:**
- The latest audit of seven day services demonstrated that 60% of patients have a plan in place within 8 hours of admission which rises to 83% within 72hours of admission.

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

Relationship to 2021/22 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2020/21. Access and flow will feature as a priority for the Trust during 2021/22 as part of the post-pandemic recovery work and there are links to the discharge to assess project as part of the Trust's 21/22 quality priorities.

2.1f: Priority 6: Patient Experience: Improve the quality and timeliness of complaints responses using a more individualised approach;

Summary table: Performance during 2020/21:

PATIENT EXPERIENCE:					
QP6: Improve the quality and timeliness of complaints responses using a more individualised approach.	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
a) 85% Pals responded to in 5 working days by the 31 January 2021	**56.00%**	55.00%			R
b) 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 2021	**100%**	**100%**			G
c) 100% of all complaints on 'old' process pathway to be closed by 28 Feb 2021	**100%**	**100%**			G
d) 85% of all complaints resolved within timescale by the 31 July 2021	**65.00%**	51.00%			A
e) 85% of reopened complaints resolved within 20 working days by the 30 November 2020 (Quarterly)	50.00%				R
f) 100% Complaints acknowledged within 3 days by the 31 July 2021	100.00%	100.00%			G
g) 100% complainants offered a face to face meeting during initial resolution planning by the 31 Dec 2020 [Amended]	100.00%	100.00%			G
h) 100% of all upheld complaints to have evidence of learning by the 31 October 2020	**85.00%**	83.00%			A
i) 100% formal complaint responses reviewed by Chief Nurses Office by the 31 July 2020 [Amended]	100.00%	100.00%			G
j) 50% reduction in reopened complaints by the 31 January 2021	**No data**	No data	-	-	-

Progress Made: (April 2020 – March 2021): During the 2020/21 period, the Trust has made significant improvement and progress with complaints handling processes.

- 100% of complaints open for 120 days or longer have been now closed. During March 2020 there were 97 such complaints open. The chart below demonstrates the significant improvement.

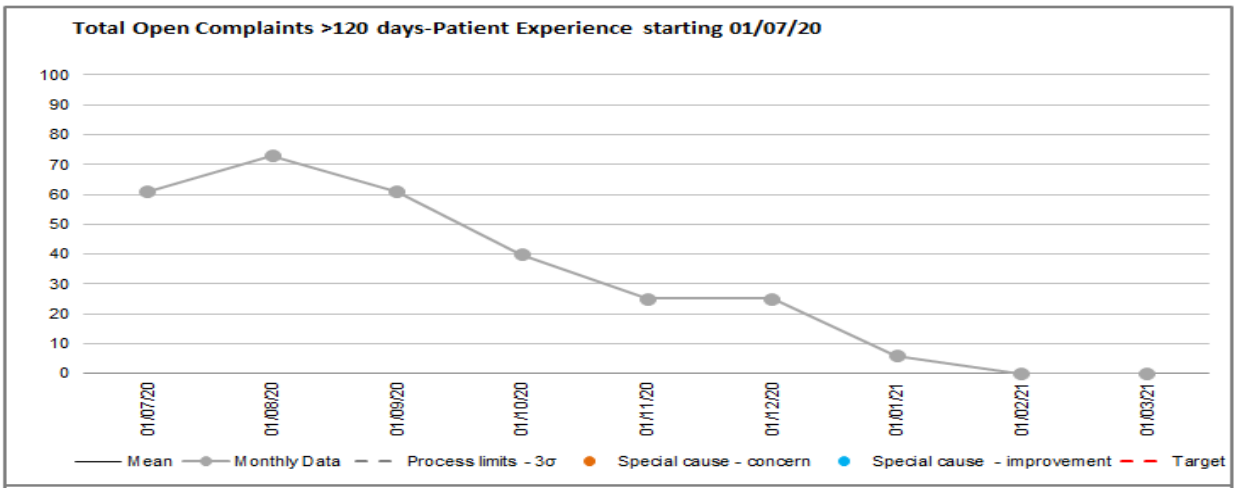


Figure 7: Reduction of the total number of open complaints exceeding 120 days

- There has been a significant reduction in the number of open complaints despite only a slight reduction in the number of incoming complaints during Covid-19. There were 219 open complaints in March 2020 compared with only 64 open complaints in March 2021.

- There has been a Trust-wide adoption of a new process, with lead investigator roles taking responsibility for investigation of complaint concerns. This has supported the quality of responses improving and learning evidenced in responses.

- Complaints resolved within timescales has a target date for achievement outside of the 2020/21 year and is on track for completion by July 2021. The May 21 data demonstrates performance of 73% which is positive.

- The focus on PALs responses will be carried forward into 2021/22 as a priority.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the integrated performance report by the Quality Governance Group, Quality & Safety Committee and the Trust Board.

Relationship to 2021/22 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2020/21. Given the significant improvements in this area, complaints will not feature as a quality priority during 2021/22. Oversight will remain to ensure improvements are embedded and sustained.

2.1g: Quality Priority planning for 2021/22

The Trust has agreed 5 quality priority areas for 2021/22:

1. End of Life and Related Mortality Indicators
   (Clinical Effectiveness & Patient Experience)

2. Deteriorating Patient & Sepsis
   (Clinical Effectiveness & Patient Safety)

3. Increasing Medication Safety
   (Patient Safety & Patient Experience)

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

5. Diabetes Management
   (Clinical Effectiveness & Patient Safety)

How these priorities were set:

The quality priorities for 2021/22 were set in harmony with the Trust's quality strategy longer term objectives. The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and patient experience teams as well as CCG partners through their social media channels.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2021/22. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

How progress against 2021/22 quality priorities will be monitored and measured:

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

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

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

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

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2020/21 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services.

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

The income generated by the relevant health services reviewed in 2020/21 represents 100% of the total income generated from the provision of relevant health and care services for 2020/21.

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

During 2020/21, 54 national clinical audits and 2 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

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

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

Despite this, many of the NCAPOP platforms and web-tools remained open. The Trust participated in 49 or 91% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

NB: *4 national clinical audits were formally suspended by national audit provider, meaning the Trust could not participate.*

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2020/21 and those in which it participated in are as follows:

NB: *The table which follows lists:*

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

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Yes	46	100%	Awaiting publication of national report
BAUS Urology Audit – Renal Colic	Yes	Yes	10	100%	Awaiting publication of results
BAUS Urology Audit - Female Stress Urinary Incontinence	No	N/A	N/A	N/A	N/A
BAUS Urology Audit – Cytoreductive Radical Nephrectomy	Yes	Yes	3	100%	Awaiting publication of results
British Spine Registry	No	N/A	N/A	N/A	N/A
Case Mix Programme (CMP)	Yes	Yes	1390	100%	Results published June 2021, Actions to be agreed
Cleft Registry and Audit Network (CRANE)	No	N/A	N/A	N/A	N/A
Elective Surgery - National PROMs Programme	Yes	Yes	468 (79%)	PROMS collections ceased during COVID 19 – Trust continued to submit	Awaiting publication of results
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database (submitted for all)	Yes	Yes	585	100%	Awaiting National Report
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	757	100%	Yes
Falls and Fragility Fractures Audit programme (FFFAP) National Falls Audit	Yes	Yes	6	Ongoing	Project still underway
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	160 (Cumulative)	100%	Yes
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	3	100%	Yes
Mandatory Surveillance of HCAI	Yes	Yes	114	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal morbidity & mortality confidential enquiries	Yes	Yes	23	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry	Yes	Yes	1 Maternal death	100%	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult COPD**	Yes	Yes	663	65% (On-going)	Yes
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult Asthma**	Yes	Yes	144	89% (On-going)	Yes
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Children and Young People Asthma**	Yes	Yes	57	100%	Awaiting publication of results
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	202	100%	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	775	100%	Report writing/action planning
National Audit of Care at the End of Life (NACEL)	Suspended due to COVID-19	*Local audit undertaken*			
National Audit of Dementia	Suspended Due to COVID-19	*Local audit undertaken*			
National Audit of Pulmonary Hypertension (NAPH)	No	N/A	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	134 (Cohort 2)	100%	Awaiting Publication of Results
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	113	100%	Project still underway
National Cardiac Audit Programme (NCAP) – Heart Failure	Yes	Yes	831	72% Ongoing	Yes
National Cardiac Audit Programme (NCAP) – MINAP	Yes	Yes	469	48%	Project still underway
National Cardiac Audit Programme (NCAP) – Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	298	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	Yes	Yes	TBC	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Adult Cardiac Surgery	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Cardiac Audit Programme (NCAP) – Congenital Heart Disease	No	N/A	N/A	N/A	N/A
National Clinical Audit of Anxiety and Depression	No	N/A	N/A	N/A	N/A
National Clinical Audit of Psychosis	No	N/A	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	*Suspended due to COVID-19*				
National Diabetes Audit – Core Audit	Yes	Yes	1220	100%	Yes
National Diabetes Audit – Inpatient HARMS	Yes	Yes	15	Ongoing	Yes
National Diabetes Audit – Foot Care	Yes	Yes	184	Ongoing	Project still underway
National Pregnancy in Diabetes (NPID) Audit	Yes	Yes	28	97%	Awaiting Publication of Results
National Early Inflammatory Arthritis Audit (NEIAA)	Communications from BSR - Non mandatory – recommenced April 21 Project still underway				
National Emergency Laparotomy Audit (NELA)	Yes	Yes	287	95%	Awaiting Publication of Results
National Gastro-intestinal Cancer Programme Bowel Cancer (NBOCAP)	Yes	Yes	263	98%	Yes
National Gastro-intestinal Cancer Programme Oesophago-gastric cancer (NOGCA)	Yes	Yes	210	85-100%	Yes
National Joint Registry (NJR)	Yes	Yes	929	96%	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes	342	100%	Yes
National Maternity and Perinatal Audit (NMPA)	*Suspended due to COVID-19*				
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	436	100%	Yes
National Ophthalmology Audit (NOD)	Yes	No	Undertaking local audit as not participating in national audit	N/A	Actions to be agreed
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	229	100%	Awaiting national report
National Prostate Cancer Audit	Yes	Yes	309	100%	Actions to be agreed
National Vascular Registry	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	No	N/A	N/A	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)	No	N/A	N/A	N/A	N/A
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	27	100%	Project still underway
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A	N/A
RCEM QIP: Fractured Neck of Femur	Yes	Yes	218	100%	Yes
RCEM QIP: Infection Control	Yes	Yes	291	100%	Yes
RCEM QIP: Pain in Children	Yes	Yes	Extended to cross 2 audit years, ends October 2021		
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	710	100%	Project still underway
Sentinel Stroke National Audit Programme (SSNAP) Early Supported Discharge Data	Yes	Yes	113	100%	Yes
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Yes	35	Ongoing	Project still underway
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	48	100%	Yes
Surgical Site Infection Surveillance Service	Yes	Yes	347	100%	Yes
The Trauma Audit & Research Network (TARN)	Yes	Yes	596	96% Ongoing	Yes
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
UK Registry of Endocrine and Thyroid National Audit	Yes	Yes	46	84%	Project still underway
UK Renal Registry National Acute Kidney Injury programme	No	N/A	N/A	N/A	N/A

National confidential enquires 2020/21

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Out of Hospital Cardiac Arrests	Yes	Yes	Yes	10	100%	Yes
Physical Health Care of inpatients in Mental Health Hospitals	No	N/A	N/A	N/A	N/A	N/A
Dysphagia in People with Parkinson's	Yes	Yes	Yes	4	100%	Awaiting national report

A number of published **national** clinical audits were reviewed by the provider in 2020/21 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

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

- National Paediatric Diabetes Audit:
  - Regular contact and education with children and young people to encourage and facilitate self-management of diabetes.
  - Monthly data from retinal screening to be reviewed to identify missed appointments and provide further education to children, young people and parents by the Paediatric Diabetes Specialist Nurses.
- National Neonatal Audit Programme:
  - Provide education to parents on reducing environmental factors that could negatively impact upon the infant's ability to regulate their own temperature.
  - Identify and provide consistent discharge advice for parents once correct home room temperature is identified.
- National Pregnancy in Diabetes Audit: Provide educational sessions to the public at Local Diabetes UK groups.

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

- National Emergency Laparotomy Audit:
  - Results of the audit to be displayed on theatre screens to raise staff awareness of performance
  - To highlight the requirement for prompt data collection, as part of the Doctors Induction process in General Surgery.
  - To re-inforce to all anaesthetics trainees that emergency laparotomy's should not be commenced before a consultant is present if the mortality risk is >=5%.
- National Joint Registry: Collation of best practice information shared within the orthopaedic department
- National Paediatric Diabetes Audit: Training to be provided on how to record albuminuria correctly.
- National Pregnancy in Diabetes Audit: communication to be shared amongst the public and primary care practices regarding the availability of pre-conception clinics in the community/GP practices.
- National Neonatal Audit programme:
- Posters to be displayed on the Workstation on Wheels (WOW) stations reminding the team to document if parents are not present at time of the ward round.
- Education to be provided to all NICU / maternity staff on submitting DATIX incidents for low temperature.

- Education to be provided to all NICU / maternity staff regarding the importance of ensuring babies on the Hypoglycaemia pathway have their temperature and room temperature checked when blood glucose noted to be low.
- Display thermoregulation posters in the NICU / Maternity units.
- Educational update to be provided to all NICU / midwifery staff promoting the consideration of how to keep baby warm.
- Raise awareness at daily huddles/clinical audit meeting to ensure that staff:
    - understand the parental consultation (within 24 hours of admission) discussion should be following admission to the unit and any discussions that took place in theatre will not be taken into account
    - understand the importance of welcoming parents to the neonatal unit
    - communicate to parents the value of their presence on the ward round and involve them directly in the ward round

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

- National Pregnancy in Diabetes Audit: Local deep dive review to ascertain indications for the high rates of deliveries of 'large for gestational age babies'.
- National Maternity and Perinatal Audit: Measure local compliance for the use of the new document for babies requiring 'Enhanced Midwifery and/or Transitional Care'.
- National Neonatal Audit programme: Case note review to be undertaken on every baby admitted to NICU at term gestation to identify the reason for admission.
- National Neonatal Audit Programme: Mothers who are breastfeeding with a baby on the neonatal unit to be audited using the UNICEF audit tool (providing their feedback as recommended by NNAP).
- National Bowel Cancer Audit: An audit was undertaken of the Stratified Pathway to provide assurance that patients with bowel cancer are being added to the pathway.
- National Joint Registry: To undertake a local audit of knee arthroplasty infections.
- GIRFT SSI Breast Action re: collating a local list of suspected Breast Surgical Site Infections and collecting data on such cases action – if this has been covered as now under W&C then ignore otherwise ask me for detail.
- National Lung Cancer Audit: Separate deep dive audit undertaken by clinical lead as per National Audit and GIRFT recommendations reviewing cases that fit in to multiple standards/KPI's to review quality of care provided.
- National Audit of Dementia: Local review of delirium screening audit was undertaken despite the Pandemic which evidenced improvement in performance against national standards.
- Core Diabetes Audit: Separate quality priority work doing continuous audit on blood glucose management on the wards and feeding back to wards and Quality and Safety Committee.

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

- TARN Audit: New CT Scanner in place from January 2021 to increase capacity and aid compliance with TARN standards.
- National Lung Cancer Audit: Single site MDT put in place to ensure consistent decision making.
- National IBD Audit: Trust Electronic Systems edited to include a module to ensure correct screening investigations and key performance indicators are met prior to commencement of a new biologic drug.
- Fracture Liaison Service Database: Changed the process to request DXA scan (to measure bone density) in the 1st fracture clinic. This sped up the process and improved performance in follow up and commencement of bone therapy.
- National Joint Registry: Data validation via web tool data review system on an ongoing basis.

- National Emergency Laparotomy Audit: A pre-operative discussion to take place between surgery Consultant and Anaesthetics Consultant for all patients who have a mortality risk of 25% or greater.
- National Bowel Cancer Audit:
    - To document the presence of any stoma and its potential reversibility at the MDT meeting so this information is clearly available to the Clinical Nurse Specialists.
    - To commence a spreadsheet to record cases which have a reversible stoma allowing such cases to be easily identified and highlighted to surgeons 10 months post-operatively.
    - Consider pooling lists of stoma reversals on to one Trust-wide Theatre list at either site if this will increase efficiency.
    - To contact patients at the relevant timeframe point for their stratified pathway review, even if investigations are not available at the time, and then to contact them again with results if necessary.
- National Prostate Cancer Audit: The urology team trialled the use of fusion transperineal biopsy equipment and is now in the process of purchasing the equipment.
- National Bladder Outflow Obstruction Audit: The urology team are to implement a trial of the use of Greenlight laser equipment.
- National Percutaneous Nephrolithotomy Audit:
    - Junior Doctors to add the patients bone profile to initial blood test.
    - To undertake a trial of Trilogy equipment.
- National Maternity and Perinatal Audit: The Maternity and Neonatal (MatNeo) Safety Improvement Programme to be implemented to include quality improvement work on reducing major PPH rates.
- National Maternity and Perinatal Audit: Introduce Midwifery Enhanced Care model into practice to allow babies (term and late pre-term) who require additional care to be looked after with the mother on a postnatal area by midwives and/or neonatal staff (depending on the area of care at the time).
- National Audit of Care at the End of Life:
    - Standardise the pain assessment tool across the trust.
    - Rollout of RESPECT document and accompanying training.
- National Maternity and Perinatal Audit: OASI bundle to be introduced across the Trust
- MBRRACE-UK Perinatal Mortality Surveillance Report: Better Births initiative to be implemented.
- National Paediatric Diabetes Audit: 'One-stop Service' where patients can have 'catch up' of Annual Review care processes to be introduced.
- National Neonatal Audit Programme:
    - 'Care Plan and Evaluation for Babies who require Additional Care on a Postnatal Area Provided by Midwifery and/or Neonatal Staff' to be introduced for use and used by midwives and/or neonatal staff (depending on the area of care at the time).
    - Introduce new ophthalmology examination sheet for completion by the Ophthalmologists.
    - Babies who require 2 year follow up to be seen in a dedicated consultant led clinic.
    - Record room temperatures (LDRP, Theatre, Transitional Care SGH and Pool rooms) at the beginning of each shift.

A number of **local** clinical audits were reviewed by the provider in 2020/21 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

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

- Epilepsy in Pregnancy: Counselling and birth plan documentation to be amended at SGH to ensure women receive the required information for pre/post-natal care.

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

- Intentional Rounding/Patient ID Wristband/Nursing Documentation: Results to be discussed at Patient Safety Days to raise awareness amongst all ward level staff groups regarding the expectation to comply with the clinical audit standards and retrospectively evidencing when a rounding chart is not required.
- Patient ID Wristband: Targeted visits / education to be provided regarding the appropriate use of wristbands to wards with low compliance: C2, Holly, Rainforest, Endoscopy (DPOW), HDU, GNRC).
- Audit of Nutritional Risk Assessment: Education to be provided to Nutrition team and all levels of nursing teams at Nursing Quality & Safety Day.
- Patient ID Wristband: Ongoing surveillance of compliance through the monthly 15 steps assessment with live feedback / action taken to address any issues identified.
- Community Record Keeping: Record keeping workshops to be held to train Audit Champions on good record keeping / inform them what the issues are so they can discuss with their teams and set out the expectations for the role.
- PEWS: SBAR sticker to be re-launched for use on Disney and Rainforest wards.
- PEWS: Discussion amongst medical and nursing staff of the need for documentation of deviation from escalation process.
- Paediatric Sepsis: Continuous education and support for completion of the sepsis screening chart and pathway to be provided at SIP Healthcare Assistant training days.
- Caesarean Section Audit: Provide education to all new doctors rotating into Obstetrics & Gynaecology at doctor's induction on how to complete and work through the Maternity theatre record / working as part of a safe team in theatre.
- Audit of Electronic Discharge Summaries: Discussion at Medical Quality and Safety Meetings and Medicine Audit Meetings to raise awareness of completion of key fields
- Blood Glucose Testing in the ECC: Audits continuously escalated to Governance and Audit Meetings to Raise Awareness, Cases validated by Paediatric Emergency Nurses.
- PEWS in ECC: Escalation/discussion at ECC/A&E Audit meeting regarding the requirements to complete all PEWS parameters in Children.

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

- Assess knowledge of the identification and management of third/fourth degree tears amongst midwifery staff.
- Pre-Assessment Documentation Audit: Following confirmation of improved performance via a re-audit informal spot checks to continue on a local basis to ensure continued compliance.

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

- Intentional Rounding: Introduction of new Patient Safety Nurse with a focus on intentional rounding compliance.
- Nursing Documentation Audit: Adult admission document to be reviewed and updated by Task and Finish Group following introduction of the IAAU model.
- Weighing and Prescribing Audit: Prescription chart to be amended and adopted for use within neonatal services.
- Surgery & Critical Care Documentation Audit: Stamps to be provided to permanent members of the ENT staff to allow then to record their printed name and grade more quickly.
- Oxygen Prescribing in the ECC: Dedicated Oxygen prescribing sections added to ECC/A&E prescription charts to facilitate clear prescribing of oxygen, including target ranges and flow rates.
- Pain scoring in children (ECC/A&E): Added to Symphony chronology and made it a requirement to do pain scoring at streaming.
- Blood glucose testing in the ECC: Added blood glucose to the Acute admissions profile for adults to ensure is undertaken as a matter of course/process.

2.2c Information on participation in clinical research

The research team priorities for 2020/21 have been urgent Public Health studies.

The Trust's main recruitment has been Clinical Characterisation Protocol for Severe Emerging Infection (CCP), RECOVERY and SIREN studies which are all Covid-19 studies. They have all helped to gain knowledge and develop treatments during the pandemic.

The Research team adapted to this sudden change in process well and have been successful in reporting high numbers of trial participants even though the Trusts Covid-19 positive patient numbers were nationally considered low.

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 987.

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

Due to the unprecedented impact on the NHS of Covid-19, the use of the CQUIN framework was paused during 2020/21, therefore, the Trust's income during 2020/21 was not conditional upon achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

The monetary total value for 2019/20 CQUIN indicators was £3,750,766. The Trust received payment for £3,301,539 during 2019/20.

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

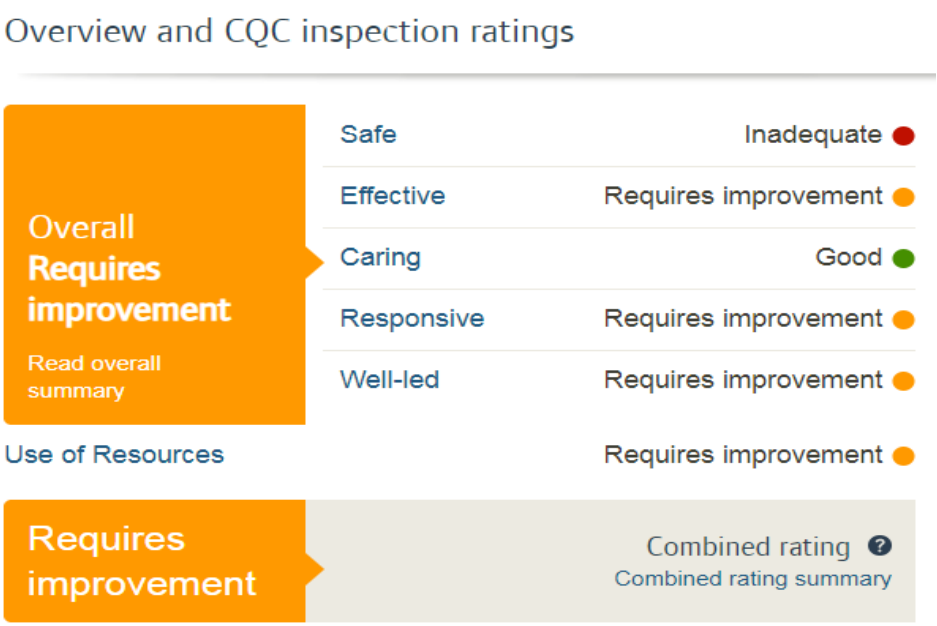
Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2020/21.

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

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

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



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

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

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

Despite the pandemic, the Trust has continued to progress with the CQC improvement programme of work following the last inspection. A monthly report provides detail and assurance on progress.

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

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

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

2.2f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS Number was:

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

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

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

2.2g Information governance assessment report

Throughout 2019/20 and 2020/21 there have been a number of changes to the reporting of the data and Security Protection Toolkit (DSPT). NHSX recognised that organisations would find it difficult to fully complete the toolkit without impacting on their Covid-19 response. Therefore NHSX took the decision to push back the final deadline from the 31 March 2020 to the 30th September 2020 for the 2019/20 submission. This meant that the Trust were able to continue working on the gaps which had been identified within the improvement plan, reducing the number of actions contained within. The 2019/20 improvement plan has been updated and reviewed a number of times by NHS Digital throughout 2020/21. The 2020/21 Version of the DSPT was launched on the 1st December 2020, with an initial submission date of the 31 March 2021 however this has also been extended to the 30 June 2021. So at the time of compiling this report the Trust has still yet to submit its final response so is not in a position to provide a submission statement.

2.2h Information on payment by results clinical coding audit

Northern Lincolnshire & Goole NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

2.2i Learning from Deaths

During 2020/21, 1,830 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 428 in the first quarter;
- 332 in the second quarter;
- 583 in the third quarter;
- 487 in the fourth quarter

By 20 July 2021, 1,307 case record reviews and 73 investigations have been carried out in relation to 1,830 of the deaths included in item 27.1. In 16 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 280 in the first quarter;
- 156 in the second quarter;
- 497 in the third quarter;
- 447 in the fourth quarter.

1 representing 0.05% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. *[Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].*

In relation to each quarter, this consisted of:

- 1 representing 0.05% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record. Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust's Serious Incident Framework. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care. The denominator used in the calculation is the total number of deaths during 2020/21.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2020/21;

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2020/21;

And,

An assessment of the impact of the actions taken by the Trust during 2020/21:

The Trust has not found, from the mortality reviews completed, evidence of systematic failings in care delivery leading to 'Avoidable' deaths. The Trust views mortality reviews as an opportunity to review the quality of care provided to these patients. From these mortality case reviews, the following quality improvement themes and learning lessons have been identified:

Healthcare System Themes:

- Advanced care planning: The Trust's review of mortality within its hospitals or within 30 days of discharge has consistently identified as one of the main themes, advanced care planning to support those patients who are entering the end of life phase of their care. It is likely this contributes to the Trust's higher out-of-hospital SHMI performance.

- In a number of cases reviewers have concluded that greater consideration and planning what happens at end of life could have prevented the patient from being admitted to hospital and could have enabled the patient to die in their own homes with community support in place. In other cases, even when plans are in place, these are not always followed due to a number of reasons, resulting in the patient attending the acute hospital at end of life.

- In such cases, wider community and primary care reviews are undertaken for some of these care episodes to identify cross system learning and sharing. This has supported the development of a community-focussed improvement plan which seeks to focus on and improve elements of care in primary care and support to care and nursing homes to prevent hospital admission. The key actions being taken or planned relate the following areas:

- **RESPECT (Recommendations Summary Plan for Emergency Care and Treatment)** is a document that is designed to facilitate conversations at an early stage between healthcare professionals and patients and their families to ensure the preferences at end of life are at the forefront of the care packages. The RESPECT document is in the process of being rolled out and embedded in community and within the acute Trust. This is a priority project with a project team and dedicated trainer/lead facilitator supporting.

- **Electronic Palliative Care Coordination System or (EPaCCs)** is being rolled out across the wider Humber Coast and Vale Integrated Care System and therefore covers Northern Lincolnshire. EPaCCs is designed to support communication across different care sectors and organisations to support patient choices and preferences at end of life to be delivered on irrespective of which care setting has contact with the patient. This has now been rolled out across the majority of community settings and plans are in place to ensure this is accessible to hospital based clinicians.

- **Primary Care Network (PCNs)** are established in Primary Care and are working to establish support to community providers, especially care homes, and regularly undertake reviews of people to ensure proactive planning in place to prevent access to unplanned services within the acute Trust. Key performance indicators are being established to monitor the impact of this development. The impact of the Covid-19 vaccination rollout has delayed elements of this whilst resource was prioritised.

- **Support to care homes** is a review of training needs and wraparound of other support functions such as pharmacy to support medication reviews. This is designed, along with other initiatives, to support more proactive management of residents health needs and prevent, where possible, access to unplanned services from the ambulance service or the acute Trust.

- The Trust and community partners have also been supported by NHS Improvement / NHS England to review the provision of services at end of life. An audit is underway during April and May to review end of life care delivery from an external team of expert reviewers to identify other areas of end of life care provision that would benefit from further focus.

Learning from deaths within the acute hospitals:

- The Trust's delivery and planning of **end of life (EOL)** services is also an area where action is being taken on the back of themes from mortality and other feedback mechanisms. Whilst the Trust's end of life improvement work interacts closely with the wider systems end of life improvement plans, it also has areas of specific focus. Action at present has been and is being taken to ensure specialist palliative care team provision is supportive by ensuring mandatory training is up to date, effective governance and oversight improvements are enacted. The teams are currently reviewing the documentation and controls in place to support good end of life care provision on hospital wards for those patients who are receiving in-hospital care.

- Use of **do not attempt cardio-pulmonary resuscitation orders (DNaCPR)** has also been a theme identified from either completion of documentation or delays in considering this as part of the patients longer term planning on admission. The Mortality Improvement Group (MIG) requested divisions to assess their performance and processes in place with regard to this and the use of RESPECT during 2020/21. Divisions are in the process of feeding back to the group the specific actions taken to promote early consideration. This has included the use of education and reminders.

- The quality of **documentation and record keeping** remains an area needing further attention and improvement. Education and feedback is provided to clinical staff to help them reflect on the importance of comprehensive record keeping. Completion of specific documents designed to support and guide best practice relating to end of life and sepsis are specific areas of focus by the EOL team and the Deteriorating Patient and Sepsis team. These actions and reminders will remain active actions throughout 2021/22.

- Mortality reviews have also identified general **clinical care management** themes relating to delays in taking action, acknowledging results and undertaking assessments. A theme was identified relating to the management of diabetic ketoacidosis (DKA) which led to a specific review of these cases by the team followed up with education and reminders to department staff.

- **Medication** themes are identified from mortality reviews, these are fed back to the Trust's Safer Medications Group to inform their ongoing oversight of medication safety and action in response to mortality themes alongside other triangulated sources of intelligence overseen by the group.

- **Fluid management** has been identified from the mortality screening process. During 2019/20, additional work was invested into changing the documentation to record this information and to act as a prompt for nursing staff to support improved recording. To ensure themes from mortality are reviewed in the context of wider improvement fluid management has been added to the remit of the Deteriorating Patient and Sepsis group with reporting from mortality reviews into this group.

- During the pandemic **patient flow** was a constant area of focus to prevent and mitigate the spread of Covid-19 within the Trust's hospitals. Actions taken included the zoning of in-hospital locations which, coupled with normal winter pressures, has put a strain on services and the Trust's ability to see and treat patients in the Emergency Department within normal timeframes. The Trust is currently taking action, along with NHS Improvement / NHS England and system partners to embed the Discharge to Assess programme to support effective management of patient flow and reduce bed occupancy and length of stay to mitigate delays in patients being assessed and admitted. This remains an ongoing action planned during 2021/22.

147 case record reviews and 3 investigations completed after 01st April 2020 which related to deaths which took place before the start of the reporting period.

1 representing 0.05% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated based on the number of patients reviewed. Each case was reviewed using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record. Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust's Serious Incident Framework. It should be stressed that this data is not a measure of deaths that were avoidable, rather it is designed as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

9 representing 0.52% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

2.2j Details of ways in which staff can speak up

Annual Update on Speaking Up:

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

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

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:
    - Through the Trust's nominated Freedom to Speak Up Guardian;
    - Via the Human Resources Department, a part of the Trust's People and Organisational Effectiveness Directorate;
    - Or by logging an incident on the Trust's incident reporting tool hosted on DATIX;
    - 'Ask Peter' which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian:

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

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events, and additional magazine features. The Guardian also featured as part of the National 'Speak Up' campaign in October, writing a blog which was shared nationally. The Guardian is now active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email address and a dedicated mobile telephone number.

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

The Trust's Freedom to Speak Up Guardian meets monthly with the Chief Executive and Executive Director and bi-monthly with the Trust Chair and Non-Executive Director with specific responsibility for Freedom to Speak Up who provide support to this function. A quarterly Freedom to Speak Up Guardian report is reviewed by the Trust Management Board and the Workforce Sub-committee prior to being presented to the Trust Board by the Freedom to Speak Up Guardian. This ensures the Trust and its board are kept up-to-date on concerns including sufficient details as per the National Guardian's recommendations. An overview of the report is

shared with all staff by quarterly infographics. The Guardian is also sharing information to all Divisions about the number and nature of the concerns raised via the HRBPs. This information now forms part of the PRIM information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2020/21 there has been a significant increase in concerns raised with 143 cases brought to the Guardian, this compares with 70 the previous year. This is one indication of an improvement in staff feeling more secure in raising concerns. The latest staff survey also shows improvement in staff perception that they will be treated fairly, and that the organisation is moving towards a learning environment.

2.2k Annual report on rota gaps and plan for improvement

The Trust has made significant progress with management of Medical and Dental rotas. The latest data for April 2021 showed a vacancy rate of 15.40%, compared with 12.90% in 2020. This higher vacancy rate is due to an increase in establishment of 37.09 whole time equivalent staff for 2020/21. For trainees, the latest data available is for August 2020, this demonstrated a fill rate of 91.12 % which was an improvement of 3.1% in comparison to the previous year.

Workforce and Recruitment meetings are planned to take place regularly (monthly and by exception) with Temporary Staffing as part of the development of the Workforce Resource Centre (WRC) and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. Staffing levels continue to give cause for concern and more is needed to be done to develop alternatives such as Physician's Associates (PA) and Advanced Clinical Practitioners (ACP). The Trust has drafted a revised people strategy, overseen by the Workforce Committee. This will lead to a high level delivery plan which will incorporate these roles. ACP roles are currently being developed in the Trust with support from Health Education England, Yorkshire and the Humber.

Rota Co-ordination has improved in 2019, the Trust is in the process of transitioning to an electronic rostering system for greater visibility to identify the workforce needs and but there is still work to be done. The Trust is continuing its efforts to diversify the clinical workforce and thereby reduce sole reliance on medical staff.

2.2l Summary of Invited Service Reviews during 2020/21

During 2020/21, the Trust commissioned one invited service review. The Trust commissioned the Royal College of Surgeons (RCS) to undertake a review of the Urology surgical service to conduct a clinical record review and external scrutiny of the Urology MDT processes. The invited service review visit was held in November 2020 and the report back to the Trust received in January 2021.

Background:

The Trust made the decision to commission the invited service review following a Never Event occurring within the Surgical Division that, following investigation, identified some potential areas for improvement in the process by which treatment decisions were made.

Terms of Reference for the review:

The review set out with the following objectives:

- Review of relevant documentation that supports treatment decisions being made by the multi-disciplinary team and a consideration from this as to the effectiveness of current processes;

- Team working within the Trust and with the local Tertiary services provider;
- Clinical leadership, timeliness and record keeping.

Summary of conclusions from the review and Trust action in response:

- The review concluded that provision of specific specialist surgery for renal cancer was not sustainable within the Trust alone and closer working was recommended with the local cancer centre and specific and complex types of surgery should be planned alongside the multidisciplinary team at the cancer centre.

- **Trust action taken/in progress:**
    - The Trust is currently looking to recruit additional consultant surgeons with expertise in this area.
    - In line with the Trust's wider plans to support the development of an Integrated Care System, closer working with the cancer centre and looking to develop further joint pathways of care are ongoing.
    - A standard operating procedure has been developed to ensure that patients requiring complex specialist surgery are discussed with the cancer centre to agree treatment plans. This will be written into the wider specialties operational documentation and monitoring/audit arrangements will be developed to track progress.

- The review team did not identify any negative behaviour that could undermine decision-making, or team working in the local MDT. Some improvements were identified though in how the MDT meetings functioned and the governance arrangements.

- **Trust action taken/in progress:**
    - The Trust will ensure that a chair for each multi-disciplinary (MDT) meeting is clearly defined to enable their preparation for the meeting. This will be written into the operational policies the team use.
    - Specific and additional time is to be provided to medical staff within the team to prepare the cases for presentation to the MDT to enable the group to understand key details to help them plan appropriate treatments. This will be also written into operational policies.
    - Work has been completed to make sure the environment and the IT infrastructure is conducive to enable an effective meeting to be held and key decisions made.
    - The MDT business meeting has been reformed resulting in better attendance by the wider team to ensure service improvement discussions can take place. This approach will be documented within operational policies.
    - Plans for future submissions as part of the Quality Surveillance (QST) to include descriptions of compliance with NICE guidance.
    - Work underway to ensure surgeons within the Trust have applied and evidenced their inclusion on the specialist register.

2.3 Reporting against core indicators

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

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

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

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

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

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

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

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

2.3a Summary Hospital-Level Mortality Indicator (SHMI)

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

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

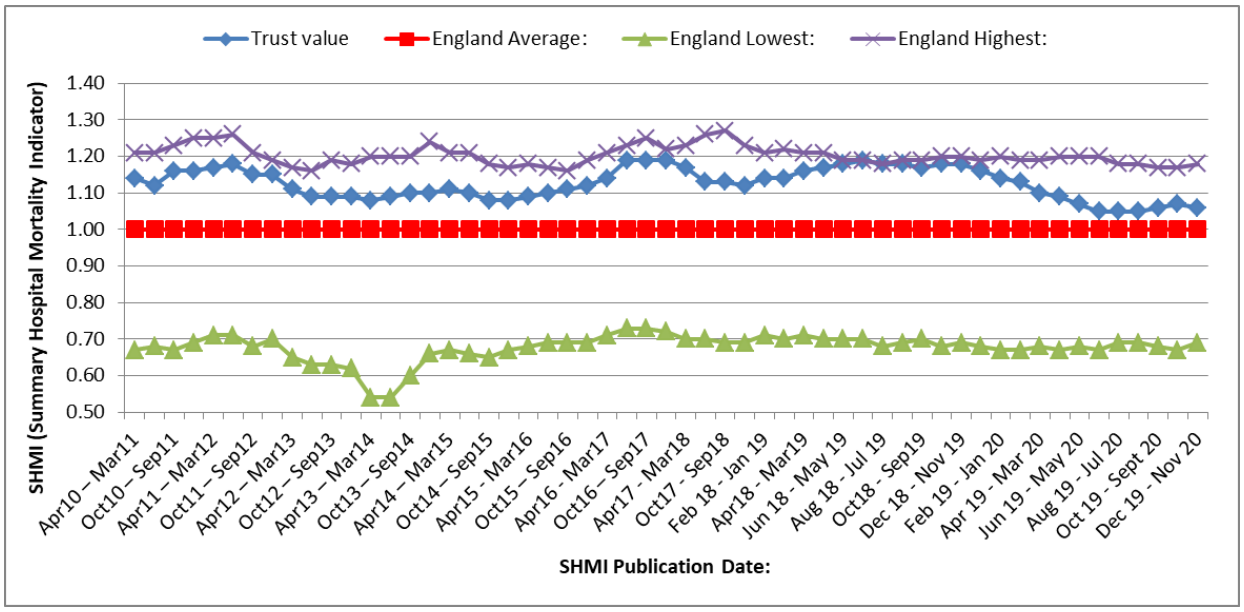


Figure 8: Trust's SHMI score, trended over time

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

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

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

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

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

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

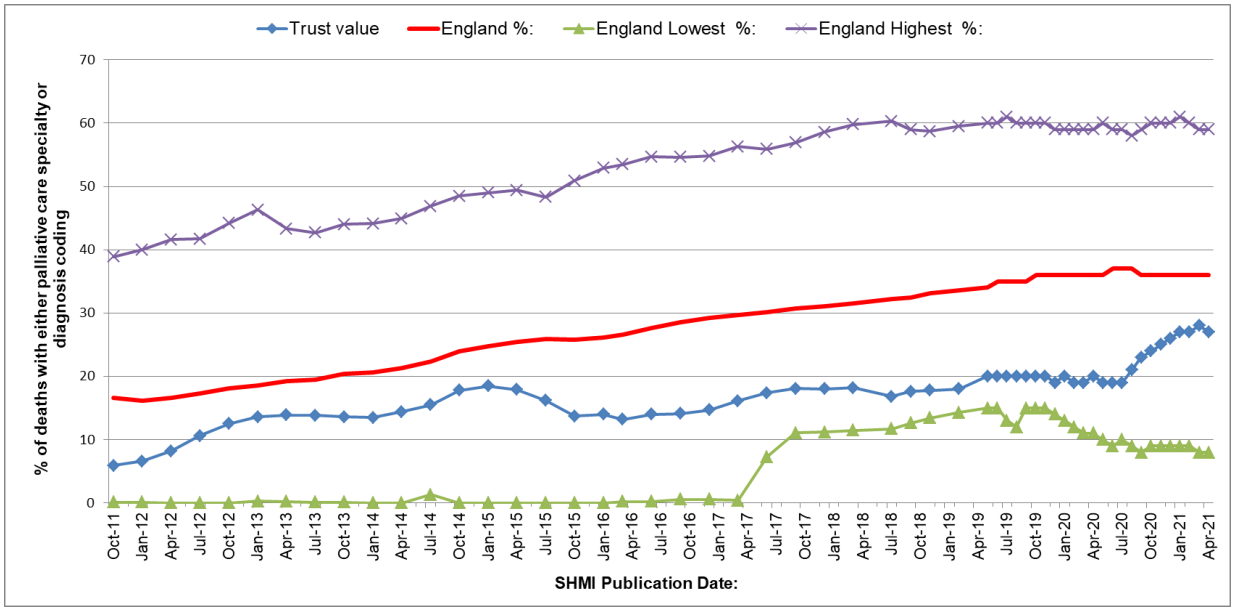


Figure 9: Percentage of patients with a coded palliative care code, compared with other UK Trusts

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

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

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

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

- The chart shows during 2020/21 an increase in the number of patients with a palliative care code. This is as a result of a data quality project undertaken that aimed to ensure processes in place for recording and coding of mortality related data were clinically validated, this resulted in improvements in the quality of captured and coded data relating to mortality. This means that the Trust are better able to make use of mortality data to understand trends and identify any diagnoses groups that have higher levels of mortality that require further review and scrutiny.

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

- During 2020/21 the Trust has been working to implement its Improving Mortality Strategy. Two specific elements of this strategy were with regard to improving the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.

- The palliative care level information captured has increased during 2020/21. When this is broken down by hospital site, there is a disparity with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative

care provision between both hospitals and related CCGs. This likely has an impact on levels of palliative care coding, which then can in turn influence mortality indices such as HSMR. This is currently being reviewed and addressed through collaborative work between primary and secondary care, supported by NHS England / NHS Improvement.

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

- The quality and accuracy of underpinning data has been improved, along with the Trust's process for processing this data on a monthly basis. This has been as a result of clinician led validation of all mortality data, centralisation of coding to experienced coding team members and increased confidence in obtaining information from the specialist palliative care teams across the Trust. This has resulted in greater confidence in the intelligence derived from mortality data and shown a reduction in mortality outlier notifications for symptoms (i.e. chest infection; pneumonia; acute bronchitis) and a shift to underlying diagnoses alerts (i.e. secondary malignancies; lung cancer) which helps the Trust better understand specific areas requiring Trust and wider system focus.

- Using this data, the Trust at present is an outlier for the SHMI indicator for secondary malignancies and lung cancer. The Trust is working with community partners to review these outlying areas in greater detail.

- As the SHMI includes out-of-hospital deaths (within 30 days of discharge), it can be broken down into in-hospital and out-of-hospital mortality indices. The in-hospital SHMI performance is 'as expected'; however, the out-of-hospital SHMI is significantly higher with a difference of more than 35 points. The Trust's mortality reviews have identified a recurring theme of patients being admitted to hospital at end of life. In some cases, this is the preferred place of death chosen by the individual, however, in other cases, where the acute hospital is not the chosen place of death, clear advanced care plans set with the individual and their family can prevent admission to hospital. Good advanced care planning ensures that symptoms are well managed and planned for. In such cases where an advanced care plan is not in place, admissions to hospital at end of life for symptom support may well have been avoided. Such admissions will contribute to the out-of-hospital SHMI and the disparity currently seen between the in-hospital and out-of-hospital mortality rates.

- The Trust had planned to focus on improved consistency of mortality reviews during 2020/21 with the aim of reviewing 50% of all hospital deaths. The Covid-19 pandemic had a significant impact on many of the Trust's plans for 2020/21. Despite the pandemic, the Trust were able to link the quality of data, clinician led validation sessions with the quality of care screening reviews and have exceeded the target set, reviewing >60% of hospital deaths. This process improvement will continue during 2021/22 with the Trust focussing now on improving the process to support improved learning from these reviews to better support improvement in processes and reflective practice.

2.3b Patient Reported Outcome Measures (PROMS)

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

a) Groin hernia surgery (no longer a PROM)
b) Varicose vein surgery (no longer performed by this Trust)
c) Hip replacement surgery
d) Knee replacement surgery.

During the reporting period.

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

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

Comment:

- The Patient Reported Outcome Measure (PROMs) is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The 3 areas listed above are nationally selected procedures. Varicose vein surgery is not performed by the Trust, therefore no data is available.

- The above tables show the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery.

- EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value.
- The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health).

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

- Patient-reported outcomes following primary hip replacement and primary knee replacement surgery remain within the statistically calculated confidence intervals, demonstrating no significantly different performance compared to the UK.

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

- Data made available from the PROMs dataset is presented within the division of surgery to support reflective practice and agreement of actions needed to improve on processes. An overview report is also prepared and presented at the Quality Governance Group and also the Quality & Safety Committee.

- Previously when data concerns have been identified, this has been discussed with Trauma and Orthopaedic Surgeons who have identified areas of improvement and implemented change to address this.

- It is likely that the next annual release of data for PROMs will show an impact from the actions taken during Covid-19 pandemic which will have impacted upon planned surgery provision.

2.3c Readmissions to hospital

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

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

Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

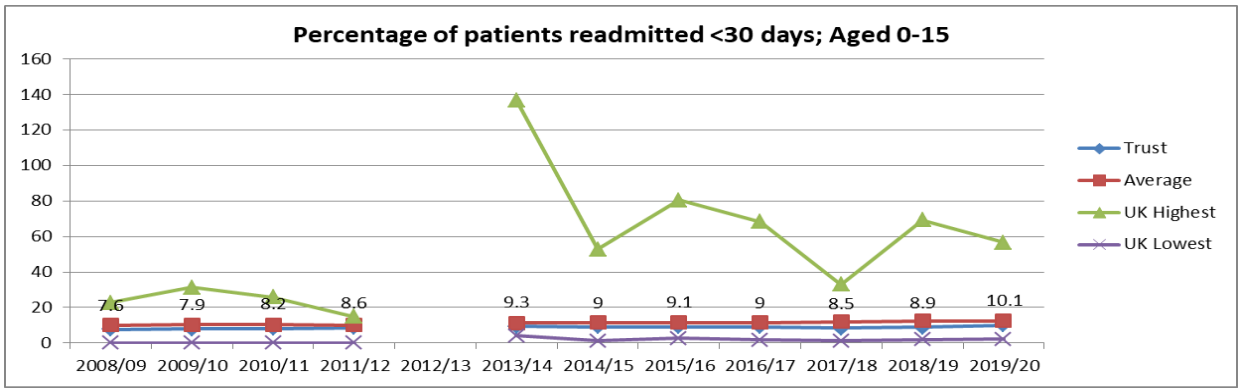


Figure 10: Chart demonstrating % of patients aged 0-15 readmitted within 30 days

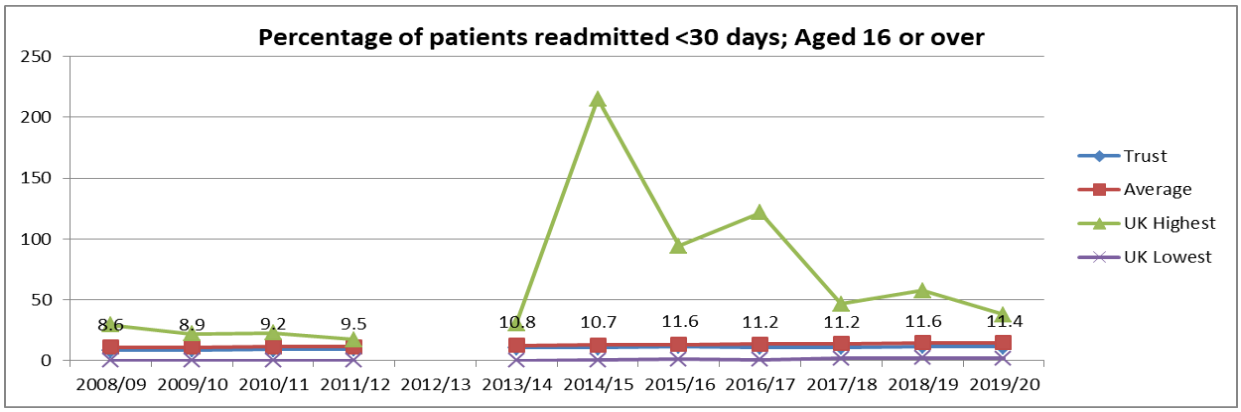


Figure 11: Chart demonstrating % of patients aged 16 or over readmitted within 30 days

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

Comment:

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

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

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

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

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

2.3d Responsiveness to the Personal needs of patients

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

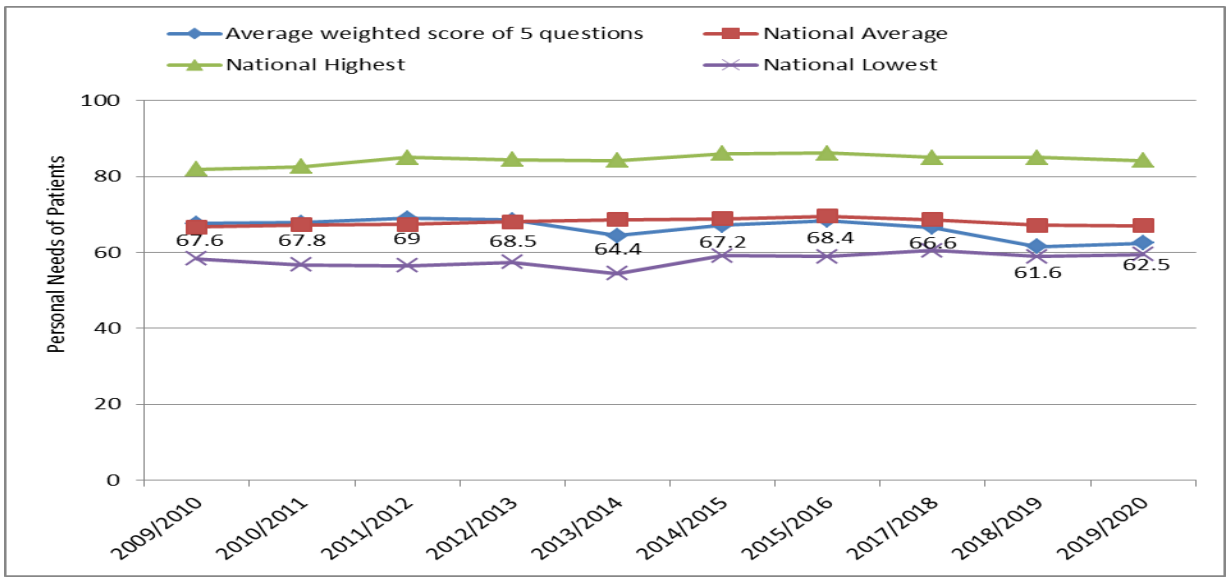


Figure 12: Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services

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

Comment:

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

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

  "*Responsiveness to patients' personal needs".*

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

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

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

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

- Due to Covid-19, the surveys that provide this data were halted, and therefore no more recent data is available. The data presented here was the same as reported in the 2019/20 quality account.

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

- The Matron role has been reviewed to allow more dedicated oversight of ward areas, including escalation of any issues. Visitors have a clear point of contact and can discuss any issues if needed.

- Ward based daily huddles also help promote conversations about safe and effective discharge. Discharge planning continues to be a priority and the Trust is looking at how staff are equipped with key skills to ensure discharge is a unified process with all those involved. Recurring issues involving discharge are to be explored via the Patient Experience Group where appropriate.

- The Trust continues to work towards creating spaces across all ward areas and departments where patients and families can have private conversations. Equally, the Trust is working with teams to involve patients in conversations at the bedside in dignified and respectful ways.

- Patient information leaflets that provide key information have patient involvement in the process; these are being used to signpost people to additional support. This will be replicated on the Trust's website.

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

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

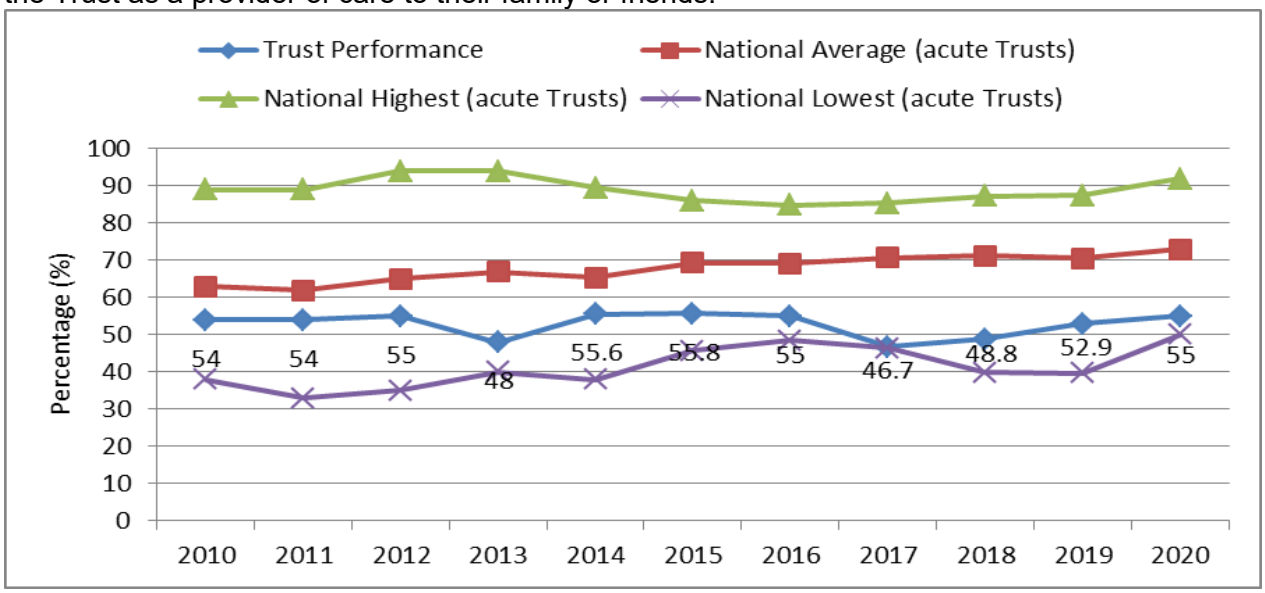


Figure 13: Trust reported performance for staff recommending the Trust as a provider to family and friends

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

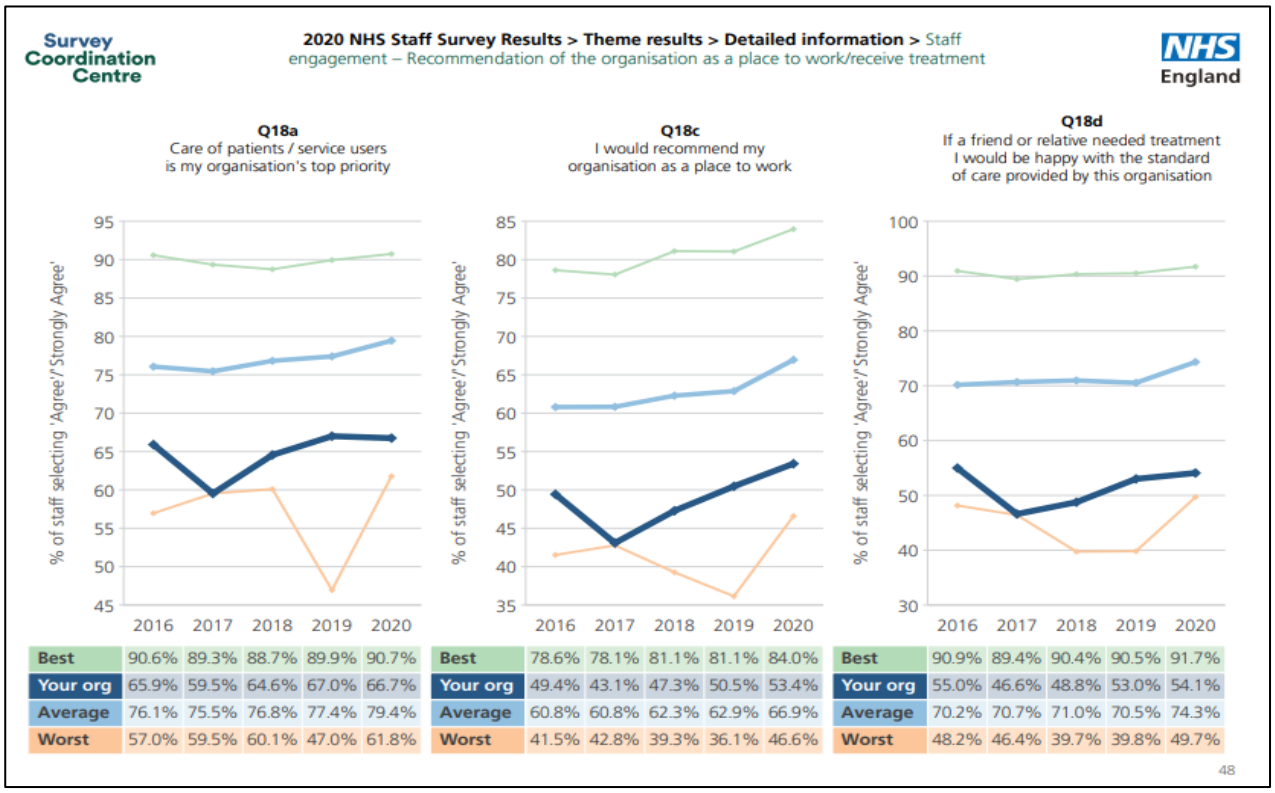


Figure 14: Trust reported performance for staff recommending the Trust as a provider to family and friends

Source: NHS Staff Survey Results

Comment:

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

- 55% of staff surveyed would recommend the Trust; this is the third consecutive year where an improvement is seen and demonstrates that Trust staff are seeing evidence of improvements. The Trust recognises that whilst this is positive, more work is needed to continue improving.

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

- Despite the unprecedented pressures the COVID-19 pandemic brought to the NHS and the Trust we continue to see improvements within the 2020 staff survey when compared against 2019. There are statistically significant improvements against the Health and Wellbeing and Safety Culture domains which reflect the investment in staff and their wellbeing made during 2020. The Trust notes that the Team Working domain shows a statistically significant decline but upon investigation this solely relates to a reduced number of team meetings. It should be noted that within the pandemic staff communications and engagement dramatically increased with alternatives to team meetings being put in place. The Trust considers appropriate measures have been put in place to improve wellbeing and further developments will be supported by the Trust’s People Strategy.

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

- For the last two years significant work has gone into transforming the culture and supporting staff on front line services of the Trust, and more latterly significant investment in Health and Wellbeing of staff. The outputs of this work can be seen in the last two staff surveys. Actions already taken include:

    - An investment in staff engagement and a launch of a range of staff recognition schemes.

    - The contracting of two nationally recognised Health and Wellbeing providers to support psychological wellbeing of staff, namely VIVUP and Remploy.

    - The Trust has been awarded two significant funding bids to further bolster its wellbeing offer, including to the funding of Schwartz Rounds/Team Time, Trauma Debriefing and the contracting of the Citizens Advice Bureau to support financial wellbeing.

    - Continued investment into medical staff engagement, and a repeat of the Medical Engagement Scale survey with a marked improvement across the Trust compared to the previous results in 2017.

    - Significant investment has been made in staff engagement to support staff during the pandemic. This has been done via virtual staff briefings using MS Teams, the development and implementation of a new smartphone staff app and the launch of NLaG Staff Facebook account.

    - Investment has been made, to uphold government guidelines, in agile working and risk assessing all staff for health conditions in line with COVID, and from this redeploying staff to keep them safe.

- Successful application for funding from Health Tree Foundation for a full-time Health and Well-Being OD Practitioner due to start in August 2021.

2.3f Risk assessed for venous thromboembolism

The data made available to the Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

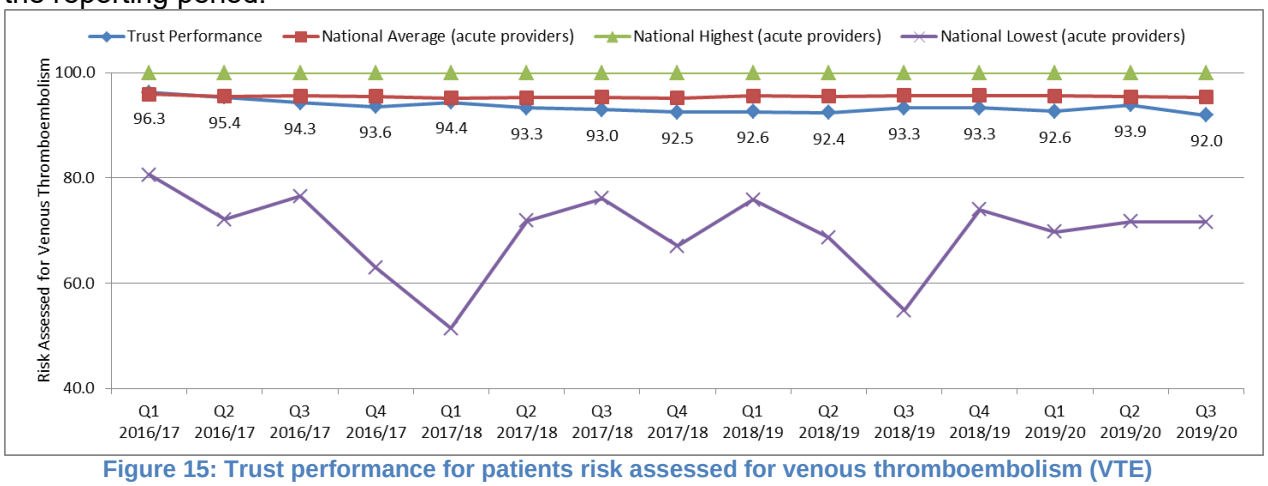


Figure 15: Trust performance for patients risk assessed for venous thromboembolism (VTE)

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

Comment:

- The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter one, 2016/17. The Trust is not at present achieving the 95% target for this area.

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

- The Trust oversees compliance with VTE risk assessments and prophylaxis prescribed through monthly reporting through the Trust's performance framework. Where possible this overall compliance is broken down to ward and department level to aid continued understanding and improvement.

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

- The Trust's Quality Governance Group receives a highlight report in relation to VTE screening performance from the Trust's Deputy Medical Director.

- The Trust has rolled out an Electronic Prescribing and Medicines Administration (EPMA) system at Scunthorpe General Hospital and Goole hospital and is partway through implementation of this at Diana, Princess of Wales hospital. This improved system will enable greater controls to be in place supporting improved prescribing that will lead to safety benefits including greater ability to ensure VTE risk has been fully assessed prior to prescribing or administration of medications.

- Two clinical leads have been appointed to focus on further improvement around VTE and this has resulted in some improvement when looking at the April/May 2021 data. Part of their focussed work will be to launch an electronic VTE risk assessment process to support timely completion of the risk assessment process.

2.3g *Clostridium Difficile* infection reported within the Trust

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

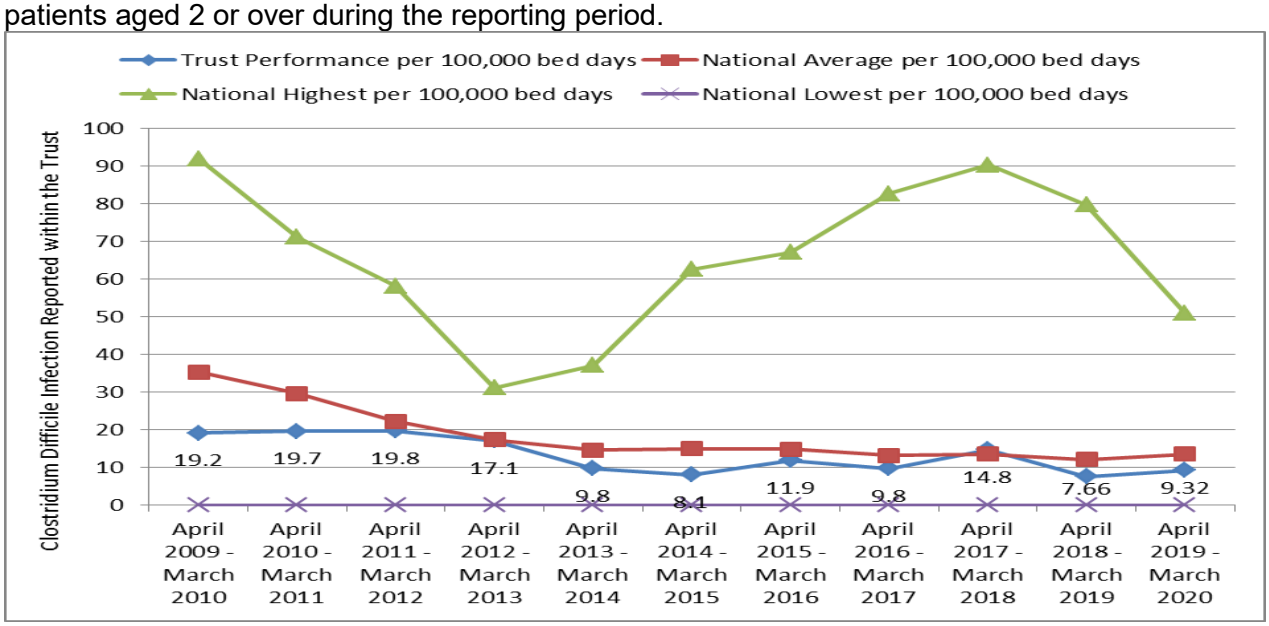


Figure 16: Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

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

Comment:

- The above table illustrates the rate of *C. difficile* per 100,000 bed days, for the Trust (Hospital onset only), for specimens taken from patients aged two years and over.
- The data shows that the Trust, for the latest reporting period, is beneath the UK average.

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

- The Trust reported 28 healthcare acquired cases to date compared to 38 last year. The definitions for reporting *C. difficile* cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital onset as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Hospital related if the patient was an in-patient within the previous 4 weeks.

	Hospital onset	Community onset
Diana, Princess of Wales Hospital (DPoW)	11	6
Scunthorpe General Hospital (SGH)	6	5
Goole District Hospital (GDH)	0	0

- The Trust has detected 1 lapse in practice/care associated with non-compliance with Trust antimicrobial guidance or delay in taking samples.

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

- Capital and planning teams have factored the need to increase isolation capacity into future building schemes;

- The Trust has an evidence-based *C. difficile* policy and patient treatment care pathway;
- Multi-disciplinary team meetings are held for inpatient cases to identify any lessons to be learnt and post-infection review is conducted for hospital onset cases deemed unavoidable;
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives' audit tools;
- Themes learnt from the Post-Infection Review (PIR) process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies;
- The development of a bespoke IPC WebV module that will alert the IPC team to previous cases of *C. Difficile* infections;
- GPs will be sent an email to inform them of a patient's *C.difficile* / Glutomate Dehydrogenase (GDH) status again to help reduce the amount of antimicrobial use and prevent future *C. Difficile* cases;
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control group;
- PathLincs antimicrobial formulary reviewed with latest national standards;
- The publication of a new antimicrobial HUB site to make access to content easier for prescribers.

2.3h Patient safety incidents

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

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

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days	Acute – Non-specialist highest rate per 1,000 bed days	Acute – Non-specialist lowest rate per 1,000 bed days
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2016 – September 2016	5,953	49.5	40.8	71.8	21.1
October 2016 – March 2017	6,536	52.3	41.1	69.0	23.1
April 2017 – September 2017	6,347	52.4	42.8	111.7	23.5
October 2017 – March 2018	5,897	48.0	42.6	124.0	24.2
April 2018 – September 2018	5,806	48.3	44.5	107.4	13.1
October 2018 – March 2019	6,176	50.0	46.6	95.9	16.9
April 2019 – September 2019	7,275	59.2	49.8	103.8	26.3
October 2019 – March 2020	8,105	65.5	50.7	110.2	15.7

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

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

- The above table demonstrates the total number of reported patient safety incidents and the rate per 1,000 bed days reported.

- Northern Lincolnshire and Goole NHS Foundation Trust average rate of patient safety incidents reported is above the average of other acute non-specialist NHS organisations. The Trust actively promotes and encourages staff to report all incidents as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicates a high level of safety awareness.

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

Time frame	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2016 – September 2016	7	0.06	0.16	0.60	0.01
October 2016 – March 2017	21	0.17	0.16	0.53	0.01
April 2017 – September 2017	24	0.20	0.15	0.64	0.00
October 2017 – March 2018	21	0.17	0.15	0.55	0.00
April 2018 – September 2018	21	0.17	0.16	0.54	0.00
October 2018 – March 2019	15	0.13	0.15	0.49	0.01
April 2019 – September 2019	31	0.25	0.16	0.67	0.00
October 2019 – March 2020	20	0.2	0.16	0.5	0.00

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

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

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

- The Trust continues to promote high levels of incident reporting, viewing this as a learning opportunity promoting a positive patient safety culture.

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

- The Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities.
- The Trust oversees serious incidents (SI) weekly at the SI panel ensuring that appropriate investigation is undertaken in line with agreed timescales.
- The Trust is working towards improving learning in the organisation and has developed a learning strategy.
- The Trust have also introduced a Serious Incident Review Group to look back at older cases to determine if there is anything further we can do to increase safety.

Part 3: Other information

An overview of the quality of care based on performance in 2019/20 against indicators

3.1 Overview of the quality of care offered 2020/21

The Trust set out 6 key quality priorities for focus on within 2020/21, which were:

(1) Improve the Trust waiting list;
(Patient Experience)

(2) Reduce mortality rates and strengthen end of life care;
(Clinical Effectiveness)

(3) Improve the management of diabetes;
(Patient Safety)

(4) Improve the effectiveness of cancer pathways;
(Patient Experience & Clinical Effectiveness)

(5) Improve safe flow and discharge through the hospital;
(Patient Safety, Experience & Clinical Effectiveness)

(6) Improve the quality and timeliness of complaints responses using a more individualised approach.
(Patient Experience)

For a more detailed narrative and explanation of performance, see part 2.1 of this report.

Priority 1 – Improve the Trust waiting list

PATIENT EXPERIENCE:					
QP1: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
1a) Reduce delayed transfers of care to 60 (move flow and access)	**8.3**	No data			G
1b) Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021	**21,969**	27,803			R
1c) 52 week waits to be at zero	**1187.0**	1285.0			R
1d) The overall RTT waiting list to be less than it was on 31 January 2020	**28,853**	28,307			R
1e) 50% of out-patient summary letters to be with GPs within 7 days of patient's attendance	**35.00%**	40.00%			R
1f) Reduce the number of face to face follow up appointments by 10%, to support the delivery of an overall reduction by a third by March 2023	**13,657**	11,279			R

Comments:

- Progress against these priorities have been significantly impacted upon by the Covid-19 pandemic.
- These areas are remaining as key Trust priorities to support recovery actions that have already commenced.

Priority 2 – Reduce mortality rates and strengthen end of life care

CLINICAL EFFECTIVENESS:					
QP2: Reduce mortality rates and strengthen end of life care;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
2a) Reduction in the Trust SHMI to within expected range	**106.4**	106.8			G
2b) Mortality screening: 50% of all deaths	**82.00%**	84.00%			G
2b) Mortality SJR: 100% for those cases identified as requiring SJR	**9.00%**	25.00%			R
2c) a) Adults: Timeliness of observations to 85% within 30 minutes of due time	**90.89%**	88.97%			G
2c) b) Children: PEWS: Observations recorded at least every 4 hours (first 12 hours) to 85%	**85.00%**	88.90%			G
2c) c) Full observations a minimum of 12 hourly & relevant observations as clinically indicated between times to 85%	**92.30%**	100.00%			G
2c) d) New admissions must have all 9 observation parameters (including temperature) recorded and scored at the first assessment to 85%	**80.00%**	80.00%			A
2d) Improve frequency of sepsis screening and robustness of reporting	**No data**	No data			R
2e) Gather patient and carer feedback for end of life care with local hospices	**No data**	No data	-	-	-
2f) 80% of inpatients (exc. maternity) screened for alcohol and tobacco use	**No data**	No data	-	-	-
2g) 90% of inpatients (exc. maternity) receive brief advice on tobacco use if smoke	**No data**	No data	-	-	-

Comment:

- Significant progress has been made against the Trust's mortality related quality priorities.

Priority 3 – Improve the management of diabetes

PATIENT SAFETY:					
QP3: Improve the management of diabetes;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
3a)i) Improvement in monitoring of blood sugar in patients with diabetes - DPOW	**81.11%**	86.51%			A
3a)ii) Improvement in monitoring of blood sugar in patients with diabetes - SGH	**66.42%**	80.95%			R
3b) Reduction in insulin errors which cause significant harm to less than 5% of overall reported insulin incidents	**0.00%**	0.00%			G
3c) Achieve 85% compliance with role specific mandatory training for diabetes	**85.00%**	85.00%			G
3d) Adults: Blood glucose taken in ECC if NEWs > 1 in 95% of cases	**92.50%**	95.00%			A
3d) Children: Blood glucose taken in ECC if PEWs >1 in 95% of cases	**80.00%**	90.00%			R

Comment:

- Good progress has been made against these indicators. This will remain as a quality priority for 2021/22 to ensure actions and improvements remain embedded.

Priority 4 – Improve the effectiveness of cancer pathways

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:					
QP4: Improve the effectiveness of cancer pathways focussing on time to diagnosis;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
4a) Time to diagnosis and patient informed by day 28 to be at 75%	**59.70%**	65.19%			R
4b) Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	**20.00%**	25.00%			R
4c) Request to test report turnaround to be no more than 14 days in 100% of cases	**84.77%**	84.48%			R
4d) Develop a clear service model and a Trust target to ensure that cancer services are maintained	**No data**	No data	-	-	-
4e) Number of combined site MDTs to be 100%	100.00%	100.00%			G

Comments:

- Progress against these priorities have been significantly impacted upon by the Covid-19 pandemic.
- These areas are remaining as key Trust priorities to support recovery actions that have already commenced.

Priority 5 – Improve safe flow and discharge through the hospital

PATIENT SAFETY; CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE:					
QP5: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
5a) Reduction in the average length of stay to less than 4 days	**4.05**	3.99			A
5b) Increase in the zero length of stay to 32%	**28.94%**	29.03%			A
5c) Sustained improvement in the 0 – 1 day length of stay	**6578.0**	No data			G
5d) Reduction in non-elective length of stay to less than 4.1 days	**4.18**	4.18			A
5e) Reduction in elective length of stay to less than 2.4 days	**2.54**	1.91			A
5f) Reduction in the number of medical outliers					
5g) 85% of discharge letters to be completed within 24 hours post discharge	**87.62%**	88.60%			G
5h) Progressive improvement in the number of golden discharges from April 2020 (target: 35%)	**16.8%**	16.2%			R
5i) Increase in A&E performance to 83.5%	**72.2%**	73.3%			R
5j) Reduction of non-emergency patient transfers at night after 10pm by 10% (Target: 48)	**9.84%**	8.5%			R
5k) Reduction in average ward moves for non-elective patients for non-clinical reasons by 7% (Target: 4.6%)	**15.04%**	12.8%			R
5l) Number of early supported discharges to increase by 10%	**No data**	No data	-	-	-
5m) Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire	**No data**	No data	-	-	-
5n) All patients requiring mental health support in ED will be assessed within 4 hours of referral	**No data**	No data	-	-	-
5o) Patient in in-patient wards will be assessed and have a plan in place within 8 hours of referral	**No data**	No data	-	-	-

Comment:

- Good progress has been made with a number of these areas, however, the impact of Covid-19 has also impacted on full delivery of these quality priorities.

Priority 6 – Improve the quality and timeliness of complaints responses using a more individualised approach

PATIENT EXPERIENCE:					
QP6: Improve the quality and timeliness of complaints responses using a more individualised approach.	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
a) 85% Pals responded to in 5 working days by the 31 January 2021	**56.00%**	55.00%			R
b) 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 2021	**100%**	**100%**			G
c) 100% of all complaints on 'old' process pathway to be closed by 28 Feb 2021	**100%**	**100%**			G
d) 85% of all complaints resolved within timescale by the 31 July 2021	**65.00%**	51.00%			A
e) 85% of reopened complaints resolved within 20 working days by the 30 November 2020 (Quarterly)	50.00%				R
f) 100% Complaints acknowledged within 3 days by the 31 July 2021	100.00%	100.00%			G
g) 100% complainants offered a face to face meeting during initial resolution planning by the 31 Dec 2020 [Amended]	100.00%	100.00%			G
h) 100% of all upheld complaints to have evidence of learning by the 31 October 2020	**85.00%**	83.00%			A
i) 100% formal complaint responses reviewed by Chief Nurses Office by the 31 July 2020 [Amended]	100.00%	100.00%			G
j) 50% reduction in reopened complaints by the 31 January 2021	**No data**	No data	-	-	-

Comment:

- Significant improvements have been made with respect of the Trust's complaint handling processes and performance during 2020/21.

3.2 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Single Oversight Framework (SOF) are shown as follows for 2020/21.

Indicator	Quarter 1 20/21			Quarter 2 20/21			Quarter 3 20/21			Quarter 4 20/21			20/21 Performance
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	66.7%	60.7%	53.1%	49.1%	55.7%	61.8%	65.2%	66.3%	64.3%	63.4%	63.7%	65.2%	Full Year: 61.43%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	87.9%	91.1%	89.0%	89.7%	87.8%	84.1%	75.5%	71.0%	71.9%	74.4%	73.3%	72.2%	Full Year: 80.64%
All cancers: 62-day wait for first treatment - GP Referral	69.6%	60.2%	71.2%	83.7%	67.8%	63.1%	70.8%	70.2%	67.6%	70.9%	56.3%	64.0%	Full Year: 67.9%
All cancers: 62-day wait for first treatment - Screening	33.3%	0.0%	100.0%	33.3%	0.0%	100.0%	50.0%	66.7%	42.9%	100.0%	83.3%	84.6%	Full Year: 66.7%
C.difficile: variance from plan [lapses in care] (target 21)	2	4	3	4	3	3	1	2	2	1	1	2	Full year: 28
Maximum 6-week wait for diagnostic procedures	67.3%	65.7%	51.5%	44.0%	48.2%	44.1%	40.1%	40.4%	43.8%	45.3%	38.9%	35.8%	Full Year: 46%
Venous Thromboembolism (VTE) risk assessment	87.6%	88.7%	90.1%	87.7%	85.9%	88.3%	88.2%	84.7%	75.7%	74.6%	76.5%	77.6%	Average 83.8%
Summary Hospital-level Mortality Indicator	110	107	106	105	105	106	107	107	106	*Not yet published*	*Not yet published*	*Not yet published*	Average SHMI for Apr 20 - Dec 20 period: 107

3.3 Information on staff survey report

Summary of performance – NHS staff survey

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

Timeline

Survey Window:	October/November 2020
Embargoed Findings:	Received mid-February 2021
NHSEI Publication:	11 March 2021

Key Facts

Benchmark Comparators:	128 Acute & Acute Community Trusts
Benchmark Response Rate:	45% (-2% on 2019 survey)
NLaG Response Rate:	36% (-3% on 2019 survey)
NLaG Survey Mode:	Paper and Online (2,420 completed)

Staff Survey 2020 findings

In 2020 reports on eleven themes, as below:

Figure 17: The ten themes now reported in the national staff survey

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.

Figure 18: Key themes from the staff survey

Health and Well-Being (HWB) – Statistical Significant Improvement

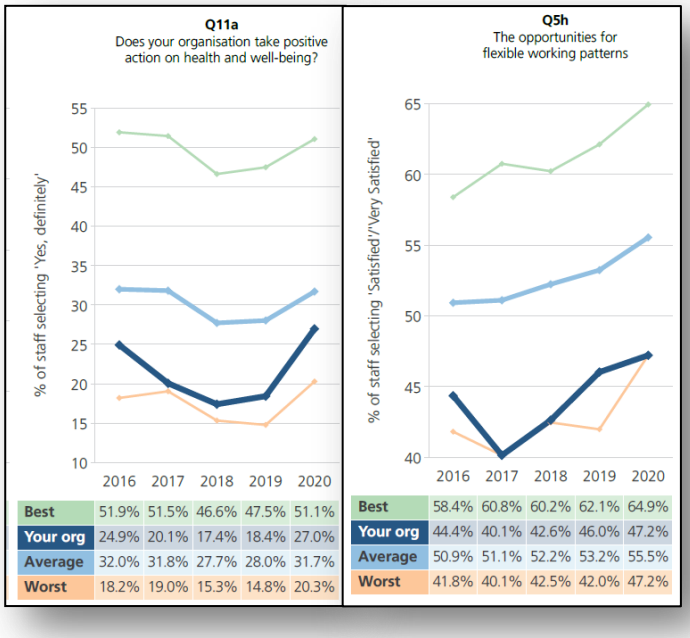


Figure 19: Focus on: Health and Well-being

From the pandemic we can evidence:

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

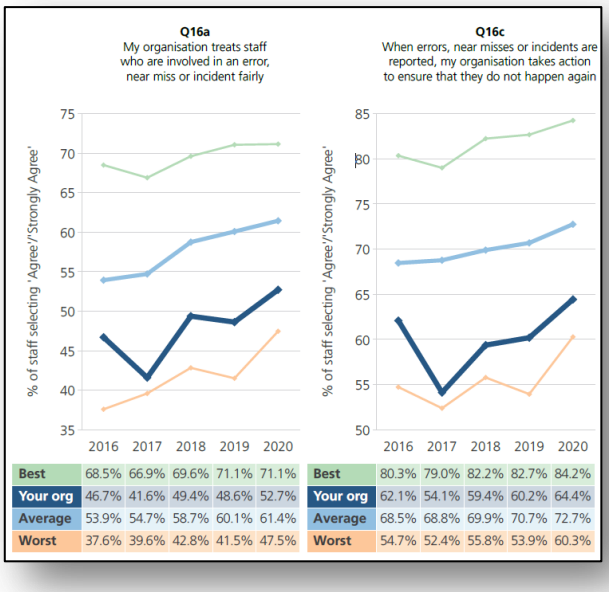
Figure 20: Focus on: Health and Well-being

Despite gains further work is still required to:

- Support staff psychological wellbeing. HWB refresh continues, and the Directorate of People and Organisational Effectiveness contracting for Critical Trauma Debriefing and Schwartz Rounds and Team Time.

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

Safety Culture (Statistical Significant Improvement)



Since 2017 significant progress has been made relating to:

- Staff perception that they will be treated fairly if they are involved in an incident/near miss (+11%)
- Reassuringly staff continue to report that NLaG takes action to address incidents and avoid them reoccurring (+10%)

Figure 21: Focus on: Safety Culture

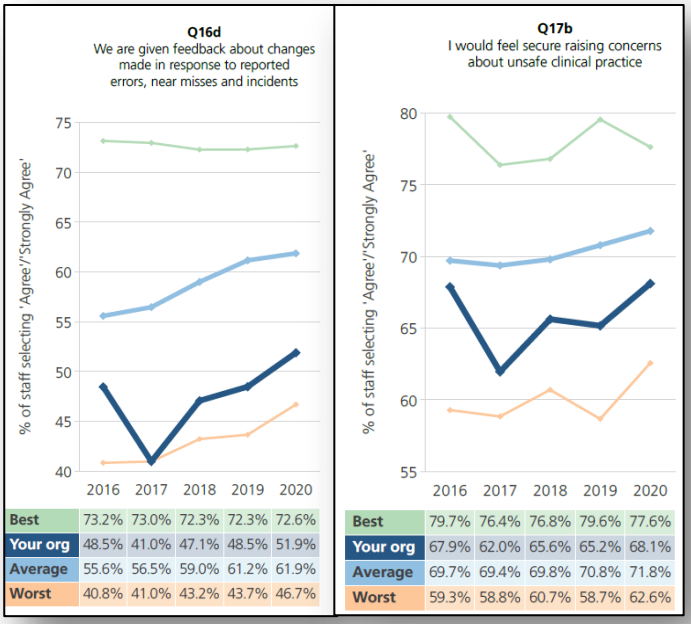


Figure 22: Focus on: Safety Culture

Since 2017 significant progress has been made relating to:

- Staffs historic perception that they did not receive feedback to DATI X (+11%)
- Reassuringly staff continue to report a growing sense they are safe and secure in reporting unsafe clinical practice/Freedom To Speak Up (+6%)

Team Working (Statistical Significant Deterioration)

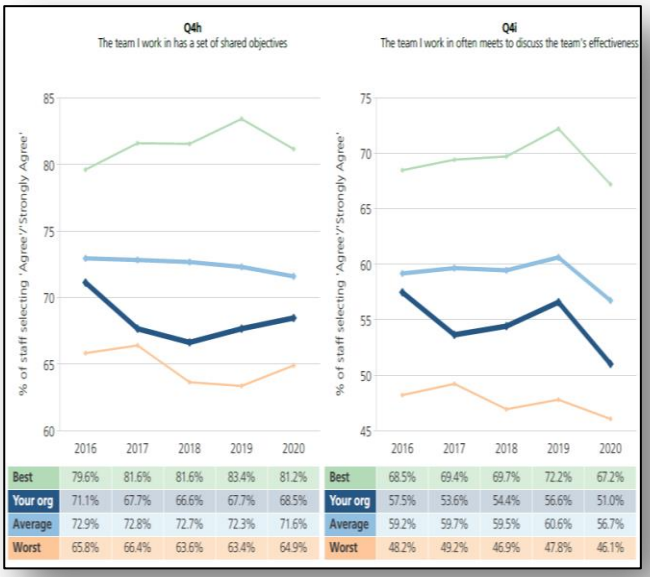
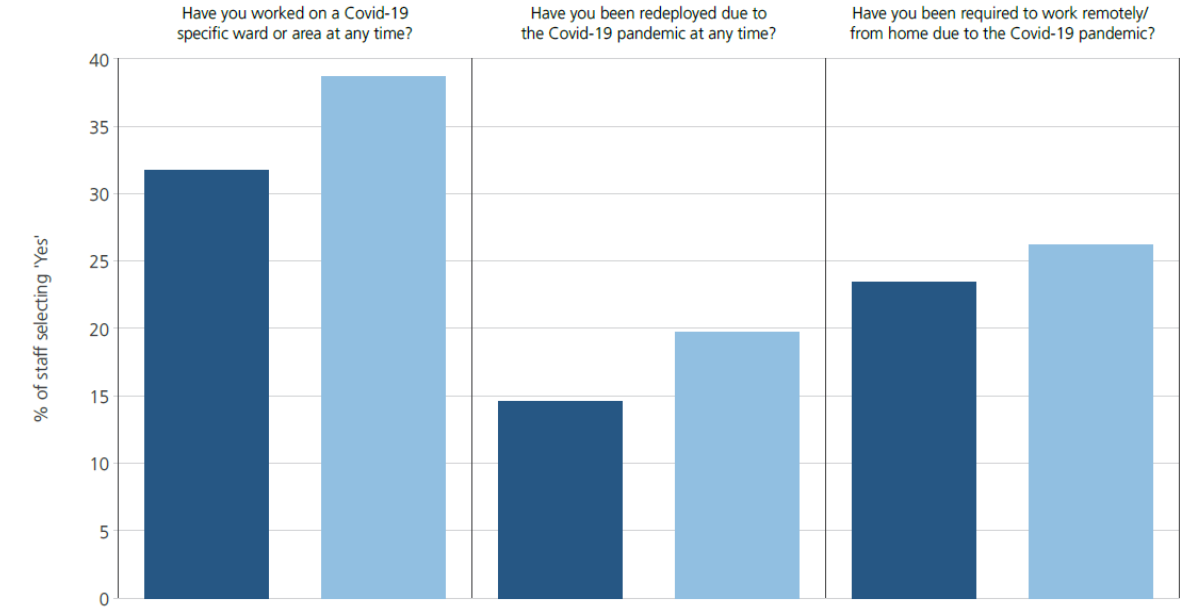


Figure 23: Focus on: Team Working

Team working theme is derived from only two questions:

- The 'statistically significant deterioration', must relate to a sharp drop in the number of team meetings taking place during 2019/20 due to the pandemic.
- This reduction in meetings has taken place across the NHS – Note the decline across all comparators. Despite this meetings must be reinstated wherever possible to recover the 2019 position.

COVID Questions (*2020 Survey only*)



	Have you worked on a Covid-19 specific ward or area at any time?	Have you been redeployed due to the Covid-19 pandemic at any time?	Have you been required to work remotely/ from home due to the Covid-19 pandemic?
Your org	31.7%	14.6%	23.4%
Average	38.7%	19.7%	26.2%
Responses	2,354	2,347	2,351

Figure 24: Focus on: Understanding impact of Covid-19

Observations:

- Staff survey results are an improvement, but the Trust acknowledges further improvement is possible.
- Whilst this is only one measure it provides the Trust with a very useful benchmark against the rest of the UK.
- Staff survey results are outputs and part of a wider cultural picture of the Trust.
- Some of the indicators within the Staff Survey will be changed (national review).
- Metrics are relevant/useful for the "soft" Workforce metrics as part of our development of Workforce metrics, i.e., engagement and health and wellbeing.

Proposed – Next Steps

- Communications to the workforce with an emphasis on improvements, i.e. safety culture and Health and Wellbeing (tie HWB in with the refresh relaunch) and acknowledgement of areas for improvement – Team Work.
- Identify any areas of immediate concern and address or continue if already underway, highlight this to staff.
- Distribution of the results to Executive Directorates and teams, to focus on any areas that need immediate attention and below Trust benchmark: Directorates with support from Human Resource Business Partners.
- Development of a Culture Steering Group – to undertake a diagnostic of "current state of play" with Trust culture (this will bring together all known evidence hard and soft, including staff survey).
- In line with the NHS People and People Strategy and Trust priorities – identify areas of improvement and build "one plan" to address (so focus on doing the right things, not just chasing staff survey results). This will include leadership development.

3.4 Information on patient survey report

Due to the Covid-19 pandemic, the National Inpatient Survey for 2020 was put on hold. As such there is no new information to report as part of the Quality Account for 2020/21.

The Trust has launched its own local inpatient programme which intended to run monthly, surveying ten patients on every adult inpatient ward. This ran successfully over two separate occasions but due to the priorities of the Covid 19 pandemic was stood down. It is planned to restart in quarter one of 2021/22.

The patient experience team actively worked on ward areas with patients during Covid 19, gathering direct feedback and intelligence. Aspects of this were received through the Patient Experience Group (in its weekly Covid 19 format) to initiate actions, monitored through its action log.

We continued to review feedback reviews shared on social media platforms, Care Opinion and through our partners at the CCG and Healthwatch.

Our Emergency Care Centres continued to send out SMS messages, despite the national pause of the Friends and Family Test and gathered hundreds of pieces of feedback, with high percentages of recommending our service.

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

Annex 1.1: Statements from Commissioners

Feedback from:
North East Lincolnshire CCG

North Lincolnshire CCG

Lincolnshire CCG

East Riding of Yorkshire CCG

Commissioners recognise this statement is written following an unprecedented year in health care, and would like to take this opportunity to thank all staff at Northern Lincolnshire and Goole NHS Foundation Trust for their hard work and dedication during the COVID19 pandemic.

Whilst the Trusts CQC rating has remained as 'Requires Improvement', Commissioners would like to acknowledge progress has been made against some elements of the CQC action plan despite the on-going pandemic.

We fully support the quality priorities identified by the Trust for the next financial year and would like to reiterate our commitment to supporting system quality improvement, recognising that improvement in these areas is likely to have not only a positive impact on patients but also on the wider systems health and care providers. It is also acknowledged that some quality priorities identified in 2020/2021 such as, sepsis and diabetes require some further embedding and improvements and have been transferred over into the 2021/2022 priorities.

We recognise the significant improvements that have been made in reducing the Summary Hospital Level Mortality Indicator (SHMI) to within the "as expected range", and the work led by the Trust in relation to improvements in End of Life Care.

Commissioners note the significant improvements that have been made in the response time for complaints and welcome the new process that has been established at the Trust with lead investigators taking responsibility for the investigations.

Through the last year the Trust have clearly invested in staff health and wellbeing and this has been reflected by the staff with the improved score seen within the staff survey regarding this. Additionally the staff survey highlighted improvements in relation to staff feeling there is a good safety culture which is positive to hear. Good quality cancer services and performance remains a commissioning priority and it is positive to see Cancer Pathways as a continued area of focus and the establishment of the Humber Cancer Board is a significant step forward, recognising the impact the COVID-19 pandemic has had on this.

We acknowledge the challenges experienced by the Trust in relation to delivery of some NHS Constitution Targets such as waiting times and A&E performance which have been exacerbated by the COVID-19 pandemic both locally and nationally. Commissioners continue to monitor the delivery of these closely and look forward to working with the Trust over the next year in achieving these.

Commissioners would like to take this opportunity to reiterate our commitment to working with and supporting the Trust's continued improvement journey.

Finally, we confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by Northern Lincolnshire & Goole Foundation Trust and that the data and information contained in the report is accurate.

Annex 1.2: Statement from Healthwatch organisations

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

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

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

The summary clearly sets out what you have achieved during 2020/21 against your 6 priority areas and what still needs working on, in the forth coming year. Here at Healthwatch we are aware that the COVID-19 Pandemic has had a major impact on the NHS and what you hoped to achieve, especially the waiting lists, but we are aware that a recovery plan is in place to achieve the position that you hoped for at the end of 2020/21 and that these priorities are to be carried forward into 2021/22.

Even though during 2020/21 the National Inpatient Survey was put on hold due to COVID-19, your patient experience team continued to work with patients on the ward and collect feedback directly from patients on their experiences of their hospital stay. This feedback has resulted in actions that your Trust has taken on board and for which you are monitoring through your action logs. Patient experiences are important for your NHS Trust to learn from and Healthwatch would like to commend you on gathering feedback from patients, even though there was a national pause on the Friends and Family Test, you continued to send out SMS messages to encourage people to share feedback with yourselves. This shows a commitment to the importance of patient feedback to yourselves and to making improvements.

Improvements have been made within the time complaints are open for and this is partly due to you adopting new processes within the Trust. The Trust has seen a reduction in the elective length of stay for patients, we would like to highlight this as a good piece of work. This is not just 'Good Practice' as far as the patient is concerned but enables the hospitals to treat more patients as the flow of patients improves. Improvements have been made in the management of diabetes and we are glad to hear there have been zero insulin errors resulting in significant harm.

Cancer targets are still a priority area for yourselves, work with community partners should continue to ensure these targets are met over the coming year. The Humber Cancer Board will help improve the current position to enable patients to access diagnostics and treatment faster. We are aware this is an issue across the Humber and it is a positive step to be part of a network that will improve pathways for patients.

The Quality Priorities that the Trust have set out for 2021/22 are clearly understandable and how you intend to measure your progress against the targets. Alongside this, the data presented is easily understandable and the use of RAG rating (colour coding) your performance measures gives an instant visual indication of your current position.

During the COVID-19 Pandemic you have adapted your services to accommodate the new regulations and your staff have maintained the level of service expected of the NHS and continued to work under extreme circumstances. A priority for yourselves has been to ensure

that your staff have shielded and isolated, when they needed to and here at Healthwatch we are aware that this has put pressure on you but the well-being of staff was prioritised.
We would like to thank all of your staff for the hard work they have put in during these unprecedented times.

Feedback from:
Healthwatch Lincolnshire

Summary
Healthwatch Lincolnshire would like to thank North Lincolnshire and Goole Trust for the opportunity to comment on their most recent Quality Account for 2020/21.

Healthwatch Lincolnshire acknowledge the work Northern Lincolnshire and Goole Trust have done over the past 12 months to improve performance and in particular the role they have played in supporting the NHS and our patients during the COVID-19 pandemic. On behalf of patients, carers, and service users, we would like to thank Northern Lincolnshire and Goole Trust for their hard work and dedication in achieving this.

We welcome opportunities like this to review and be part of commentary on the delivery of services. During the last 12 months, Healthwatch Lincolnshire have received very little feedback in relation to Northern Lincolnshire and Goole Trust. We would welcome the opportunity to work more closely with Northern Lincolnshire and Goole Trust to improve the level of engagement and feedback we hear from patients using the services.

Commentary relating to the previous year's Quality Accounts
Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups. As a Healthwatch over the last 12 month we have continually heard from patients about long waiting lists, despite this not being a set priority for the quality account 2021-22 we do acknowledge that this will be a focus for the 2021-22 year as part of the trusts wider organisational priorities, to reduce long waiters significantly to pre-covid levels. This is one of patient's biggest concerns and we advocate better communication with patients and their families in relation to waiting times and the trusts recovery plan.

Priorities and challenges for the forthcoming year
We welcome the various work streams and priorities for 2022/22. As Healthwatch Lincolnshire we encourage the promotion of the patient voice and experience in delivery of your services, we would also be an advocate to looking at not just the patient voice but that also of the carer,
Finally, we look forward to continued engagement with the Trust in the coming year.

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

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel:

North Lincolnshire Council's Health Scrutiny Panel welcomes the opportunity to comment as part of Northern Lincolnshire and Goole NHS Foundation Trust's (NLG) Quality Account. NLG are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over many years. Our day-to-day contact with the Trust is always handled in a timely, professional manner, and NLG representatives have always expressed a willingness to provide information and assist with specific issues. The panel would wish to pass on our sincere appreciation for this.

Naturally, we echo the Chief Executive's comments in his foreword about the unprecedented challenges that the Covid-19 pandemic has brought to the staff at NLG, his concerns for their

health and wellbeing, and the ongoing and planned work to support them. We very much welcome these statements, and would wish to put on record our sincere appreciation for all of the staff's invaluable, selfless and humbling contributions to their patients' wellbeing.

We acknowledge that these unprecedented circumstances have led to a marked deterioration in many areas of the Trust's performance. We are aware of the recovery efforts that are underway, and note the challenging targets the Trust has set itself around 52+ week waiters, cancer care, and other elective work for the coming twelve months.

Due to the circumstances, we intend to provide a limited response in 2020/21, with an anticipated much fuller reply in 2021/22.

We have long held concerns around a number of specialties at NLG, and about the corporate ability to improve as a Trust. However, we have detected signs of progress in recent years, as identified at the last CQC inspection, and it was hugely disappointing that the pandemic necessarily impacted upon that trajectory. Despite this, there are areas that have continued to improve, including the SHMI mortality rates and some of the key NHS survey results, which have concerned the scrutiny panel for more than a decade. We do not intend to comment on other indicators, due to the context of the pandemic.

The panel intends to meet regularly throughout the coming 12 months with Trust representatives, commissioners, and other interested parties, to discuss in detail both the clinical recovery, and how services are likely to be stabilised, then improved, in the coming years. We are naturally keen to represent the views of our residents in these discussions to ensure they meet both the clinical, and the social, needs of patients. We particularly look forward to discussions with providers and commissioners alike, to ensure that the delivery of core services remains within the North Lincolnshire area, in line with the stated aim of North Lincolnshire CCG, unless there is a clear, unequivocal, and publicly supported rationale not to.

It would be remiss of us not to note and reflect upon the many deaths of patients in the last year where Covid-19 was a causal or contributing factor. Each of these people's lives should be celebrated and remembered, and we welcome the steps that the Trust, families and loved ones, and others are taking to ensure this occurs.

Finally, on work-related issues, Trust representatives have been very open to work with the panel and other scrutiny colleagues for many years, most recently on oncology and the Humber Acute Services Review. We believe that this is clear evidence that the Trust has a genuine desire to improve services through working more co-operatively with partners. Finally, any day-to-day queries have always resulted in a swift and comprehensive response, and we thank the Trust for this.

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

The North East Lincolnshire Council Health and Adult Social Care Scrutiny Panel has continued to observe the progress being made by NLaG through regular reports and attendance at panel meetings. The panel appreciated and noted the impact of the Covid-19 pandemic on the Trust's ability to deliver against all six quality priorities.

Concerns were raised over the Trust's waiting list time scales and the panel sought assurance from the trust that whilst this had been adversely impacted on by the pandemic the trusts focus on recovery was the number one priority. The panel was reassured that the trust had a good handle on the safety element and prioritisation of patients and that recovery had started and good progress was being made.

It was positive for the panel to hear that the hospital flow and discharge improvement work had reduced the length of unnecessary stay within the hospital that was freeing up space on the wards and enabled patients to return home where safe to do so. The panel felt it was extremely important because the best outcomes for patients were often as a result of recuperating in their own homes.

The panel welcomed and the five priorities for 2021/22 set out within the Quality Account and that the improvements made from the CQC inspection feedback were embedded and making a difference for patients and staff whilst remaining cautious that as winter approached the pressure on services would increase.

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire:

The Health Scrutiny Committee for Lincolnshire is grateful to Northern Lincolnshire and Goole NHS Foundation Trust for sharing its draft quality account for 2020/21 and recognises the Trust's continued provision of acute hospital services to residents in the north of the administrative county of Lincolnshire, in particular to those residents in Louth, Mablethorpe and the surrounding areas.

The Committee would like to record its gratitude for all the staff at the Trust for continuing to respond to the Covid-19 pandemic and at the same time maintaining and restoring other health care services during the last year.

While the Committee is focusing on the detail of the quality accounts of two other local NHS trusts for 2020/21, it is pleased to note the five priorities for improvement for 2021/22 and the Trust's arrangements to monitor progress with these priorities.

The Committee recognises that engagement between the Trust and health overview and scrutiny committees is usually focused on those committees in North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. However, there may be opportunities at a later date for engagement to take place between the Health Scrutiny Committee for Lincolnshire and the Trust.

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

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

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is pleased to have the opportunity to comment on the 2020/21 Quality Account which demonstrates that significant quality improvements have been achieved despite the extraordinary challenges posed by the coronavirus pandemic. We would like to place on record our appreciation of the incredible commitment made by Trust staff to the delivery of high quality patient care in the most difficult of circumstances.

Throughout the year governors have continued to prioritise seeking robust assurance regarding the quality and safety of services provided to patients, specifically in the context of our duty to hold Non Executive Directors (NEDs) to account for the performance of the Trust Board. We receive regular reports at Council of Governors meetings on progress against the Trust's quality priorities, we are represented in an observer capacity at meetings of the Quality & Safety

Committee and the NED committee chair makes himself available to answer searching questions at Governor Assurance Group meetings.

Although the Trust remains in quality special measures, governors are greatly encouraged by the progress that has been achieved in addressing the 'must do' and 'should do' recommendations made by the Care Quality Commission following its 2019 inspection. Perhaps most pleasing has been the consistent downward trajectory in hospital mortality which was one of the 2020/21 quality priorities. Despite coronavirus constraints it is good to see that progress has also been made against most of the other priorities. Inevitably the pandemic has severely impacted the length of waiting lists, but governors are reassured by the robust risk stratification measures that have been put in place to ensure that treatment delays do not result in patient harm.

The Council of Governors supports the five quality priorities agreed for 2021/22. Governors were consulted in the process of determining these priorities and we were pleased that the Trust also sought service user feedback in identifying a shortlist of potential quality improvement areas. Governors will continue to support the Trust as 'critical friends' in delivering quality improvements over the coming year during the course of which we hope that the tremendous efforts of Trust staff will be rewarded by the lifting of quality special measures.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 2020/21.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2020/21 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2020 to March 2021
    - Papers relating to quality reported to the board over the period April 2020 to March 2021
    - Feedback from commissioners dated 28 June 2021
    - Feedback from governors dated 30 June 2021
    - Feedback from Local Healthwatch organisations dated 02 July and 14 July 2021
    - Feedback from Overview and Scrutiny Committees dated 24 June; 01 July and 16 July 2021
    - The trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2021
    - Latest national inpatient survey 2019
    - Latest national staff survey 2021
    - The head of internal audit's annual opinion of the trust's control environment dated May 2021
    - CQC inspection report dated 7 February 2020.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

…….. Date …… Chair

…….. Date …… Chief Executive

Annex 3: Independent auditor's report to the Board of Governors on the Annual Quality Report

Due to the Covid-19 pandemic, no independent auditor's report has been required as part of the 2020/21 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

Annex 4: Glossary

CQUIN or Commissioning for Quality & Innovation Framework: The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Mortality Data: - How is it measured?

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

NEWS stands for the National Early Warning Score which is a nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 5: Mandatory Performance Indicator Definitions

Due to the Covid-19 pandemic, no external audit of indicators included in the report has been required as part of the 2020/21 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

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NLG(21)157

DATE OF MEETING	03 August 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
BACKGROUND DOCUMENT (if any)	Not Applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Not Applicable
EXECUTIVE SUMMARY	The people report outlines highlights, low lights and risks in month. The risks are aligned to the People Risk Register and are consistently triangulated. Consultation has been launched with the People Directorate and is currently on-going.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Actions and outcomes outlined in this paper are triangulated with the BAF Strategic Objective 2 – To Be A Good Employer				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

People Directorate July 2021

Highlights	Lowlights	Risks
Workforce Committee Updates on delivery against the NLAG's People Strategy implementation plan and NHS People Plan have been produced and tabled at the Committee which outlines achievements against objectives and any escalation required. The BAF and Integrated Performance updates are also tabled at the Committee for oversight and assurance. **People Directorate Restructure** The consultation for the Directorate went live on Tuesday 6th July and is planned to close on the 17th August. A pre-engagement event has been held as well as two formal launch events with all staff invited from the Directorate and Unions. A number of 1:1's continue to be held with staff from the Directorate. The consultation paper has also been issued on the Trust intranet page and comments invited. **NHS People Plan** Work continues on the People Performance Framework development so the Trust can demonstrate how it is delivering against the specific targets through the ICS framework. We are on track with the key deliverables. **WORKFORCE:** Following recent Government guidelines a new on line tool has been developed to assist staff that have been 'pinged' by Track and Trace. This enables a review of their criteria to establish if they are exempt and can return to work or whether they should remain isolating. It is hoped that this will help with staffing capacity for front line staff. **AFC Panel Process** Progress has been made on the review of the AfC panel process and training has taken place. There is a need to strengthen resource from management, HR and trade unions.	**Travel and Sourcing of international recruits** Covid continues to make international recruitment difficult due to the closure of borders. Travel restrictions will make international travel complicated for staff wanting to travel abroad on holidays. The Trust continues to update guidance for staff and managers. Turnover has gradually deteriorated over time since the start of the pandemic in April 2020 to present**.** The latest turnover data point is 9.6% which is just over the Trust target of 9.4% which indicates that the turnover position is not improving or seeing signs of recovery in relation to pre-pandemic levels of turnover of 9%.	**As per the People Risk Register** **Staff Personnel Records –** There is no central system for the management of staff personnel files meaning lots of different systems exist at a divisional level – potential to not be compliant with GDPR prompting the risk of potential interest from the ICO. Work continues on the business case for consideration at TMB. **Recruitment -** Failure to recruit to clinical hard to fill posts could result in an increased vacancy rate with increased agency cost and compromised service delivery

Vacancy Position
The overall Trust vacancy position improved slightly by 8.83WTE with the rate being 9.5%. The position for medics improved slightly by 0.81WTE (currently at 15.8%) and registered nurse vacancies increased by 4.23WTE (currently at 9.7%).
Work continues on the real-time Operational Dashboard. This dashboard is being designed to provide the user with intelligence around the profile of their area's workforce, this will include PADR, Mandatory Training, Turnover, Absences and Vacancy data altogether in a dashboard view.

Sickness Absence - Over the last 3 months the sickness rates have slowly increased to 4.94%as of May 2021.

The main reason for absence in terms of **overall days lost** is anxiety/ stress/ depression/ other psychiatric illnesses. The Trust has now employed a new Health and Wellbeing business partner to specifically drive the Health and Wellbeing agenda due to commence 31st August.

Daily monitoring has recommenced with ICC and Infection Control lead to monitor specifically covid absences. Staff who are shielding due to Post Travel, Household Member with Symptoms and Track and Trace, impacts staffing levels as the special leave type is starting to increase. High portion of NLAG staff are double vaccinated ,the end to test and trace self-isolation from the 16th August, those employees that have come to contact with a positive case of coronavirus will be except from quarantining at home for up to 10 days

Overall Nursing and Midwifery and Additional Clinical Services staffing groups had the highest levels of sickness within the period of May 2021 and have continued to have the highest levels since January 2021.

Trade Union Partnership
Work continues with our Union colleagues. A report will be submitted to TMB re proposals re: Facility Time. It is hoped that this will help assist moving forward with a number of key pieces of work and an engagement day with Unions and HR with support from ACAS is currently being planned for September/October. A workshop was held with HR/Unions to review the current Disciplinary Policy/Procedure which was very productive and helps move to a 'Just & Learning Culture'. First draft procedure to be shared with Workforce Committee August 21.

COVID Booster/FLU Campaign – Flu working group and COVID group have met and agreed next steps in terms of running both campaigns together until further guidance is issued. Business case to be prepared for TMB to outline proposal and resources required.

WRES/DES Data – Data is currently being collated and will be presented to the Workforce Committee for approval prior to the submission date at the end of August 2021. **CULTURE:** **OD Support** - The Equality and Diversity Networks have been relaunched with virtual drop in sessions. Moving forward terms of reference and nominated Chair's to be agreed with dates to be placed in the diary. Insights Discovery Model to promote self-awareness and team effectiveness has recommenced where possible. Review of champion roles within the Trust to be reviewed linked to relaunch of Pride and Respect and what that is going to look like. **Risk Assessments** - Work continues with risk assessments and are now part of the on-boarding process for new starters and are managed by recruitment and work. Current continues to finalise those outstanding **7693** out of which we have a total of **7224** completed RA's and **418**. Of the 418 outstanding 50% of these are for bank staff. **Current EAP** (Vivup) has been renewed supported by COVID funding as well as additional time of our contracted Doctor to help with delays for an appointment. **Culture Task and Finish Group** – this will formal launch in August/September, but work continues to be reviewed of the work streams on culture will take place led by the new AD – Culture and Leadership. The People Pulse Survey went live in June and will be run on a quarterly basis to support the yearly staff survey. **Thank you and Additional Day's Leave** - A letter to all staff awarding an extra day's annual leave and saying 'Thank you' was sent on behalf of Dr Peter Reading and a prize draw (£10k prizes) supported by funding by Health Tree Foundation was undertaken. **LEADERSHIP:** **Mandatory training and appraisal –**Core mandatory training is currently 91% for the Trust, role specific 81% and PADR 81%, there has a been a steady increase in compliance. The training team continue to work closely with HRBPS and divisions to ensure data is correct and put in place support to target low compliance. Focussed work on areas of non-compliance continues. This was discussed at the Workforce Committee.	**Long Service Awards** Continues to be delayed due to the pandemic. **Staffing** Low number of staff in culture team Culture due to turnover of staff and lag into recruitment. This is impacting on our ability to support divisions with OD intervention and take forward some of the plans outlined in our People Strategy and NHS Plan, Recruitment to address are underway. Extensions to current temporary staffing resources have been agreed to assist with the shortfall. Unable to recruit to vacant posts until consultation closes. **Annual Appraisal** – not complaint with Trust target- currently 81% against a target of 85%.	**Culture** - There is a risk that organisational culture adversely affects the Trust's ability to continuously focus on quality improvement adversely affecting patient care and the Trust's reputation and relationship with regulatory bodies. **Mandatory Training and Appraisal** – Due to the current capacity issues staff are not released for training, and some training has been stood down and therefore training compliance will not

Leadership development is in place for clinical leads and new consultants. This is being well received by the participants. A Leadership Development Programme for all leaders will be scoped out this year **Executive Development** continues in July and 360 feed-back for the team is underway.	**Mandatory Training** –. Currently achieving 91% against a target of 90% for core mandatory training and 81% against a target of 85%for role specific mandatory training- remains on People risk register until consistently achieving	progress.

NLG(21)158

DATE OF MEETING	03 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Highlight Report and Board Challenge
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The Committee received and discussed the Annual Organisation Audit - Annual Medical Workforce Revalidation Report. The Committee RECOMMENDS that the Board accepts the paper and endorses the Accountable Officer signing the Statement of Compliance. No other matters were highlighted for escalation to the Board.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	The Committee reviewed the revised Board Assurance Framework and felt that the likelihood should change from 4 to 3 and the risk rating for strategic objective 2, to be a good employer, could be reduced from 20 to 15. However, given the wider implications for workforce felt that this would be strengthened by a discussion with the wider board.

	The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients. The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
			✓	✓	

Northern Lincolnshire and Goole NHS Foundation Trust

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	03 August 2021
Report From:	Michael Whitworth, NED & Chair of Workforce Committee
Highlight Report: Workforce Committee – July 2021	

1 Introduction

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

2 Items Highlighted by the Committee for the Attention of the Board

2.1 The Committee received and discussed the Annual Organisation Audit – Annual Medical Workforce Revalidation Report.

2.1.1 The Committee RECOMMENDS that the Board accepts the paper and endorses the Accountable Officer signing the Statement of Compliance.

2.2 No other matters were highlighted for escalation to the Board.

3 Items for Committee Ratification and Assurance

3.1 The Committee signed of the revised Annual Work Plan.

3.2 The Committee had a deep dive session on workforce (Recruitment. Workforce planning and HR Business Partnering) and was assured of the progress being made.

3.3 Updates were given on the Workforce Race Equality Standards Annual Report and Disability Equality Standards Annual Report. These will be scrutinised and endorsed by the Committee before they are submitted.

3.4 The quarter 1 Freedom to Speak Up Guardian Report was received and discussed. Some concerns were raised in relation to safety concerns not being raised through the assured organisation processes, and the Guardian being used inappropriately. However, assurance was gained that the Freedom To Speak Up process is also actively educating and encouraging staff to report issues and incidents through the appropriate mechanisms.

3.4.1 The increasing number of issues being raised openly with the Guardian was welcomed and the Guardian was commended on her good work.

Confirm or Challenge of the Board Assurance Framework:
The Committee reviewed the revised Board Assurance Framework and felt that the likelihood should change from 4 to 3 and the risk rating for strategic objective 2 could be reduced from 20 to 15. However, given the wider implications for workforce felt that this would be strengthened by a discussion with the wider board.
Action Required by the Trust Board:
The Board is asked to receive and note the content of this highlight report. **The Board is asked to endorse the Accountable Officer signing the Statement of Compliance for the Annual Organisation Audit – Medical Workforce Revalidation.**

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NLG(21)159

DATE OF MEETING	03 August 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 Q1 (April to June 2021)
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee – 27 July 2021
EXECUTIVE SUMMARY	The FTSU Guardian Q1 2021 Report gives an update from the report, an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by the Trust's FTSU Guardian

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	✓
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	This report relates to the following risks within the BAF: 2 - To be a Good Employer, and 5 - To Provide Good Leadership				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
				✓	

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q – April – June 2021

Liz Houchin
14 July 2021

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q1 2021-22 (which covers the period April –June 2021). Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

This paper satisfies the Trust Strategic Objective of 'Being a good employer', and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

3. Introduction / Background

3.1 The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement (updated July 2019). The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

4. Assessment of FTSU Concerns Raised

4.1 In Q1 2021-22 the number of concerns received were 33.

- No concerns were raised anonymously in Q1.

- In 2020-21 143 cases were raised to the Trust Guardian, this compares to 72 for the peer group with a national median of 70.

- In 2020-21 36 concerns involved an element of patient safety. This puts the Trust in the top quartile nationally, the peer figure being 9 and the national median being 12

- In 2020-21 30 concerns involved an element of bullying and harassment which puts the Trust in the third quartile nationally, the peer figure being 11 and the national median being 18

4.2 The Q1 figure of 33 is slightly below the quarterly average for 2020-21 but is higher than 2020 Q1.

4.3 The main themes raised were around behaviours, process and worker safety. Worker safety is a new category and includes whether staff feel psychologically safe. The high number of concerns relating to behaviours may still 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 Director of People/Chief Executive Officer for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data ie HR information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified and interventions put in place where needed.

Q4. 2020 21 (January March 2021)			**Q1. 2021 2022 (April June 2021)**
Concerns	**35**		**33**
Themes	Behaviour / relationships	10	21
	Bullying & Harassment	5	9
	Culture	2	2
	Leadership	0	0
	Patient Safety	9	7
	Process/Systems	12	10
	Personal Grievance	0	1
	Worker Safety	N/A	10
	Staff Safety	10	4
How Raised	Openly	13	12
	Confidentially	22	21

	Anonymously	0	0
Perceived detriment		0	1

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

Report Breakdown by Division and Role.

Q4. 2020 2021 (January March 2021)			Q1. 2021 2022 (April June 2021)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor	2 x Medicine 2 x S&CC 1 x Med Director	5	Doctor	2 x Medicine 1 x S&CC 1 x Med Director	4
Nurse	3 x Medicine 2 x S&CC 1x C&T 2 x W&C 1 x CSS	9	Nurse	6 x Medicine 2 x S&CC 4 x W&C 2 x Chief Nurse 1 x CSS	15
HCA	1 x Medicine 1 x C&T 1 x W&C	3	HCA	2 x Medicine 1 x S&CC 1 x C&T	4
Midwife	W&C	2	Midwife	W&C	1

Admin	1 x Medicine 3 x C&T 1 x Medical Director 2 x CSS 1 x IT Digital	9	Admin	2 x Medicine 1 x Medical Director 2 x CSS 1 x Corporate	6
AHP	1 x S&CC 3 x C&T 1 x CSS	5	AHP		0
Other	1 x Medicine	1	Other	CSS x 2 C&T x 1	3
	Facilities	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 staffs that have spoken up and has been predominantly positive.

Quarter 2021 22	Feedback received	Would you speak up again? Yes
Q1	9	8
Q2		
Q3		
Q4		

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

Liz was very kind, approachable. Listened to the concerns raised. Did not judge. Liz was aware that there are always more than one side to a story so it was good to have an impartial member of staff to talk to. I received regular updates. I am awaiting a response from the senior team.

I would definitely approach Liz again. The issues were taken to the senior team in a timely manner and have been taken seriously. I am grateful to have this service.

I feel approaching the Guardian has subsequently led to a fracture in my relationship with my line manager.

4.7 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

FTSU Guardian was contacted by some therapists about patient care when an anxious patient didn't want to stay in hospital and discharged themselves against medical advice. Therapists were told by colleagues that there would be no further appointments and no discharge summary sent to the GP. FTSU Guardian contacted the Medical Director for guidance as to whether this was a Trust policy and if there is flexibility around offering treatment in a different way ie as a day case, outpatient appointments etc. Medical Director shared the Discharge policy and asked that the divisional management team were involved to ensure lessons were learnt. Team learning followed with the policy being shared and discussed. Patient experience and safety will have improved as a result.

5. Regional and National Information and Data

5.1 National update

The National Guardian's Office reported 20,388 cases were brought to Guardians in 2020-21; this is an increase of almost 3500 from the previous year. There are now nearly 700 Guardians in the NHS and independent Sector

.

Henrietta Hughes – National Guardian for the NHS is leaving in September, the Care Quality Commission will be overseeing the recruitment of a new National Guardian.

The NGO have published a draft 5 year strategy for comments, the FTSU Guardian has sent comments to the Regional Chair. The final Strategy has not been published to date.

The NGO will be publishing their next case review in the coming weeks.

The third module in the HEE/NGO FTSU training package will be released in September/October and is called 'Follow Up' and will be for senior leaders.

Q1 data for 2021-22 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 discussions around the use of champions and ambassadors within organisations and incorporating the NHS 'civility and respect' toolkit into the workplace. The regional network has now developed a 'gap analysis' tool for NGO case reviews.

6. Proactive work of the FTSUG during Q1

- Monthly 1 to 1's with Director of People/Chief Executive Officer
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Health & Wellbeing Steering Group
- Attendance at Doctor's Engagement huddle
- Walk Round at GDH to increase staff awareness of the role

Future Plans

- Work to define the future work of combined Champions to include Pride and Respect, FTSU and Health and Wellbeing is ongoing by the People Directorate
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian
- Work with the Health & Wellbeing Guardian
- Attendance at all network meetings

7. Conclusion

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

8. Recommendations

The Committee is asked to:

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

Compiled By: Liz Houchin, Date: 14 July 2021

NLG(21)160

DATE OF MEETING	3 August 2021
REPORT FOR	**Trust Board of Directors**
REPORT FROM	Lee Bond, Chief Financial Officer
CONTACT OFFICERS	Brian Shipley, Deputy Director of Finance Matt Clements, Assistant Director of Finance – Management Accounts
SUBJECT	**Executive Report – Finance – M03**
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee
EXECUTIVE SUMMARY	This report highlights the reported financial position of Month 03 of the 2021/22 reporting period

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
		✓		

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance	✓	**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Risk 6				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
			✓		✓

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Finance Report Month 3

June – 2021/22

Executive Summary Month 3 2021/22

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The Trust reported a £0.10m deficit for the month of June, £0.20m underspent against a planned deficit of £0.30m. The year-to-date position is now a £0.42m surplus, £0.24m better than plan.

Income was £12.67m below plan in month.

- This includes a £10.48m adverse donated income variance which is excluded from NHSE&I financial targets, and is due to the re-profiling of EPC capital funding grants. ERF income was £1.65m below plan primarily due to low elective/day case activity . Other income was £0.58m below plan primarily as a result of education income, which was below plan due to CPD timing.

- Elective Recovery Funding (ERF) – the trust has achieved an estimated £3.28m ERF income year-to-date. Further validation of the activity will need to be undertaken and the Trust achievement of ERF income is dependant on the overall ICS position with the baseline and gateway conditions still to be agreed by NHSE&I. NHSE&I have recently communicated that from July the base activity thresholds will increase from 85% to 95% of 19-20 activity. This will have a significant adverse impact on future expected incremental income for ERF activity, which will mean the trust now has to achieve 95% productivity (compared to 19-20) within existing budget, otherwise additional ERF capacity costs could potentially exceed the ERF income.

Pay was £0.57m overspent in month.

- Medical staff was £0.56m overspent in month. This was partly due to Anaesthetic Middle Grade rota delays, and due to agency premiums for covering vacancies predominantly in Urology, ENT and T&O. The overspend was also as a result of additional waiting list expenditure including Ophthalmology risk stratification activity.
- Nursing was £0.09m overspent in month due to supernumerary overspends following international recruitment partially offset through continued underspends in Midwifery.
- Other Pay variances include £0.03m Flowers costs, for which the Trust has not been reimbursed (£0.09m year-to-date).

Non Pay was £2.83m underspent in month, mainly because of slippage in planned Independent Sector additional capacity and the consumables costs associated with it offsetting the loss of income as above.

Post EBITDA items were £0.1m underspent in month due to reduced PDC as a result of capital programme delays.

Income & Expenditure to 30th June 2021

Income & Expenditure	Annual Plan to 31st March 2022 £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Income	344,241	28,687	28,766	79	86,060	86,067	7
ERF Income	9,761	1,676	29	(1,647)	5,736	3,283	(2,453)
Block Top Up	59,816	4,985	4,984	(0)	14,954	14,953	(1)
Covid Inside Envelope Block	13,524	1,127	1,127	0	3,381	3,381	0
Covid Outside the Envelope	690	115	77	(38)	345	468	123
Other Income	37,182	3,098	2,515	(583)	9,295	9,035	(260)
Donated Income	41,638	10,853	369	(10,484)	16,578	2,323	(14,255)
Total Operating Income	**506,852**	**50,541**	**37,868**	**(12,673)**	**136,349**	**119,510**	**(16,839)**
Clinical Pay	(247,987)	(20,903)	(21,446)	(543)	(63,090)	(62,715)	375
Other Pay	(67,795)	(5,623)	(5,653)	(29)	(16,872)	(16,865)	7
Total Pay	**(315,783)**	**(26,526)**	**(27,099)**	**(573)**	**(79,962)**	**(79,580)**	**382**
Clinical Non Pay	(68,025)	(6,077)	(6,216)	(140)	(17,667)	(16,893)	774
Other Non Pay	(68,375)	(6,062)	(6,352)	(290)	(18,061)	(16,771)	1,290
ERF Expenditure			3,254	3,254		0	0
Total Non Pay	**(136,400)**	**(12,139)**	**(9,314)**	**2,825**	**(35,728)**	**(33,665)**	**2,063**
Operating Expenditure	**(452,183)**	**(38,665)**	**(36,413)**	**2,252**	**(115,690)**	**(113,245)**	**2,445**
EBITDA	**54,669**	**11,876**	**1,455**	**(10,421)**	**20,659**	**6,265**	**(14,394)**
Depreciation	(12,539)	(948)	(918)	30	(2,785)	(2,710)	75
Interest Expenses & Other Costs	(186)	(16)	(29)	(13)	(47)	(59)	(13)
Dividend	(4,939)	(382)	(298)	84	(1,134)	(926)	208
Fixed Asset Impairments and Revaluations	0	0	0	0	0	0	0
Total Post EBITDA Items	**(17,664)**	**(1,346)**	**(1,245)**	**101**	**(3,965)**	**(3,695)**	**269**
Remove Capital Donated I&E Impact	(41,374)	(10,831)	(312)	10,520	(16,514)	(2,151)	14,363
Remove Impairments (allowable)	0	0	0	0	0	0	0
Remove net impact of consumables DHSC	0	0	0	0	0	0	0
I&E Surplus / (Deficit)	**(4,368)**	**(302)**	**(102)**	**200**	**181**	**419**	**238**

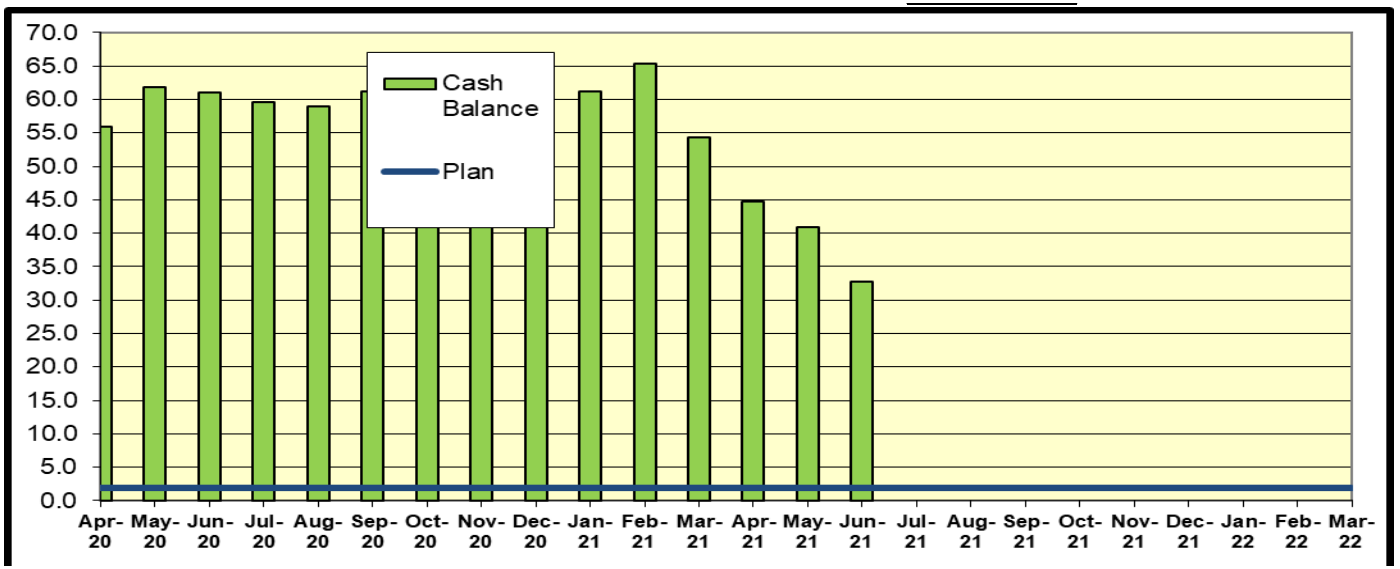
COVID-19 Expenditure

Expenditure Category	Year-to-date 20-21		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	678	0	678
Additional Sick pay at full pay for all staff policy - full pay for COVID-related staff absence (for those not normally entitled to sick pay)	0	0	0
Existing workforce additional shifts to meet increased demand	1,765	0	1,765
Backfill for higher sickness absence	743	0	743
Total Testing - In Envelope	136	21	157
PPE associated costs	0	3	3
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	5	5
Remote management of patients	5	0	5
Segregation of patient pathways	0	19	19
Decontamination	0	42	42
After care and support costs (community, mental health, primary care)	0	19	19
Outside Envelope COVID-19 Total Testing - Reimbursed	0	264	264
Outside Envelope COVID-19 - Vaccination Programme - Provider/ Hospital hubs	66	1	67
Outside Envelope COVID-19 - Deployment of final year student nurses	137	0	137
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	79,580	33,665	113,245
COVID-19 % of Total Trust Operating Expenditure	4.4%	1.1%	2.4%

Cash

The cash balance at 30th June was £32.69m, an in-month decrease of £8.21m.

	£m	£m
Cash Balance as at 30th June		**32.69**
Commitments:		
WebV bank account	0.02	
Income received in advance	1.92	
Capital creditors	3.15	
Capital loan repayments	0.17	
June PAYE/NI/Pension	10.82	
Public Dividend Capital	0.93	
Annual leave income	4.49	
Invoices due for payment not yet authorised	3.17	
To support other creditors due	6.12	
		(30.79)
NHSi minimum balance		**1.90**



Balance Sheet as at 30th June 2021

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	193.35	194.95
Stocks & WIP	3.07	3.32
Debtors	14.12	12.41
Prepayments	5.16	4.93
Cash	40.88	32.69
Total Current Assets	63.23	53.34
Creditors : Revenue	38.74	34.91
Creditors : Capital	6.58	3.15
Accruals	14.64	13.42
Deferred Income	2.29	1.92
Finance Lease Obligations	0.01	0.01
Loans < 1 year	0.67	0.69
Provisions	1.39	1.72
Total Current Liabilities	64.32	55.82
Net Current Assets/(Liabilities)	(1.09)	(2.48)
Debtors Due > 1 Year	0.89	0.89
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	5.43	5.43
TOTAL ASSETS/(LIABILITIES)	178.16	178.37
TOTAL CAPITAL & RESERVES	178.16	178.37

- Stock within Pharmacy, Pathology and Equipment stores have increased in month.
- Debtors have reduced in month, this relates to additional income for elective recovery, based on the latest information available. The debtor at the year end for annual leave, PDC refund and 'flowers' is still outstanding, these are expected to be settled in August.
- Prepayments have reduced in month, relating to maintenance of equipment & IM&T systems.
- Revenue creditors and accruals have also reduced. Costs incurred in relation to the elective recovery plan have reduced in line with income. The BPPC figures for June showed in month improvement for both NHS and non-NHS invoices. The in month value of non-NHS invoices was 93.69% and the number of invoices paid 91.38%. NHS invoices, the in month value of NHS invoices paid within 30 days was 96.912% and the number of invoices paid 93.94%. All invoices need to be authorised promptly in order to comply with this

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NLG(21)161

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Shauna McMahon, Chief Information Officer
CONTACT OFFICER	Shauna McMahon, Chief Information Officer
SUBJECT	Digital Strategy 6 month Update
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	F&P July 28th DSB -being reviewed comments due back by July 29 TMB – Aug 2 (to be reviewed/noted)
EXECUTIVE SUMMARY	Six month update of Digital Strategy Progress Attached is main narrative of highlights, second document includes the Roadmap progress chart and status. All is tracking well, a bit behind schedule on funding spend/procurements however this should get back on track in a couple of months (PAS). The PAS and possible HUTH/NLaG Data warehouse work is complex and taking more time on "technical spec and review".

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓			✓	✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	✓
Finance		**The NHS Green Agenda**	
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	This align with BAF of the Digital Strategy and Roadmap S1.05				
BOARD / COMMITTEE	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**

ACTION REQUIRED (please tick ✓)		✓		✓	

Northern Lincolnshire & Goole NHS FT

Website: www.nlg.nhs.uk

Digital Services
Trust Board 6 Month Update

Shauna McMahon, Chief Information Officer

Email: shauna.mcmahon@nhs.net

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CONTENTS

Digital Strategy

Executive Summary

In January 2021 the Trust Board approved our 2021-2024 Digital Strategy. The ambition articulated is to deliver a digital first strategy and sustained digital transformation at all levels to enable the organisation to better meet its objectives and improve safety and quality of care. We will transform our health service through the integration of digital technologies across NLaG through collaboration with our partners across the region, delivering high quality care using innovative care models, supported by cutting edge technology. We will achieve this through the courageous and inspiring teamwork of our employees and clinicians and their drive for excellence to deliver patient centred care.

Our vision:

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

Included with this brief overview is a power point slide deck that highlights workplan and progress over the last six months. We continue to make good progress and are making changes in how we support, track and deliver through improved governance, project management and seeking opportunities to reduce duplication and partner where it makes sense to do so. This report provides an update of our achievements in the past six months. I trust you will be as excited as we are in digital services to see the progress made and how we are advancing our patient focused, digital first strategy.

Digital Supporting Patient Care

The Trust has implemented software called Patient Knows Best (PKB) with the first service to pilot the functionality being Cardiology. PKB is a patient health record providing a portal and for patients to access health information, record personal data and receive reports and important information on their health status.

Cardiology is also piloting at home monitoring with patients to be able assess patient status before a serious event.

Jackie France and team have led an excellent program to continue to build our virtual and digital offering to patients. Media coverage of the work is included below and provides information on this exciting project. We are now hitting close to 60% using the digital application for outpatient letters and appointment management.

- Digital Health **(plus the daily newsletter)**
- Building Better Healthcare
- Healthcare IT News
- Journal of mHealth
- Health Tech World
- Health Tech Digital
- The Health Guild

Supporting Covid and Business Intelligence

Our applications development team developed applications so that employees could book their Covid vaccination appointment and also record their lateral flow tests. This was done in a short period of time and supported an easier way for staff book and for our BI teams to pull the data through for reporting. Business Intelligence was able to provide the numerous requests for SitReps throughout the pandemic with workload often consuming 2 days of a WTE effort to produce the reports.

Short term developments were completed on WebV to assist frontline staff in reporting back swabbing results to wards. Oxygen monitoring was also supported in the application and allowed to Trust to report back on risks to medical gas infrastructure.

Business Intelligence plays a key role ensuring all data is reported to NHS/NHSE&I and available to internal teams for performance management. In addition, they have been supporting the data requirements for the HASR planning. It is our plan that the new Data Warehouse and Power BI

reporting will provide further efficiencies and enable us to reduce duplication; speed some report creation and support more user friendly dashboards.

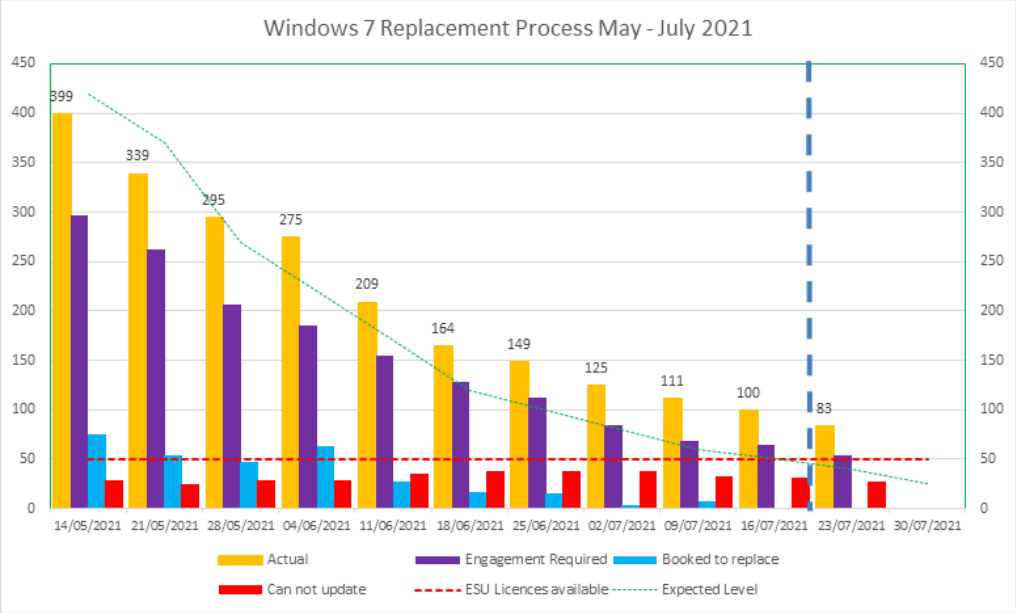
The Business Intelligence reporting suite has been successfully moved onto the NHS Office 365 tenant, which will allow end users to view BI reports with the same user credentials as NHS Mail. Access is also available on mobile devices with a specific PowerBI apps available to download from either Google Play Store or Apple AppStore.

Information Technology

The following additional devices have been procured and are in the process of being rolled out:

Desktops	950	Ward Screens	50
Laptops	1050	WiFi access points x	350
All in ones	72	Wows	10

NHS D – standard for Win 7 running is 1% or less of estate. We are on track to meet that standard end of July early August.



Clinical Coding

Grant Thornton has completed their end of year 2 review of the Clinical Data Improvement Program (CDIP) - End of Year 2 Position. The program has delivered a significant proportion of what it set out to achieve at Year 2. Key success and areas for improvement:

- The Trust's clinical data now better reflects the care delivered and the patients treated.
- Mortality improvement –support provided by Grant Thornton is now embedded within the Trust and has brought the SHMI value within normal limits for the first time in five years.
- Improved accuracy contract baseline –the CDIP has delivered a recurrent increase in the contract baseline of £8.4m within 2 years against a 3-year target of £9m agreed with commissioners.
- Clinical engagement –direct engagement with services has been crucial to driving improvement, although further work to create a more sustainable model in year 3 is needed.
- Coding resilience –despite the impact of COVID-19, operational issues within the coding team and long-term sickness, the coding team has improved the depth of coding at the Trust, and maintained this improvement.

- Auto-coding –a sustainable process has been developed and implemented in admitted patient care and A&E. This uses existing clinical information to inform and improve the efficient production of clinical data.

- As a result of the improvement and benefits achieved through the CDIP, the Trust and Grant Thornton were shortlisted in June 2021 for a HSJ partnership award. Unfortunately, we did not win in the category but were awarded a highly commended status.

Moving forward, NLaG and HUTH are working on a Memorandum of Understanding to for a shared management model with Information Governance & Coding.

Information Governance & Cyber Security

The Data Security & Protection Toolkit was submitted end of June. We have 8 assertions to mitigate over the next six months. Our annual audit final assessment is below. The two key areas of focus for us to improve is to revise and update our Business Continuity and Disaster Recovery plans and our Asset Risk Register. We have put our focus on these areas.

Audit Assessment

Final Assessment (June 2021)	**Risk Rating across all 10 NDG Standards**	**Limited**
	Assurance level based on the confidence level of the Independent Assessor in the veracity of the self-assessment	**High**

The above ratings are reflective of the review findings at the date of the report, 24th June 2021, after consideration of the additional information and evidence provided for stage two of the audit, and as determined by the new audit methodology. The audit guide prescribes a 'Limited' rating overall, where none of the ten data security standards are rated 'Unsatisfactory', but two or more are given a 'Limited' rating. In making our assessment, we have taken into account the progress made since the last review in March 2020, as well as the work continuing this year to meet the exacting standards of the new audit framework.

Applications and Information Services

Electronic Patient Record (WebV EPR)

- Successful pilots have been completed for integrating EPMA data into the Trust's discharge process and capturing Outpatient consultation data directly in the EPR instead on a separate dictation system.

- Comorbidities data collections within EPR to support improvement management of patients is steadily increasing. Increased usage of clinical noting is also being seen, with focus support on the Stroke unit being the next priority for recording electronically in the EPR

- Commercial activities have focused on maintaining our existing customer base and limiting new commercial opportunities. The approach is giving benefits and improving relationships with long standing customers, enabling higher quality of products to be deployed.

Urgent and Emergency Care

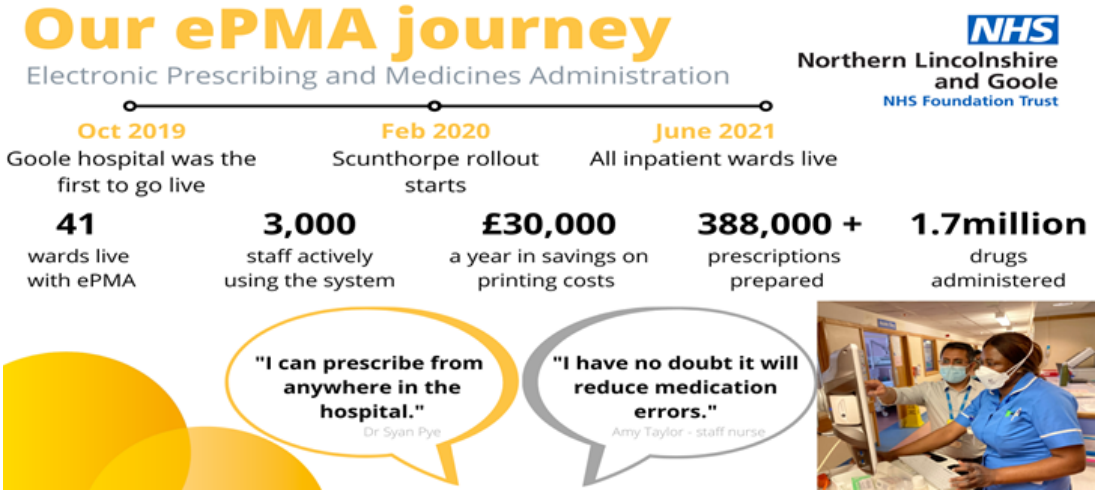
- A range of new clinical information and display changes have been added to Symphony to help Emergency Departments improve the speed and efficiency of viewing and capturing data to support decision making. This is part of an ongoing push to reduce the amount of paper recording within the departments.

- New functions including access to inbuilt electronic Child Protection alerts and a full Paediatric attendance record will be launch in the next few weeks.

Electronic Prescribing and Medicines Administration (ePMA)

ePMA is now live across the planned inpatient wards. The maternity and paediatric inpatients are planned next. The system allows doctors to prescribe from anywhere in the hospital. They can use the system to check appropriate doses and to cross check for allergies as well as drug interactions while they are prescribing. Nurses can see clearly what drug and dose has been prescribed and they can look up information on drugs at their fingertips rather than referring to the paper copy of the formulary.

As of 24th June 2021 388,109 electronic prescriptions have been performed on the system with 1.7million drugs administered. We have over 3000 trained staff actively using the system trust wide and have issued over 1000 accounts to agency and locum staff to cover shifts at short notice. ePMA is helping the Trust 'go greener' and saving approximately £30k per annum, the equivalent of 6 pallets of paper.



Areas to Focus Improvement:

- As noted in audits, improve data entry into digital systems.
- Decrease the areas where printing is enabled when there is digital functionality.
- Focus on the core priority and digital aspirant projects that will make a transformational difference.
- Map out plan to meet gaps identified in the HIMSS INFRAM & EMRAM assessment.
- Review and update Business Continuity & Disaster Recovery Plans and our Asset Risk Register.
- Continue improvement work on Data warehouse and supporting performance reporting identified as priority in the IPR and PRIMS.

The Next Six Months:

- Complete procurements for remaining Digital Aspirant programs.
- Complete recruitment and resourcing of programs management office with supporting project managers.
- Continue to support information sharing with YHCR.
- On-going work with ICS Digital Strategy.
- On-going work supporting HASR and the Acute Care Collaborative.
- Continue to work with HUTH to improve digital services for our acute services.
- Continue to work with HUTH to improve digital services for our acute services.

In conclusion, our strategy has been well regarded, and was referenced as one to review in the NHS Providers Board Development program. We are moving forward with the support and leadership from the Board, Executives, our digital team that is working hard to deliver innovation and all the employees and our partners that are supporting our digital journey.

As CIO, I am so proud to work with everyone at the Trust on this journey.


Digital Services Update
Joint MAC & HCC July 12/21 1300-1400hrs

NLaG Digital Investment Principles

- Focussed on transformation and everything we do will be focussed on achieving our future ambition

- Principles for determining our Digital work internal & with ICS. Does the Digital proposal:

  - ✓ Facilitate system level Transformation
  - ✓ Contribute directly to our strategic & quality programme
  - ✓ Transform to achieve paperless – Digital First
  - ✓ Ensures sustainability of a local system where there is an unavoidable technical or business pressure
  - ✓ Focus on the people (patients, family & employees)

- Digital ‘asks’ should be discouraged if they:

  - × Invest in strategically divergent technologies or solutions
  - × Invest in legacy systems without a genuine sustainability requirement
  - × Address a national target but have no transformation justification

NLaG Digital Solutions Outcomes Long Term

- Patients able to control who accesses their record via the portal – “consent only once”
- Increase out of hospital care when appropriate, maximizing virtual visits and patient wearables with care provider monitoring
- End users experience modern devices in care areas, with clinical pathways integrated across digital solutions
- RPA is used to support repetitive tasks and eliminate duplicate, manual processing
- Paperlite-Paperless drives decision making across all departments
- Multi-disciplinary Teams drive digital investments
- Supported and continuous learning for digital literacy

Strategic Approach

- Foundations
  - Hardware / Systems / Network / Connectivity
  - Interoperability / Security
- Patients
  - Records Access / Service access
  - Information & Advice / Monitoring / PIFU
- Staff
  - Digital Literacy support
  - Mobile working / single sign-on / workflow transformation
  - Information Access / Useable and Useful BI

- Where we are now…
  - HIMSS Assessments

INFRAM

Achievement Overview

Stage Achievement	2	Highest Stage Achieved
Percent Achievement	37%	% accomplishment against INFRAM model
Stage 7	22%	Validation Required
Stage 6	11%	Validation Required
Stage 5	28%	Stage Not Achieved
Stage 4	62%	Stage Not Achieved
Stage 3	62%	Stage Not Achieved
Stage 2	84%	Stage Achieved
Stage 1	95%	Stage Achieved

Color Legend	
	Stage has met 70% of criteria
	Stage has not met 70% of criteria

Breakdown by Focus Area

Stage	Transport	Wireless	Collaboration	Security	Data Center
Stage Achievement	3	1	2	2	2
Percent Achievement	50%	64%	37%	43%	35%
Stage 7	33%	0%	26%	32%	21%
Stage 6	0%	0%	14%	25%	14%
Stage 5	0%	40%	36%	16%	38%
Stage 4	53%	77%	38%	77%	65%
Stage 3	74%	75%	55%	68%	44%
Stage 2	90%	67%	88%	94%	73%
Stage 1	100%	100%	100%	100%	71%

EMRAM

Assessment Achievement Overview

Stage achievement	0	Highest stage achieved
Percent achievement	69%	% accomplishment against EMRAM model
Stage 7	N/A	Validation required
Stage 6	90%	Validation required
Stage 5	20%	Stage not achieved
Stage 4	61%	Stage not achieved
Stage 3	29%	Stage not achieved
Stage 2	64%	Stage not achieved
Stage 1	89%	Stage not achieved

Color Legend	
	Stage has met 100% of criteria
	Stage has not met 100% of criteria

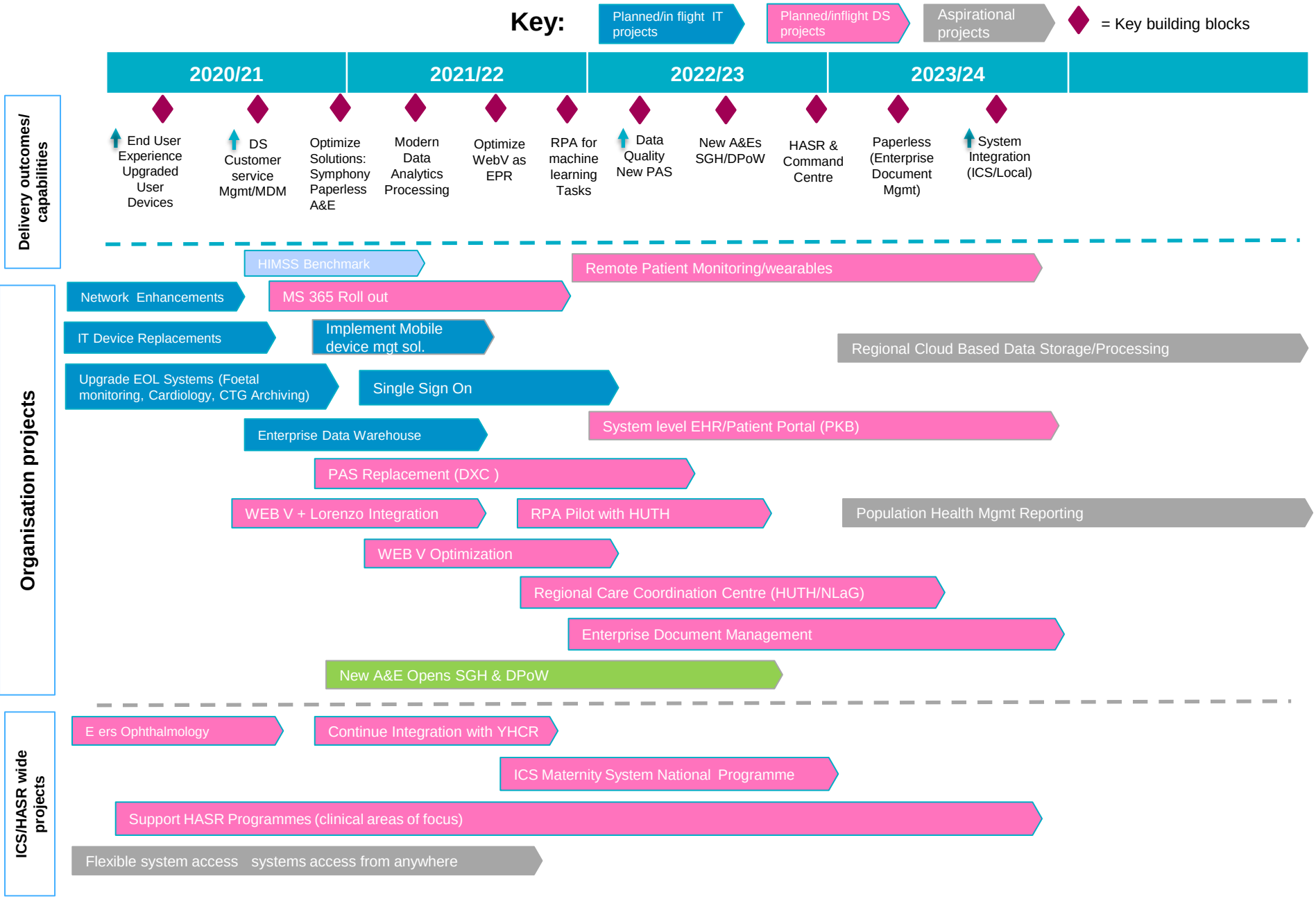
Breakdown by Focus Area

Stage	Clinical Documentation	EMR/CDR	IT Security	Closed Loop Administration
Stage achievement	2	0	1	5
Percent achievement	46%	62%	81%	86%
Stage 7	N/A	N/A	N/A	N/A
Stage 6	100%	100%	92%	86%
Stage 5	0%	N/A	75%	N/A
Stage 4	60%	0%	86%	N/A
Stage 3	20%	N/A	100%	N/A
Stage 2	N/A	40%	71%	N/A
Stage 1	N/A	89%	N/A	N/A

NLaG Digital Priorities 21/22

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: 1. Improved access to patient information by linking WebV and HUTH Lorenzo EPR, & Yorkshire and Humber Care record and other sources; 2. Upgrading the Trust data warehouse to improve business intelligence and data management; 3. Upgrading versions of current inhouse systems to support paper lite/paperless working; 4. Investing in solutions & devices to enable real time clinical data entry and single sign on; 5. Piloting a scalable automation platform (Robotic Processing Automation RPA) to reduce the burdens of repetitive data entry.	Chief Information Officer	The Digital Transformation Programme that supports the Digital Strategy is tracked across its various projects via a programme tracker which provides a RAG rating framework for the schemes. National reporting rated the programme at **Amber+.**	• Digital Aspirant award at April 2021 Baseline has been reported as **Amber+**, successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into major issues threatening delivery • Development of PMO resources within Digital Services is underway with a permanent Programme Manager commencing in post in Oct 2021 • £2.27m of 2021/22 capital and £196k of 2021/22 revenue is reliant on having a Funding Evidence Report (FER) completed and approved by NHSX in Sept 2021 • 2020/21 funding for devices and infrastructure was spent successfully before 31st March 2021. Kit deliveries were received and are continuing to be rolled out across all areas. • HUTH/NLG have been working closely on Lorenzo/WebV click through access. Development of Lorenzo->WebV viewer is complete and testing is underway and completion scheduled by end of August 2021 • Lorenzo PAS technical proposal currently being assessed by both Trusts with Business Case/options paper to be provided to ET/TMB in August 2021 • Data Warehouse project outline understood, and procurement options assessed. Discussion underway with HUTH DW supplier around shared proposal that would link into support the preferred PAS option. Otherwise a separate procurement exercise would be undertaken in September. • Clinical system upgrades have been purchased from suppliers and form part of the schedule of planned work across the Digital Teams. Priorities around CTG archiving, Cardiology and Obstetric ultrasound systems. • RPA 'envision' workshop held with Patient Admin teams at both Trust and Northampton General (Automation Accelerator). Feedback on priority processes by end of July. Productive discussion with NHSEI to support shared RPA infrastructure for initial pilots.

Digital Services Investments & Priority Road Map 21-24



Strategic Plan Roadmap

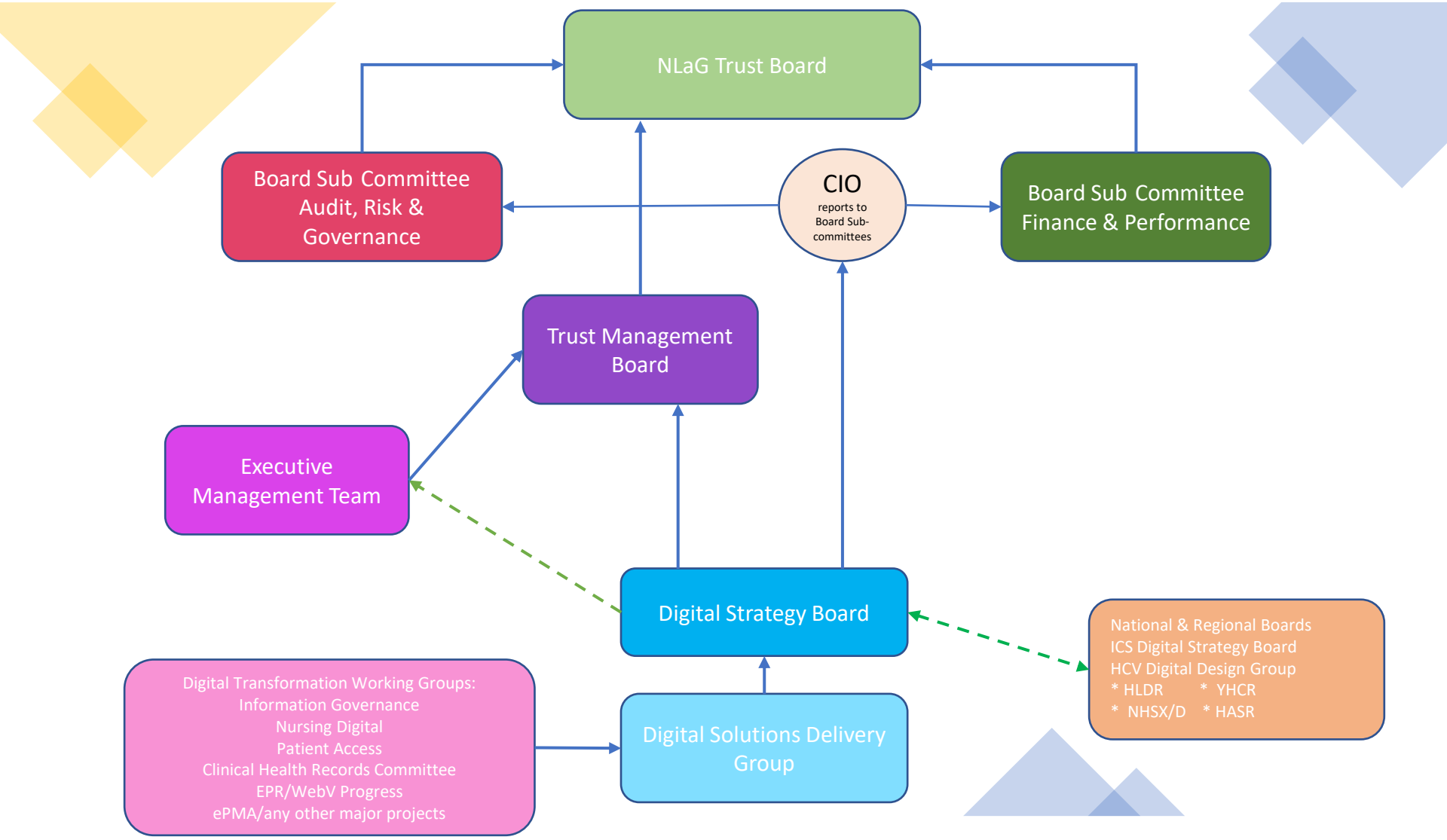
Project	
CMIO & CN&AWP IO in Post – continue to build on clinical engagement	Completed
HIMSS INFRAM & EMRAM Assessment	Completed
Consistent/updated hardware & devices across site	InProgress
Network/Cyber security upgrades	In Progress
Fully Digital A&E workflow	Upgrade complete/still working on eliminating print processes/Amb handovers/ePMA
Maximize N365 Functionality Across Trust	Project Manager Assigned/Roll out in Progress
Improving the Integrated Performance reporting to Board and for Divisions	Work on going with NHSE/I
Risk Stratification for P4	System work with GP/Acute Partners
Focus on Theatre digital workflow and improvements	In Progress –NHS Model Health System Mandatory Reporting
ICS BI/PHM system Approach	CIO facilitating discussions as part of ICS Digital Board
Digital Services Staff alignments (PMO/PM)	Programme Manager recruited (currently Interim in place with Interim Project Managers
Business Case Development /Procurement • PAS (remove current “work arounds” and link to HUTH PAS) • Data Warehouse (will support reducing duplication & enable responsive dashboards) • Single Sign on (reduce lost clinical care time with efficient log in/system access) • Enterprise Document Management (repository for management /storing documents) • Care Coordination Centre (Command Centre)	
Yorkshire Humber Care Record – NLaG data flows	In Progress –working with system/Deloitte PMs to ensure integration for document /data transfer
NLG Electronic Patient Record (WebV/EPR)	

Strategic Plan Roadmap

Project	
Use Digital Systems to support outpatient care (consultations/Communications)	In progress: over 60% of patients accessing letters via Health Communications application
Pilot Robotic Processing Automation with HUTH	In Progress
HASR BI/GIS support	In Progress with support from external provider: South Central & West CSU
Home Monitoring (Cardiology Pilot)	In Progress
Patient Access to Medical Record (PKB – pilot –Cardiology)	In Progress
Continue to explore Partnering and linkages with HUTH	On-Going Shared management being explored for IG & Coding
ED New builds Technology Workstream	In Planning/Progress
Ophthalmology Digital Processes	In Progress
Pathology Long Term Storage - IS	In Progress
Radiology Digital Processes	In Progress
NLG Electronic Patient Record (WebV/EPR)	There are 4 contracts with external customers for WebV/EPR.

April 2021

Digital Strategy & Transformation Governance



Digital Strategy & Transformation Governance

NLaG Board

- Chair- Terry Moran
- Semi Annual Report (Sept, Mar)
- Provide a more detailed report on the progress of digital transformation
- ARG & F&P will include Digital as appropriate in the sub-committee reports through out the year
- Digital Strategy every 3 yrs

Audit, Risk & Governance

- Chair – Andrew Smith
- 3 times per year (June, Oct, Feb)
- Expect to report Data Protection & Security Toolkit, Cyber security items related to Information Governance and protection of data

Finance & Performance

- Chair – Neil Gammon (05/31/21)
- Gil Ponder (01/06/21)
- Quarterly (Apr, July, Oct, Jan)
- Expect to report on how Digital Strategy is progressing, major projects and financing /benefits

Trust Management Board

- Chair – Peter Reading
- 2 /Month
- Digital Strategy Board Highlight Report on Key Strategic Performance in relation to Digital Strategy, Regional developments
- Min. 1 update/month/ or as needed

Executive Management

- Chair – Peter Reading
- 2-3 mtgs / Month
- Discuss Digital Strategy/Transformation & Regional developments to discuss any critical items for TMB
- As needed/appropriate
- Review DSB highlight report

Digital Strategy Board

- Chair - Shauna McMahon (Interim – will review when CMIO/CNIO are in post)
- Monthly
- Review Digital Strategy Progress
- Updates & Progress on full Programme of Digital Projects
- Finance/BC approvals
- Approve Project Priority List
- Drive forward future digital innovations

Digital Solutions Delivery Group

- Chair – Steve Mattern
- Monthly
- Reviews all projects in flight/Tracks to Plan
- Reports Status to DSB
- Recommends projects/BC to DSB

Digital & Clinical Transformation Working Groups
Feed in to Digital Solutions Delivery Group

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)162

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Gill Ponder, NED / Chair of Finance & Performance Committee
CONTACT OFFICERS	Lee Bond, Chief Financial Officer
SUBJECT	F&P Committee Highlight Report – June & July 2021 – **FINANCE ONLY**
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY	The attached highlight report summarises key issues presented to, and discussed by the Finance & Performance Committee at its meetings on 30 June & 28 July 2021 and worthy of highlighting to the Trust Board.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	✓
Finance	✓	**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable	BAF Risk SO3 (3.1-3.2)				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	3 August 2021
Report From:	Finance & Performance Committee – 30 June & 28 July 2021

Highlight Report:

F&P Committee – 30 June 2021

Delivery of Financial Plan

The Trust had a very slight deficit against plan in Month 2.

Elective Recovery Fund Income

Elective Recovery Fund income was dependent on the overall ICS meeting the eligibility conditions. Given the uncertainty around the income, the Trust had prudently accrued for corresponding expenditure. The Trust's submitted financial plan for H1 only included a marginal value for ERF contribution with the full income and costs included as a memo item. Since the submission, all providers have been asked to include the ERF values in their plans. A revised plan including ERF income and expenditure would be reported from the July meeting onwards.

Covid Expenditure

Covid Expenditure remained steady at £1.2m a month, which was just within current funding received. Bed base and staffing were the biggest challenges. Covid was the main focus at PRIMs to review Covid expenditure and where recurrent costs were to be included as part of the H2 plan, as there was no additional funding for it in H2.

Cost Improvement Plans

CIP were on target at month 2, with risks to delivery in recruitment and reduced agency spend, due to delays with potential overseas staffing as a result of ongoing Covid restrictions. Pipeline and mitigation schemes were being identified to bridge the current gap of £1.2m, but there was a need to get pipelines to deliverables to address the gap.

Capital Programmes

The SGH MRI capital programme is 10 weeks behind plan. The Finance team were working through the consequent revenue implications, such as the possible need to extend mobile scanners to create capacity. Agreement to extend the timescale to spend the allocated EPC funding to March 2022 was expected. ED / AAU schemes were behind plan and over budget with the biggest cause an increase in material costs. A further update would be provided at the July meeting.

Financial Special Measures Exit Criteria

The Trust had received a letter from NHSI giving the criteria that would need to be met for the Trust to exit from Financial Special Measures. These were:

1. Both the Trust and System to achieve the H1 financial plan.
2. Completion of the planned restructuring of the Finance team.
3. CIP programmes delivering planned savings.
4. A long term financial plan in place with a focus on reducing Covid expenditure and the underlying run rate.

A report of plans and progress against these criteria would be brought to the August Committee meeting. The Committee requested that the plan include specific milestones and dates to enable the Committee to provide assurance to the Board on delivery of the plan.

Use of Resources

The formal assessment process would not take place this year, but the Trust would go through the process anyway to set up for future assessments. A paper would be brought to the July meeting.

Digital Strategy

There was nothing on the Committee's workplan for June, but a report would be presented at the July meeting.

F&P Committee – 28 July 2021

Delivery of Financial Plan

The Trust reported a £0.10m deficit in June, £0.20m better than plan. The year to date position is a surplus of £0.42m, £0.24m better than plan.

Income was below plan, but there was a corresponding reduction in non-pay costs due to slippage in planned Independent Sector activity. Pay was £0.57m overspent in the month mainly due to spend on agency staff to cover medical vacancies and to create additional capacity.

The Finance team were benchmarking agency spend at NLAG against HUTH, as there was a significant variance between the 2 organisations.

The Committee requested an update on progress with recruitment plans and key workforce milestones from the Workforce Committee, as this was a key enabler to delivery of the financial plan.

Elective Recovery Fund Income

NHSE/I had advised that the base activity threshold for eligibility for ERF income would increase from 85% to 95% of 19-20 activity from 1-7-21. This would have a significant adverse impact on future expected incremental income, which would mean that the Trust and system would have to achieve 95% productivity within existing budget to mitigate the risk of additional ERF costs exceeding the income received.

Covid Expenditure

The Trust must vastly reduce Covid spend run-rate by September to avoid a risk of large overspends in H2, as available Covid funding mostly runs out by then.

Cost Improvement Plans

Delivery of savings was £226k better than plan, but 47% of this were non-recurrent savings. There remained £435k of savings still to be identified.

Capital Programmes

Capital spend was £17.87m behind plan, due to groundworks issues at Scunthorpe, backlog maintenance schemes due to conclude in July and the grant-funded EPC schemes, which would now be completed by 31-3-22 after agreement was given to re-profile the spend over a more realistic time period for the completion of the work.

Financial Special Measures Exit Criteria

Work continued on the requirements for the Trust to exit FSM, with the intention of meeting all the criteria by the end of September. The biggest risk was the H2 planning process where the efficiency requirements and funding available was not yet clear.

Use of Resources

Metrics would be updated by the end of September and a report brought to the October Committee meeting.

Digital Strategy

Clinical Data Improvement Programme

By the end of year 2, the Clinical Data Improvement Programme had delivered benefits in coding accuracy leading to an improvement in the Trust's SHMI value and £8.4m increase in contract baseline against a 3 year target of £9m. The programme had been highly commended for a HSJ partnership award.

Digital Transformation Programme – Financial Update

Both capital and revenue spend was significantly behind plan, but was due to increase in months 4-8 as prerequisite work was completed, allowing procurement to commence. A draft financial plan would be provided in September to support delivery of the Digital Strategy until 2024.

Digital Strategy Update

A digital maturity assessment had taken place and a roadmap and governance developed. Delivery of the strategy was on track, but there was a need to maintain pace. Project Management expertise would be used to keep the programme on track, using digital aspirant funding.

Confirm or Challenge of the Board Assurance Framework:

The BAF was not presented at the June meeting.

The Committee reviewed the BAF on 28-7-21 and decided to review each strategic risk on a rotational basis at monthly meetings. The intention was to ensure that the Committee did a deep dive on each risk to gain assurance on the risk score, target score, controls, mitigations and control gaps.

Action Required by the Trust Board:

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

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)164

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors (Public)
REPORT FROM	Ivan McConnell, Director of Strategic Development
CONTACT OFFICER	Kerry Carroll, Deputy Director of Strategic Development, Claire Hansen, HAS Programme Director P1, P2
SUBJECT	**Executive Report - Strategic & Transformation**
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 4 – To work more collaboratively** The attached template provides the highlights, lowlights and risks against the Trust Priorities 4 and 9. The Board is asked to note: • The progress that is being made on the delivery of the Humber Acute Services critical milestones of both P1 – the Interim Clinical Plan and P2 Core Service Change • The progress that is being made on the development of a Capital Pre SOC to support major capital investment within NLAG and HUTH • Our continued participation in and leadership of collaborative ventures through partnership working

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
			✓	

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety		**Digital**	✓
Estates, Equipment and Capital Investment	✓	**Strategic Service Development and Improvement**	✓
Finance	✓	**The NHS Green Agenda**	
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**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 system, service and organisational sustainability including the ability to attract inward investment and Trust clinical strategy which delivers long term

BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			✓

Strategic Service Development and Improvement – July 2021
Strategic Objective 4 – To work more collaboratively

Trust Priority 4: **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 2022;
    - 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, Neonates & Paediatrics
    - Planned Care and diagnostics

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
    - Acute Collaborative
    - Community Collaborative
    - Integrated Care Partnerships of North and North East Lincolnshire
    - 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.

Trust Priority 4:

- With Hull University Teaching Hospitals, we will complete the Interim Clinical Plan ***(programme 1)***
- 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 ***(programme 2) linked to submission of a Capital EOI and Pre SOC (Programme 3)***

	Lowlights	Risks

Review of UEC undertaken by Reg Clin Director UEC and Reg Clin Director Primary Care

- Engagement with ICS, HEE and NHSE/I National workforce planning leads on areas to consider for future healthcare skills planning
- Engagement with Doncaster and Lincoln health systems re potential displacement activity
- NHSE/I monthly assurance review
- Pre Consultation Business Case framework agreed and documents being populated
    - Case for Change
    - PH Data
    - Options – Case for change, benefits, pathways, patient and staff impact, evaluation

Programme 3

- Development of EOI to support Capital Investment through HIP schemes

- The delivery of changed pathways will require capital investment in digital as well as wider infrastructure
- Planned care pathways must align to wider ICS CDH programme implementation

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

Highlights	Lowlights	Risks
Humber Coast and Vale (HCV) Health & Care Partnership: NLaG is an active member of a number of Boards/Groups across the Humber Coast and Vale ICS: • CEO and Chairman are a member of the HCV Partnership Board • The CEO, Director of Strategic Development and Chief Operating Officer (COO) are members of the Collaboration of Acute Providers Board and other members of the Trust leadership community participate in sub groups • Actively involved various community collaborative (i.e. Outpatients Transformation, Planned Care Programme, Diagnostics, Urgent & Emergency Care Network, Community Paediatrics) • The Trust Chair and CEO are members of the Integrated Care Partnership (ICP) Board and the Director of Strategic Development is a member of the ICP Steering Group • The Trust COO and Head of Cancer are members of the HCV Cancer Alliance Board • Senior leaders from across the Trust are active participants in HCV Clinical Networks **National and regional networks:** • Members of the Trust Board and Senior Leadership Community are active members of national and regional networks. The Trust is an active participant in Getting It Right First Time (GIRFT) reviews and recently participated in the HCV review of ENT, Urology and Orthopaedics • As part of the HAS Programme the Trust is actively engaged with National and Regional Network and GIRFT leads on Urgent Emergency Care, Maternity and paediatrics and a number of planned care specialties	• Pace of design and development of ICPs • Place Based Boards – lack of clarity of role • Multiple Primary Care Networks (PCNs) at different paces – to rethink engagement	• Aligning the development /strategies/objectives/ priorities of the PCNs to HASR

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)165

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee
CONTACT OFFICERS	Ellie Monkhouse – Chief Nurse Dr. Kate Wood – Medical Director
SUBJECT	HTF Trustees' Committee Highlight Report – 15 July 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	-
EXECUTIVE SUMMARY	The attached highlight report summarises key issues presented to, and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 15 July 2021 and worthy of highlighting to the Trust Board.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓				

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable	N/A				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	3 August 2021
Report From:	Health Tree Foundation Trustees' Committee held on 15 July 2021

Highlight Report:

Health Tree Foundation Appeals

- Following on from HTF Trustee Approval in May 2021 for five wishes related to the new ED builds at SGH and DPOW and capitalising on significant local fundraising interest, enthusiasm and opportunities, a new fundraising campaign has been launched. The aim is to raise £70,000 before end of 2021 to fund these wishes and a communications plan, news release and social media campaign are all underway in support. Early signs are most promising.

- The IMAGE Appeal, which was launched in November 2019 to raise £55k for the enhanced MRI equipment at DPOW, is now closed. This was a victim of the pandemic, since planned fundraising opportunities were severely curtailed. Despite this, £7,000 was raised by valiant fundraisers and the remainder required was taken from already existing funds raised to help support trust-wide cancer services.

- The Goole Therapy Garden Appeal will continue, although pandemic constraints and the lack of 'Sparkle' support have hampered planned progress to date. However, there is continuing enthusiasm for this project and the HTF Team are keen to re-invigorate the work here.

- Dementia Friendly Wards Appeal. Again the pandemic pushed this appeal off course, since the original ideas could not be carried out. Wards were moved and re-purposed, whilst the urgent need to make the hospitals Covid safe militated against putting some other ideas into practice. Moreover, in hindsight, perhaps the appeal was too general in nature – a lesson learned. This appeal has also been closed, but this does not mean that wishes focused on enhancing patient experience for those patients affected by dementia will not always be welcomed – see next point.

Wishes Approved

- Trustees approved the purchase, trust-wide, of a further 7 Reminiscent Interactive Therapeutic Activity (RITA) machines for use by patients with dementia. This supports the 11 machines already in use and will allow more wards to have their own rather than need to borrow when required. Significant discount of £19k achieved by this HTF initiative of bulk purchase

- Trustees approved purchase of Breast Ultrasound Machine for DPOW to replace the one that the Trust Charity bought 6 years ago. Trustees asked that effort be made to re-cycle the old machine, since it was bought with charitable donations, to deserving cause, perhaps in a less well-off country than ours.

Confirm or Challenge of the Board Assurance Framework:

Not Applicable

Action Required by the Trust Board:

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

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)166

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Michael Whitworth, Non-Executive Director
CONTACT OFFICER	As above
SUBJECT	Committees in Common Highlight Report & Board Challenge Humberside Acute Service Review Development Committee - June 2021
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	The same report has been presented to the Hull University Teaching Hospitals NHS Trust
EXECUTIVE SUMMARY	1) The first meeting of the Joint Committee was held on 25th June 2021. 2) The Terms of Reference and governance arrangements were agreed.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓				

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	✓
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**Strategic Objective 4 – To Work More Collaboratively**				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Humberside Acute Service Review Development Committee

Summary Report to Boards

Meeting Date	25th June 2021	Chair	T Moran	Quorate (Y)

Key items discussed

1) The Committee received a copy of the current Terms of Reference and subsequent amendments to the NLAG ToR for review. Recognised this presented high opportunity and likened an Ice-breaker" approach.
2) Discussions took place regarding the rolling monthly review from the ICs and NHSE/I. Recognition was made of the progress of the overall review, in developing a Pre-Consultation Business Case and Strategic Objective Business case.
3) The Committee reviewed HAS Programme overview and P1, P2, P3 Status report, with a particular focus on development of the Clinical Plan and business case planning, to be in place by September 2021. Key areas reviewed included:
   - Allocation of dedicated resources to support the programme.
   - Undertaking wide ranging external engagement. Including – OSCs, CCGs,LAs and focus groups.
   - Undertaking a number of clinical workshops for the design of urgent, emergency care and maternity with circa 450 staff from across secondary, primary and community care.
4) The HASR Memorandum of Understanding, developed to facilitate movement of staff across Trust boundaries spanning the Humber without the need for additional contracts of employment. This included the development of a "Staff Passport".
5) The Committee reviewed the development of a Governance Service Level Agreement for joint working arrangements and to jointly access and monitor improvements in quality and safety. As part of problem resolution this involves settlement of incidents, complaints and claims. It was recognised that the process would involve building on existing governance.

Key decisions made/items agreed.

1. The Terms of Reference were agreed. The amendments contained in the revised NLAG ToR to be incorporated into the HUTH document.
2. Noted.
3. The Committee reviewed the work plan Key decisions and timescales for the CIC.
4. The governance framework in relation to liabilities, complaints and indemnities was agreed and subsequently approved by the Committee.
5. Joint bi-monthly quality meetings are to be held to review and facilitate the key elements of the SLA. By building on existing governance the Committee would avoid replicating Board Committees. The Committee approved the contents of the SLA presented at the meeting and agreed final version approval would be delegated to the respective Quality Committees.

Risk and assurance matters to be escalated.

Nothing to note

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)167

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Board Development Timetable 2021/22
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	Board development is a key element of good corporate governance and is recognised as such in best practice guidance including NHS Improvement (NHSI) Well-Led Framework, the Healthy NHS Board and Foundation Trust Code of Governance 2013. Board development is also an integral part of and consistent with the People Strategy. The proposed priorities for Board development are informed by a number of drivers: - The publication of the ICS Design Framework - The collaboration and partnership working across the Integrated Care System - The constantly changing and demanding external environment - The key roles of the Board in respect of risk management and patient safety - That the Board leads organization-wide leadership development and models the leadership behaviours. The Board Development Timetable can be reviewed in Appendix 1.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
				✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)		N/A			
BOARD ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

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Trust Board Timetable – 2021-22

Month	Meeting	Topic (where applicable)
6 April 2021	Formal Board Meeting and Board Briefing	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Governance
4 May 2021	Board Briefing and Board Development Activity	**AM:** CQC Briefing
1 June 2021	Formal Board Meeting / Briefing and / or Board Development Activity	**AM and PM:** Formal Board (Public and Private)
6 July 2021	Board Briefing and Board Development Activity	**AM:** Board Briefings: Freedom to Speak Up (Part 1), Making Data Count **PM:** Well-Led
3 August 2021	Formal Board Meeting / Briefing and / or Board Development Activity	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Priorities and Risk Discussion
7 September 2021	Board Briefing and Board Development Activity	**AM:** Board Development: Insights **PM:** Board Briefing: Strategy and Vision. ICP and ICS Development
5 October 2021	Formal Board Meeting / Briefing and / or Board Development Activity	**AM:** Formal Board (Public and Private) **PM:** Board Briefing: Freedom to Speak Up (Part 2), liberty protection safeguards

2 November 2021	Board Briefing and Board Development Activity	**AM:** Strategy Session: Board to Board with Hull University Teaching Hospitals (HUTH) - TBC **PM:** Board Briefing: People Strategy - Culture Theme and Equality, Diversity and Inclusion
7 December 2021	Formal Board Meeting	**AM:** Formal Board (Public and Private) **PM:** Stakeholder Mapping
4 January 2022	Board Briefing and Board Development Activity	**AM and PM:** Board Development: Building Relationships / Team Work (facilitated)
1 February 2022	Formal Board Meeting / Briefing and / or Board Development Activity	**AM:** Formal Board (Public and Private) **PM:** Digital Transformation (joint with HUTH, facilitated by NHS Providers) - TBC
1 March 2022	Board Briefing and Board Development Activity	**AM:** Freedom to Speak Up (Part 3) **PM:** TBC

Leadership and Kark Review (To Be Confirmed)

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)168

DATE OF MEETING	3 August 2021
REPORT FOR	**Trust Board of Directors - Public**
REPORT FROM	Andrew Smith, Chair of ARG Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Audit, Risk and Governance Committee Highlight Report – June 2021**
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers 3 June 2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk & Governance Committee at its meeting on the 3rd June 2021: **1.** **Audited Annual Accounts 2020/21**: Received and discussed by the Committee, and approved for submission. **For Board to Note.** **2.** **2020/21 External Audit Completion report and Management Letter of Representation**: Unqualified opinion for the accounts. VFM work remains on-going following the receipt of NAO guidance. **For Board to Note.** **3.** **Annual Governance Statement**: Approved, subject to one minor addition relating to FOI requests. **For Board to Note.** **4.** **Head of Internal Audit Opinion**: 'Significant Assurance' rating received. **For Board to Note.** **5.** Trust Annual Report 2020/21: Approved subject to final insertions. **For Board to Note.** **6.** ARG Committee Annual Report 2020/21: Approved subject to updating for final audit reports received. **For Board to Note.**

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership
		✓		✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		Workforce and Leadership	
Quality and Safety		Strategic Service Development and Improvement	
Estates, Equipment and Capital Investment		Digital	
Finance	✓	The NHS Green Agenda	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	N/A				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	Approval	Information	Discussion	Assurance	Review
		✓	✓		

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	3rd August 2021
Report From:	Audit, Risk and Governance Committee held on 3rd June 2021.

Highlight Report:

1. **Audited Annual Accounts 2020/21** – received and approved on behalf of the Trust Board under formal delegated authority. The accounts were previously reviewed in detail by the Committee at its April 2021 meeting**.** The Assistant Director of Finance – Planning and Control advised that only two minor changes were required to the draft accounts. The Chair commented that this was impressive and formally placed on record his thanks to the Finance team for their hard work in preparing the annual accounts.

2. **2020/21 External Audit Completion Report and Management Letter of Representation** – unqualified audit opinion for the annual accounts. As a result of revised guidance from the National Audit Office (NAO), the External Auditors work in respect of reviewing the Trust's arrangements for securing value for money in its use of resources remains on-going. However, it is is anticipated to be completed in preparation for reporting their findings to the NAO by 30th June 2021. Other than this Mazars confirmed they had nothing to highlight to the Committee. Mazars advised the Committee that the quality of the Trust's accounts should not be underestimated, adding that they were very good and were a credit to the Finance team. The Chair placed on record his thanks to the External Audit team for their work undertaken on the year-end audit.

3. **Annual Governance Statement (AGS) –** The Committee approved the AGS subject to the addition of a short paragraph in relation to the timely, or otherwise, response rates to Freedom of Information (FOI) Requests. The Associate Director of Communications and Engagement advised that some breaches in FOI response times had occurred during 2020 due to the impact of Covid-19 and in the interests of transparency this information would be disclosed in the AGS.

4. **Head of Internal Audit Opinion (HoIAO)** – The Committee heard that the final HoIAO for 2020/21 was one of '*Significant Assurance*'. The Committee placed on record their thanks to the Internal Audit team for their efforts during a difficult year due to the pandemic.

5. **Trust Annual Report 2020/21** – Approved, subject to final considerations before the required deadline (i.e. insertion of AGS, audited accounts, etc.).

6. **ARG Committee Annual Report 2020/21** – The Committee approved its own annual report for submission to the Trust Board and Council of Governors, subject to updating the internal audit report section for the final report numbers/assurance ratings received since the report was prepared. This item is a separate paper on the Trust Board agenda.

Confirm or Challenge of the Board Assurance Framework:

Review of the BAF was not scheduled for this meeting, which was primarily for the approval of the Trust's public disclosure statements.

Action Required by the Trust Board:

The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed.

Andrew Smith
Non-Executive Director and Chair of Audit, Risk and Governance Committee

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)168

DATE OF MEETING	3 August 2021
REPORT FOR	**Trust Board of Directors - Public**
REPORT FROM	Andrew Smith, Chair of ARG Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Audit, Risk and Governance Committee Highlight Report – July 2021**
BACKGROUND DOCUMENT (if any)	Audit, Risk & Governance Committee Agenda Papers 22 July 2021
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk and Governance Committee at its meeting on 22nd July 2021: 1. **Audited Annual Accounts 2020/21 – VFM Conclusion**: External Auditor moving to completion of VFM commentary for the Annual Auditors Report. Extraordinary ARG Committee meeting to be arranged to consider this. Need to consider timing of Trust AGM. **For Board to Note.** 2. **IA Limited Assurance Reports and Cyber Security Arrangements Update**: Two limited assurance IA reports received but the Committee note progress on the journey, as well as a sensible approach to assigning risk ratings to these areas but that significant open risk remains. **For Board to Note.** 3. **Outstanding IA Recommendations**: There has been general progress with implementing recommendations, but concern regarding the limited numbers dating back to 2017/18. Internal Audit points should not be open past due date. **For Board to Note.**

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
		✓		✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance	✓	**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	N/A				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	3rd August 2021
Report From:	Audit, Risk and Governance Committee held on 22nd July 2021.

Highlight Report:

1. **Audited Annual Accounts 2020/21 – VFM Conclusion** – The Trust's External Auditor informed the Committee that they were moving towards completing the VFM commentary which would enable them to complete their Annual Auditors Report for the Trust, which must be done by the extended deadline of 30th September 2021. However, until this is completed the Trust's Annual Report and Accounts cannot be laid before Parliament. Parliament returns from summer recess on 6th September 2021. The Trust Secretary advised that the timescales for the Trust AGM scheduled for 13th September 2021 are of concern as it cannot be held before the Trust's Annual Report and Accounts are laid before Parliament. The ARG Committee agreed that it would also need an extraordinary meeting arranging in August to consider this final element of the External Auditors work.

2. **Internal Audit Limited Assurance Reports and Cyber Security Arrangements Update** – The Committee received details of two limited assurance reports relating to IT Business Continuity and Data Security & Protection Toolkit (Stage 2). The Committee agreed that it should express to the Board that the BAF shows a sensible approach to the the risk ratings assigned to these areas and the progress being made for the journey that they are on. Linked to this, the Committee also received a confidential update on the Trust's Cyber Security Arrangements. The Committee thanked the Digital teams involved for their hard work and progress made to date, recognising that the journey is not over and acknowledging the Chief Information Officers comments that cyber security issues are ever changing meaning their work is never done. The Committee is therefore highlighting this to the Board as a measure of its support for the ongoing work in this area but also to ensure the full Board is aware of the significant open risk.

3. **Outstanding Internal Audit Recommendations** – The Committee received the latest update on the status of IA recommendations outstanding for implementation. Although the Committee noted general progress since the last update, it was concerned that there remain limited numbers dating back to 2017/18. The Committee will continue to monitor these and hold officers to account for lack of progress with timely implementation on the basis no Internal Audit actions should be incomplete past due date.

Confirm or Challenge of the Board Assurance Framework:

The Trust Secretary updated the Committee that a full review of strategic risks had taken place with each Executive Director, which had been a useful exercise. The Committee acknowledged positive progress in the development of the BAF.

A discussion took place however, around why there were still risks with scores of 20 and posed the question of whether all work being done to address inherent risk was essentially ineffective if risk scores remained high. It was agreed that appropriate challenge on high risk scores and mitigating actions is done through the Finance and Performance Committee.

Coupled with this, the Committee considered that focus should also be on those risks which are moving away from their intended risk scores.

Action Required by the Trust Board:

The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed.

Andrew Smith
Non-Executive Director and Chair of Audit, Risk and Governance Committee

NLG(21)169

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	Helen Harris, Director of Corporate Governance
SUBJECT	Board Assurance Framework (BAF) 2021-22
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality and Safety Committee – 16 July 2021 Audit Risk and Governance Committee – 22 July 2021 Executive Team – 27 July 2021 Workforce Committee – 27 July 2021 Finance and Performance Committee – 28 July 2021 Trust Management Board – 2 August 2021
EXECUTIVE SUMMARY (including key issues of note or, where relevant, concerns that the committee need to be made aware of)	The Trust board has set its assurance framework and captured its key risks to achieving its strategic objectives. The Trust Board is asked to: a) note the over-arching report, review the detailed BAF in Appendix 1 and note the current risk scores b) seek assurance from the Sub-Committees of the Board and the Executive Owners on the controls, assurances, planned actions and the underpinning high level risks c) consider the proposal from the Workforce Committee to reduce the risk scoring of SO2 – 'the risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients' from 20 to 15 d) approve the strategic risk wording of strategic objective 1 – 1.1, from: the risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience; to: the risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by ***national*** comparison) of safety, clinical effectiveness and patient experience.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓	✓	✓	✓	✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	✓
Quality and Safety	✓	**Digital**	✓
Estates, Equipment and Capital Investment	✓	**Strategic Service Development and Improvement**	✓
Finance	✓	**The NHS Green Agenda**	✓
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	• SO1 – 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard. • SO1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance or waiting time targets. • SO1 - 1.3: The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy. • SO1 - 1.4: The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate. • SO1 - 1.5: The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources. • SO1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope. • SO2: The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients. • SO3 - 3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities. • SO3 - 3.2: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate. • SO4: The risk that the Trust is not a good partner and collaborator. • SO5: The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

BOARD ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓			✓	

Board Assurance Framework – Quarter 1 Review (1 April – 30 June 2021)

1. Purpose of the Report

To present the BAF to the Trust Board for assurance and for the Board to review the controls, assurances, planned actions and referenced high level risks.

The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack, of assurance during the year as to what extent the level of risk is being managed. The BAF is a key governance tool to measure and monitor the level of strategic risk in the organisation and determines what an acceptable level of risk would be.

The Trust has in place a 'ward to board' process for risk management and this allows for the BAF to include reference to relevant risks from the High Level Register where they may impact on the achievement of the Trust's strategic goals.

The BAF was reviewed by the internal auditors in 2020-21 and gave an opinion of 'significant assurance'. The review found that the BAF provided a very comprehensive view of the Trust's strategic risks and how these risks are being managed. There was one recommendation to further develop the BAF, which was to restructure the BAF in a way that is sufficiently comprehensive whilst focussed on the matters of relevance to the Board and to ensure that the Board and its Sub-Committees are fully sighted on the high level risks from the risk register that are considered relevant to the strategic objective. This has been built in to the attached BAF for 2021-22.

2. Background

The Trust Board has set its assurance framework and captured its key risks to achieving the strategic objectives:

SO1: To Give Great Care
SO2: To be a Good Employer
SO3: To Live within our Means
SO4: To Work more Collaboratively
SO5: To Provide Good Leadership

3. Quarter 1 Review – April to June 2021

The Sub-Committees of the Trust Board have reviewed all the strategic risks and associated controls, assurances, gaps, planned actions and the links to the high level risks.

In summary the current risk ratings by strategic objective risk are:

Strategic Risk Ratings

Strategic Objective	High Level Risk Description	Risk Rating 2021-22 Q1	Q2	Q3	Q4	Owner	Assurance (Committee)
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard	15				Medical Director and Chief Nurse	Quality and Safety
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets	20				Chief Operating Officer	Finance and Performance
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy	12				Director of Strategic Development	Finance and Performance
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate	20				Director of Estates and Facilities	Finance and Performance
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care	12				Chief Information Officer	Finance and Performance
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope	16				Chief Operating Officer	Finance and Performance
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.	20				Director of People	Workforce
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities	12				Chief Financial Officer	Finance and Performance
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital	12				Chief Financial Officer	Finance and Performance
SO4	The risk that the Trust is not a good partner and collaborator	12				Director of Strategic Development	Finance and Performance
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives	12				Chief Executive	Workforce / Trust Board

Further detail can be reviewed in Appendix 1 – Strategic Risk Ratings.

Amendments to the BAF at a high level are detailed below in sub sections 3.1 to 3.11.

3.1. SO1 – 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard of safety, clinical effectiveness and patient experience.

The strategic risk was reviewed at Quality and Safety Committee at its meeting on 16 July 2021. The strategic risk score remains at 15.

The Committee is recommending to the Board to amend the strategic risk wording from: the risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience; to: the risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by ***national*** comparison) of safety, clinical effectiveness and patient experience.

New controls in place include: the Quality Board – NHSE/I, Quality Review Meetings with CCGs, Serious Incident Collaborative Meeting with CCGs, Local Authority Health Scrutiny Committee, Healthwatch and Chief Medical Information Officer (CMIO). Gaps in control include attracting qualified staff, progress with the End of Life Strategy, ophthalmology waiting list and delays with results acknowledgement.

Additional internal assurance is the Nursing Midwifery and AHP Strategy, Risk Stratification Report and the monitoring of Care Quality Commission (CQC) Progress at Board Development Sessions.

All Planned Actions have an action date for completion. A number of new actions include the Ophthalmology Action Plan, End of Life Strategy, Risk Stratification Report, Workforce Committee overseeing recruitment and the Clinical Engagement of results acknowledgement being reviewed by the CMIO.

The high level risks now include the risk ratings to illustrate current and previous risk ratings. The Various Equipment Risks have been removed as these are monitored within the relevant divisional and directorate risk registers.

3.2. SO1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance or waiting time targets.

The Finance and Performance Committee reviewed the risk at its meeting on 28 July 2021. The Chief Operating Officer has assessed the controls, assurances, planned actions and current scoring of the strategic risk. One minor addition to assurances was added. The current risk scoring remains at 20 due to a significant number of planned actions, gaps in controls and gaps in assurances. Some of the key actions to take place to close the gaps are: the development of a cancer transformation plan, outpatient transformation plan and a review of clinical pathways linked to HASR programme.

There is a number of high level risks referenced in the BAF, which may have an impact on the risk to the strategic objective, some of those being: cancer 62 day target, constitutional A&E targets, shortage of radiologists, failure to review ophthalmology patients in specified timescales.

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

The Finance and Performance Committee reviewed the strategic risk at its meeting on 28 July 2021. The risk score remains at 12. A full review of the current controls and gaps in controls has been undertaken by the Director of Strategic Development.

Additional assurances have been added, namely key reports from Executive Director and Non-Executive Director to the Trust Board and the minutes from the newly formed Humber Acute Service Development Committee.

There are two high level risks that could have an impact on the achievement of the strategic objective: the Clinical Strategy and the HASR political and public response to service change.

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

The Finance and Performance Committee reviewed the strategic risk at its meeting on 28 July 2021. The current risk score is 20, which was reviewed by the Director of Estates and Facilities and remains unchanged from 2020/21.

The main focus for this quarter is the review of the links to the high level risk register. There is 40 high levels risks recorded at 15 or above on the Risk Register which is reviewed by the Estates and Facilities Governance Group on a regular basis. The key risks relate to water infrastructure, medical gases and fire compliance that place an increased risk to the Trust's overall strategic ability to provide patient care in a safe, secure and suitable environment.

Mitigation is the delivery of the core capital programme, transformational capital schemes, BLM schemes, the equipment plan for 2021/22 produced as part of the 2021/22 core capital annual funding and the external audits and surveys on a number of key areas such as infrastructure.

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

The Finance and Performance Committee reviewed the strategic risk at its meeting on 28 July 2021. The risk score was 16 in 2020/21, which has been assessed by the Chief Information Officer and is currently scored at 12.

A thorough review has taken place to provide the Committee with the appropriate assurances and planned actions to support the delivery of Strategic Objective 1.

The key planned actions are, to address the limited assurance from the IT Business Continuity audit with the development of a comprehensive Business Continuity Programme by Quarter 3 2021/22, and the Data Security Protection Toolkit standards with the aim to meet Cyber Essentials Plus Accreditation in July 2022. There is also a number of planned actions to secure resources to deliver the Digital Strategy and annual priorities.

There are a number of Digital Services high level risks that could have an impact on the delivery of the strategic objective. These are reviewed by the Digital Services directorate and at the Risk Register Confirm and Challenge meeting. Of key importance is the data security and cyber security infrastructure and non-compliance with the Data Protection Act 2018.

3.6. SO1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope.

The Finance and Performance Committee reviewed the strategic risk at its meeting on 28 July 2021. The Chief Operating Officer reviewed the risk prior to submission to the Committee, which resulted in the removal of some of the 'gaps in control'. However, the current risk score remains at 16, due to some key actions to be completed: an annual table top exercise by October 2021 and capacity to meet demand of beds and workforce by September 2021.

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

The Workforce Committee reviewed the strategic risk at its meeting on 27 July 2021 and propose that the score be reduced from 20 to 15. This is due to the level of controls in place, the significant assurances following internal audits in 2020 and the workforce integrated performance report.

The investment in the people directorate will support the delivery of the NHS People Plan and NLAG People Strategy, which in-turn will support the achievement of this strategic objective. The high level risks pertain to the workforce and staffing issues.

3.8. SO3 - 3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities.

The Finance and Performance Committee reviewed the strategic risk at its meeting on 28 July 2021. There is a number of significant actions to be undertaken, being, the development of a finance strategy and a full Cost Improvement Programme (CIP) by the end of quarter two 2021/22. The development of finance key performance indicators to be incorporated into the integrated performance report is to be completed by the quarter three 202122. Two high level risks have been linked to the strategic risk: COVID-19 expenditure and the savings programme, which could be a possible threat to the delivery of achieving the Trust's financial objective.

The current risk scoring remains at 12 due to gaps in control of the finance strategy, uncertainty with the H2 Financial Framework 2021/22, challenges with HASR and the CIP delivery.

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

The Chief Financial Officer and Deputy Chief Financial Officer reviewed the controls, assurances and planned actions. The planned actions include the development of a core capital programme in conjunction with the finance strategy and the financial requirements for HASR. There are a few gaps in assurance being the delivery of the CIP, individual organisational sustainability plans and Committees in Common. One high level risk has been added to the BAF – Acute Assessment Unit / Emergency Department business case, which may have an impact on the risk to the strategic objective: deploying adequate major capital to redevelop its estate. Future risks that may also have an impact are, challenges with estate major capital and COVID-19 third surge due to the lack of supplies or inflation.

The current risk scoring remains at 12 due to the gaps in assurance and the planned actions, as detailed above. Finance and Performance Committee reviewed the risk at its meeting on 28 July 2021.

3.10. SO4: The risk that the Trust is not a good partner and collaborator.

The Director of Strategic Development undertook a comprehensive review of the controls, assurances and planned actions, which has resulted in four of the planned actions being achieved: Humber Acute Services Review communication has been developed, the Integrated Care System and Humber work plan was completed in quarter one 2021, the capital investment strategy and trust priorities were approved at Trust Board and the project / programme plans have been approved.

The strategic risk was reviewed by the Finance and Performance Committee at its meeting on 28 July 2021. The current risk score remains at 12 due to the current gaps in controls and the planned actions. There are two high level risks on the risk register that could impact on the delivery of the strategic objective.

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

The Workforce Committee reviewed the strategic risk at its meeting on 27 July 2021. The Director of People reviewed the controls, assurances and planned actions. The current risk score remains at 12 due to the gap in control being: no investment for staff training / courses to support leaders work within a different context. The action to close this gap is the scoping of a leadership development programme for leaders at all levels to be developed by December 2021.

4. Recommendations

The Trust Board is asked to:

a) note the over-arching report, the detailed BAF in Appendix 1 and the current risk scores

b) seek assurance from the Sub-Committees of the Board and the Executive Owners on the controls, assurances, planned actions and the underpinning high level risks

c) consider the proposal from the Workforce Committee to reduce the risk scoring of SO2 – 'the risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients' from 20 to 15

d) approve the strategic risk wording of strategic objective 1 – 1.1, from: the risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience; to: the risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by ***national*** comparison) of safety, clinical effectiveness and patient experience.

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 neig 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 comm - 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 sta

Risk Scoring Approach

Strategic Risk Assessment

Strategic Objective		Strategic Risk	Risk Appetite
1 To Give Great Care	SO1 - 1.1	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)
	SO1 - 1.2	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)
	SO1 - 1.3	The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber acute services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.	Low (4 to 6)
	SO1 - 1.4	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)
	SO1 - 1.5	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)
	SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).	Low (4 to 6)
2 To Be A Great Employer	SO2	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	SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.	Moderate (8 to 12)
	SO3 - 3.2	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	SO4	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	SO5	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 to 12)

Risk Appetite Statement - 2021 / 22

Context

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

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

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

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

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

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

The Trust recognises it has a responsibility to manage risks effectively in order to:
- protect patients, employees and the community against potential losses;
- control its assets and liabilities;
- minimise uncertainty in achieving its goals and objectives;
- maximise the opportunities to achieve its vision and objectives.

Risk Appetite Assessment

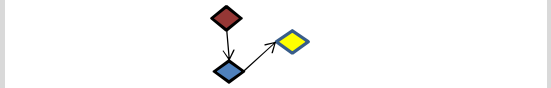
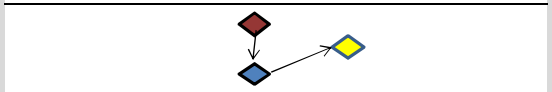
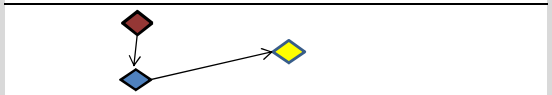
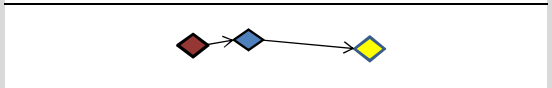
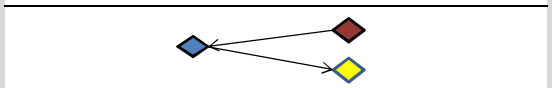
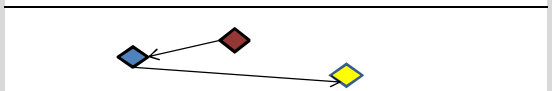
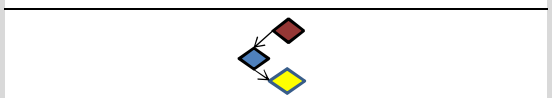
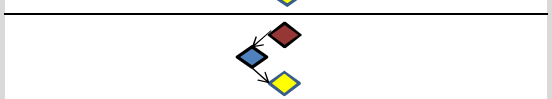
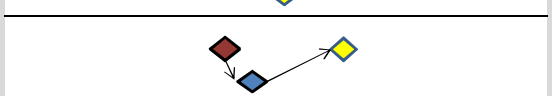
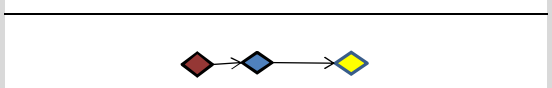
Risk Assessment Grading Matrix

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

Based on this scoring methodology broadly the Trust's risk appetite is:

- For risks threatening the safety of the quality of care provided– low (4 to 6)
- For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)
- For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Strategic Risk Ratings

Strategic Objective	High Level Risk Description	Risk Consequence / Impact Assessment	Risk Rating 2021-22 Q1	Q2	Q3	Q4	Owner	Assurance (Committee)
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		15				Medical Director and Chief Nurse	Quality and Safety
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets		20				Chief Operating Officer	Finance and Performance
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy		12				Director of Strategic Development	Finance and Performance
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate		20				Director of Estates and Facilities	Finance and Performance
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care		12				Chief Information Officer	Finance and Performance
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope		16				Chief Operating Officer	Finance and Performance
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.		20				Director of People	Workforce
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities		12				Chief Financial Officer	Finance and Performance
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		12				Chief Financial Officer	Finance and Performance
SO4	The risk that the Trust is not a good partner and collaborator		12				Director of Strategic Development	Finance and Performance
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives		12				Chief Executive	Workforce / Trust Board

KEY	
◆	**Initial risk score**
◆	**Current risk score**
◆	**Target risk score**

- To give great care

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

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

Strategic Objective 1

	Initial	Current	Target
Consequence	5	5	5
Likelihood	3	3	2
Risk Rating	15	15	10

Iniital Date of Assessment: 1 May 2019
Last Reviewed: 25 June 2021
Target Date: 31 March 2024

Lead Committees:
Quality and Safety Committee

Risk Owners:
Medical Director and Chief Nurse

Current Controls

- Quality and Safety Committee
- Operational Plan (approved Trust Board 1/6/2021)
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Register Confirm and Challenge Meeting
- Trust Management Board
- Ethics Committee
- PPE Audits
- Quality Board, NHSE/I
- Quality Review Meetings with CCGs
- SI Collaborative Meeting with CCGs
- Health Scrutiny Committees (Local Authority)
- Healthwatch
- Chief Medical Information Officer (CMIO)
- Council of Governors

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups.
- Integrated Performance Report
- 15 Steps Challenge.
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- Nursing and Midwifery dashboards
- Ward Assurance Tool
- Nursing Metric Panels
- IPC - Board Assurance Framework
- Inpatient survey
- Friends and Family Test (FFT) platform
- Nursing Midwifery and AHP Strategy (Trust Board approved 1/6/2021)
- Risk Stratification Report (COO and Medical Director May 2021)
- Board Development Sessions - Monitoring CQC Progress

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance

Planned Actions

- Mandatory Training Report to Workforce Committee (by CQC Domain) - Director of People by 31 July 2021.
- Platform for FFT reporting at local and trust level developed by 31 August 2021.
- Preparation for trust requirements in DOLs by 31 April 2022.
- Continue to establish a vulnerabilities team, Aug 2021.
- Annual establishment reviews across nursing, midwifery and community settings continue
- Continue to add metrics as data quality allows by 31 March 2022.
- Implement supportive observation by 31 October 2021.
- Update IPC BAF as national changes and requirements (ongoing)
- Continued management of Covid 19 outbreaks (ongoing).
- Ophthalmology Action Plan 2021-22 to be developed by Division of Surgery and Critical Care by August 2021.
- Implementation of End of Life Strategy by March 2022.
- Risk stratification report with trajectories and continued oversight through Operational Management Group, by March 2022.
- Workforce Committee overseeing recruitment (BAF SO2).
- CMIO to review clinical engagement of results acknowledgement, through Digital Strategy Board, by Q3 2021/22.

Future Risks

- COVID-19 third surge and impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Many services single staff/small teams that lack capacity and agility.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Changes to Liberty Protection Safeguards.
- Skill mix of staff.
- Student and International placements and capacity to facilitate/supervise/train

Links to High Level Risk Register

- Mortality performance (2418) - Risk Rating 10 (previous risk rating 15).
- Ceilings of care and advance care planning (2653) - Risk Rating 9 (previous risk rating 12)
- Deteriorating patient risks - Medicine (2388) - Risk Rating 15, Surgery (2347) - Risk Rating 15, Paediatrics (2390) - Risk Rating 8 (previous risk rating 15)
- Management of formal complaints (2659) - Risk Rating 12 (previous risk rating 15)
- Risk to overall cancer performance - Clinical Support Services (2244) - Risk Rating 12 (previous risk rating 16)
- Inequitable division of LD Nurses (2531) - Risk Rating 12 (Iprevious risk rating 20)
- Inability to segregate patients in ED due to lack of isolation facilities (2794) - Risk Rating 20
- Child Protection Information System (2914) - Risk Rating 15

(28 Moderate Risks and 5 Low Risks linked to quality and safety).

Strategic Threats

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

Adverse impact of external events (ie. Britains exit from the European Union; Pandemic) on business continuity and the delivery of core service.

Workforce impact on HASR

Gaps in Controls

- Risk stratification not complete.
- Estate and compliance with IPC requirements - see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Fully funded Learning Disabilities team across both sites
- Attracting sufficiently qualified staff - see BAF SO2.
- Delays in progress with the End of Life Strategy
- Ophthalmology Waiting List
- Delays with results acknowledgement

Gaps in Assurance

- Mandatory training
- Sepsis Web-V Tool
- Risk stratification
- FFT data reporting to Committees and Groups

Future Opportunities

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

- To give great care

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

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

Strategic Objective 1

	Initial	Current	Target
Consequence	5	5	5
Likelihood	4	4	1
Risk Rating	20	20	5

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021
Target Date: 31 March 2026

Lead Committees:
Finance and Performance Committee

Risk Owners:
Chief Operating Officer

Current Controls

- Operational Plan 2021-22 (Trust Board approved 1/6/2021)
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- Strategic Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Emergency Department (ED) Performance and Ambulance Handover Group
- Planned Care Board
- Primary and Secondary Care Collaborative Outpatient Transformation Programme

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, Strategic Planning Group, A&E Delivery Board, MDT Business Meetings, Planned Care Board.
- Integrated Performance Report to Trust Board and Committees.
- 7 Day Services Assurance Framework, action plan.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.

External:
- NHSI Intensive Support Team
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.

Planned Actions

- Diagnostic and cancer pathways reviewed and implemented by Q2 2021-22.
- Public Health England guidance (cancer diagnosis) reviewed and implemented by Q3 2021-22.
- Further developement of the ICP with HUTH by Q3 2021-22
- Workforce and resources to Humber Cancer Board by Q3 2021-22.
- Develop a joint NLAG/HUTH cancer transformation plan by Q1 2021-22.
- Diagnostic breach tracker tool by Q4 2021-22.
- Outpatient transformation plan by 2022.
- Development of Phase 2 three year HASR Plan by 2022.
- Consultant job plans to be updated by Q2 2021-22.
- Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties by Q4 2021-22.
- Continued development and implementation of risk stratification for RTT incomplete and completed pathways by Q3 2021-22.
- 40 Week RTT recovery plan to be costed and implemented by July 2021.
- RTT / Cancer Recovery Plan costed and implemented by April 2021.
- Develop divisional dashboards Q3 2021-22.
- Consultant led ward rounds, further development and implementation (ECIST) by Q3 2021-22.
- Development of an independant sector activity plan by Q2 2021-22.

Future Risks

- COVID-19 third surge and impact on patient experience.
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 62 days and 104 days breaches, due to COVID-19.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to COVID-19.
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 52 week waits and Dignostics Constitutional Standards.
- Capacity to Reduce 52 week, 104 day and over 18 week waits to meet the trusts standard of 0 waits over 40 week in 2022.
- Cancer Board and MDT Meetings not quorate.
- Limited single isolation facilities.
- Urgent Treatnent Centre gaps in North and North East Lincolnshire GP rotas
- Lack of effective discharge planning.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.

Gaps in Assurance

- QSIS Standards improvement plans.
- Demand and Capacity planning for Diagnostics.
- RTT and DM01 not meeting national targets.
- Increase in Serious Incidents due to not meeting waiting times.
- Patient safety risks increased due to longer waiting times.

Links to High Level Risk Register

- Cancer 62 Day Target (2592)
- Risks of non-delivery of constitutional cancer performance (2160)
- COVID-19 performance and RTT (2791)
- Constitutional A&E targets (2562)
- Instabilitiy of ENT Service (2048)
- Overdue Followups (2347)
- Shortfall in capacity with Ophthalmology service (1851)
- Accuracy of data of business decision making for RTT (2515)
- Delayed or missing internal referrals (2826)
- Shortage of radiologists (1800)
- MRI Equipment (1631)
- Replacement of X-Ray Room (2646)
- SGH Main MRI Scanner capacity and waiting lists (2499)
- Failure to meet 6 week target for CT/MRI (2210)
- Failure to review ophthalmology patients in specified timescales (2347)
- JAG Accreditation in housing enema room within clinical area (2694)
- Impact on Medicine Divisional business plan / service delivery (2700)

Strategic Threats

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

Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Unexpected Busniess changes from the revised EU transitio

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration

- To give great care

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

Strategic Objective 1

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

	Initial	Current	Target
Consequence	4	4	4
Likelihood	3	3	2
Risk Rating	12	12	8

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021

Target Date: 31 March 2025

Lead Committee:
Finance and Performance Committee

Risk Owners:
Director of Strategic Development

Current Controls

- NLaG Clinical Strategy 2021/25.
- Strategic Plan 2019/24.
- Trust Priorities 2021/22.
- Humber Coast and Vale Health Care Partnership (HCV HCP).
- Integrated Care System (ICS) Leadership Group.
- NHS Long Term Plan (LTP).
- Quality and Safety Committee.
- Acute Care Collaborative (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HASR).
- Health Overview and Scrutinee Committees (OSC).
- Council of Members.
- Council of Governors.
- Primary Care Networks (PCNs).
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Humber Acute Services Development Committee (HASDeC)

Assurance (internal & external)

Internal:
- Minutes from Programme Board and Executive Oversight Group for HASR.
- Minutes of HAS Executive Oversight Group.
- Humber Coast and Vale Health Care Partnership.
- ICS Leadership Group.
- OSC Feedback.
- Outcome of patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Highlight Report to Trust Board
- Minutes from HASCEC

Positive:
- NHSE/I Assurance and Gateway Reviews.
- OSC Engagement.

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel.

Planned Actions

- To formulate a vision narrative for Humber Acute Services review that is understood by partners, staff and patients by December 2021
- To undertake continuous process of stocktake and assurance reviews NHSE/I
- OSC - Quarterly Reviews.
- NED / Governor Reviews Monthly and Quarterly
- Citizens Panel held Quarterly.

Future Risks

- Change in national policy.
- Further covid-19 waves affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.

Links to High Level Risk Register

- Clinical Strategy (RR no. TBC).
- HASR political and public response to service change (RR no. TBC).

Strategic Threats

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

Gaps in Controls

- A shared vision for the HASR programme is not understood across all staff/patients and partners

Gaps in Assurance

- Feedback from patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HASR.

- To give great care

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

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

Strategic Objective 1

	Initial	Current	Target
Consequence	5	5	5
Likelihood	4	4	2
Risk Rating	20	20	10

Iniital Date of Assessment: 1 May 2019

Last Reviewed: July 2021

Target Date: January 2026

Lead Committees:
Finance and Performance Committee

Risk Owners:
Director of Estates and Facilities

Current Controls

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

Assurance (internal & external)

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

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

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

Planned Actions

- Continue to produce and revise our 3 year business plans on an annual basis in line with Clinical & Estates & Facilities Strategy. Prioritisation is reviewed and updated as part of the business planning cycle - Action date; ongoing
- Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing
- Allocation of Core Capital Funding assigned to infrastructure and engineering and equipment risks through the monthly E&F governance process - Action date; ongoing
- Estates and Facilities equipment plan produced and implemented as part of the 21/22 core capital annual funding (this may be reprioritised as no current contingency) - Action date; end of financial year 21/22
- To specifically deliver: - the Decarbonisation Funding (£40.3M) project across all three sites by 31 March 2022, - Core Capital Programme, - Transformational Capital Schemes, - BLM Schemes

Future Risks

- COVID-19 third surge and impact on the infrastructure.
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order.
- Regulatory action and adverse effect on reputation.
- Long term sustainability of the Trust's sites.
- Clinical Plan.
- Adverse publicity; local/national.

Links to High Level Risk Register

There are approximately 40 Estates and Facilities risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the physical infrastructure and engineering equipment being inadequate or becoming inadequate. Of particular note, there are a number of high risks relating to water infrastructure, medical gases and fire compliance that place increased risk to the Trust's overall strategic ability to provide patient care in a safe, secure and suitable environment.

Strategic Threats

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

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR.
- Insuffcient Capital funding.
- Timeline to deliver the decarbonisation projects.

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities.

Future Opportunities

- Closer ICS working.
- Humber Acute Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.

- To give great care

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

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

Initial	Current	Target		
	12		**Iniital Date of Assessment:** 1 May 2019 **Last Reviewed:** July 2021	**Lead Committees:** Finance and Performance Committee
			Target Date: March 2024	**Risk Owners:** Chief Information Officer

Current Controls	Assurance (internal & external)	Planned Actions	Future Risks
• Digital Strategy • Upto date Digital / IT policies, procedures and guidelines. • Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation. • Audit Risk & Governance Committee. (including external Audior reports) • Trust Management Board (TMB) • Finance and Performance Committee • Digital Strategy Board • Digital Solutions Delivery Group • Annual Penetration Tests • Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication	**Internal:** • Digital Strategy Approved by Board January 2021 • CIO in post November. 2020 • CMIO in post May 2021 • CN&AHP IO in post August 2021 • Highlight reports to Trust Board from Audit Risk and Governance Committee, Finance and Performance Committee, Digital Strategy Board, TMB. • Reporting Schedule approved May 2021 • IT Security Manager in Post 4th Quarter Fiscal 20/21. • CIO/Executive Director Report (6 monthly) to Trust Board • Approved Digital Governance Structure May 2021 **External:** • Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021 • External audit of DSPT there are 8 Assertions to address. A plan and action submitted to NHSD and action plan approved for deliver by July 31, 2021. • Limited Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019. **Positive Items to Note:** • Significant Assurance: Audit Yorkshire internal audit: Clinical Coding / Activity Recording: Significant Assurance, Q2 2019. • Significant Assurance: Audit Yorkshire internal audit: GDPR Compliance (cfwd 18/19): Significant Assurance, Q1 2019.	• Recruit Digital Leadership to drive change & engage with frontline (3rd & 4th Qtr 20/21) • Establish Digital Reporting schedule/Workplan for Board Committees (4th Qtr 20/21) • Apply for Digital Aspirant Funds to Support funding Digital Programs (20/21). • Recruit IT Security Manager (3rd Qtr 20/21) • Development of a comprehensive IT BC / DR Programme including monitoring of adherence to the programme. Results of BC / DR tests recorded and formally reported.(3rd Qtr 21/22) • Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (2nd Qtr 22/23 -July 2022). There are 8 Assertions on the Improvement plan with the end date of the 31st December 2021. • Secure resources to deliver Digital Strategy and annual Priorities (PAS; EPR; Data Warehouse; RPA; Doc Mgmt; Infrastructure upgrades).	• COVID-19 surge and impact on adoption of digital transformation. • National policy changes. • Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards. • IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG speciific agenda. • Ongoing financial pressures across the organisation. The Trust may be issued with an Information Notice to require them to provide information or an Enforcement Notice requesting them to take specified steps as required under the NIS regulation (Network and Information Systems regulations 2018).
		Links to Corporate Risk Register	**Strategic Threats**
		• Cyber security risk (windows 10 implementation/Win Server Migrations) (2463) • Accuracy of Data of Business Decision Making (2515) • The IT Operations Department require a comprehensive IT Service Management System (2675) • Risk of non-compliance with the Data Protection Act 2018 due to the Trust not having sufficient resource and technical tools (2676) • Unsupported software, hardware and applications (2369) • Data & Cyber Security: (2) Cyber Infrastructure (2408) • Updated Business Continuity & Disaster Recovery Policy & Procedure (#).	• Capital funding to deliver IT solutions. • Government legislative and regulatory changes shifting priorities as the ICS continues to evolve.
Gaps in Controls	**Gaps in Assurance**		**Future Opportunities**
• Address the assertions without evidence in the DSPT • Develop policy and procedure to address the gaps noted in the IT Business Continuity audit iin April 2020 • Achieve DSP Toolkit and mandatory training compliance. •Review ToR/recruit wider representation to the Digital Strategy Board & Digital Solutions Delivery Group. (improve attendance, representation and directorate support.) • Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions	• Integrated Performance Report - Digital. (include performance metrics of underlying infrastructure and application performance) • Posture Assessment (cyber) to be presented to AR&G June 2021. • Digital Strategy project plan. • Data Warehouse solution to support outcomes from BI review.		• Humber Coast and Vale ICS, system wide collaborative working. • Clinical pathways to support patient care, driven by digital solutions. • Collaborative working with HASR and Acute Care Collaborative.

- To give great care

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

Strategic Objective 1

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

	Initial	Current	Target
Consequence	4	4	4
Likelihood	2	4	2
Risk Rating	8	16	8

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021

Target Date: 31 March 2022

Lead Committee:
Finance and Performance Committee

Risk Owners:
Chief Operating Officer

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- Ward visiting arrangements changed and implemented, Red and Green Zones, expansion of critical care faciliites.
- COVID-19 Executive Incident Control (Gold Command).

Assurance (internal & external)

Internal:
- Regional EPRR scenarios and planning exercises in preparation for 'Brexit' have been undertaken alongside partners, including scenarios involving transportation, freight and traffic around local docks with resulting action plan.
- Business continuity plans.
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group.

Positive:
- Half yearly tests of the Major incident response.
- Annual review of business continutiy plans.
- Internal audit of emergency planning compliance 2018/19 (due 2021/22).

External:
- Emergency Planning self-assessment tool.
- NHSE review of emergency planning self-assessment 2019/20.
- Internal audit of emergency planning compliance 2018/19 (due 2021/22).

Planned Actions

- Lateral flow testing staff is coordinated through the national programme from July 2021.
- Annual table top exercise by October 2021.
- Half yearly telephone exercise completed by March 2022.
- Business Intelligence monitoring re: BREXIT and pandemic.
- Capacity to meet demand (Beds/workforce) by September 2021.
- PODs for urgent and emergency care outside of the acute hospital unavailable (UTC gaps)installed by January 2021.

Future Risks

- COVID-19 third surge.
- Availability of dressing, equipment and some medications post Brexit.
- Costs and timeliness of deliveries due to EU Exit.
- Additional patients with longer waiting times RTT, Cancer and Diagnostics due to COVID-19.

Links to High Level Risk Register

- Cancer 62 Day Target (2592)
- Risks of non-delivery of constitutional cancer performance (2160)
- COVID-19 performance and RTT (2791)
- Constitutional A&E targets (2562)
- Instabilitiy of ENT Service (2048)
- Overdue Followups (2347)
- Accuracy of data of business decision making for RTT (2515)
- COVID-19 Isolation (2794)
- C-19 Equipment (2793)
- C-19 Patient Safety (2792)
- COVID -19 pandemic - surgery & critical care (2706)
- COVID -19 pandemic - community and therapies (2708)
- COVID -19 pandemic - risk to IT Operatiions (2710)
- Impact on Medicine Divisional business plan / service delivery (2700)
- Risk arising as a result of COVID-19 - clinical support services (2704)

Strategic Threats

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

Gaps in Controls

- Capacity to meet demand (Beds/workforce).

Gaps in Assurance

- Not undertaking internal audit review of the standards.

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.

- To be a good employer

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

Strategic Objective 2

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

Risk Rating	Initial	Current	Target
Consequence	5	5	4
Likelihood	3	4 3	2
Risk Rating	15	20 15	8

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021

Target Date: March 2024

Lead Committees:
Workforce Committee, Remuneration and Terms of Service Committee

Risk Owners:
Director of People

Current Controls

- Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, Remuneration and Terms of Service Committee
- NHS People Plan
- NLAG People Strategy approved by the Board June 2020
- NHS Staff Survey - annual
- Collaborative engagement with CCG, forum established to support closer working and transformational changes.
- Holistic requirements of Humber Coast and Vale workforce led by People Lead for Humber Coast and Vale (HCV) Integrated Care System (ICS).
- People Directorate Delivery Implementation Plan 2021-22 (Workforce Committee approved 27/4/2021)

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee,Trust Management Board, Remuneration and Terms of Service Committee.
- Workforce Integrated Performance Report.
- Annual staff survey results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

Planned Actions

- Implementation of People Strategy by 31 March 2024.
- Delivery against NHS People Plan - ongoing.
- Investment in the People Directorate to develop plans for delivery against the NHS People Plan and NLAG People Strategy
- Continue collaboration between NLAG and HUTH and the HCV wider network.

Future Risks

- COVID-19 third surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes.
- Staff retention.

Gaps in Controls

- Restructure of People Directorate
- International recruitment of clinical staff due to visa restrictiions

Gaps in Assurance

- Staff morale barometer to compare engagement, value and health & wellbeing to Workforce Committee.
- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits.

Links to High Level Risk Register

There are approximately 14 staffing risks graded 15 or above recorded on the high level risk register. Of which there are a significant number of risks pertaining to the haematology workforce, staffing (nurse, midwife, medical, radiologists) tha place an increased risk to the Trust's overall strategic ability to provide a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) and to provide the levels and quality of car which the Trust needs to provide for its patients.

Strategic Threats

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

Future Opportunities

- Closer ICS working.
- Provider collaboration.
- International recruitment.

- To live within our means

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

Strategic Objective 3

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

Risk Rating	Initial	Current	Target
Consequence	5	4	5
Likelihood	2	3	2
Risk Rating	10	12	10

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021

Target Date: 31 March 2024

Lead Committees:
Finance and Performance Committee

Risk Owners:
Chief Financial Officer

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMS.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning.
- Humber Acute Services Review (HASR) engagement to redesign fragile and vulnerable service pathways at system and sub system level.
- Monthly ICS Finance Meetings
- Finance Meeting - HASR
- Operational and Finance Plan 2021-22 (approved at Trust Board June 2021)
- Financial Special Measures Meeting with NHSE/I.
- Counter Fraud and Internal Audit Plans.

Assurance (internal & external)

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

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan.

External:
- Financial Special Measures Meeting - Letter from NHSE/I related to financial special measures and achievement of action plan.
- ICS Executive Oversight Group.
- HASR Programme Assurance Group

Planned Actions

- Develop Finance Strategy, Q2 2021/22.
- Develop Finance IPR, Q3 2021/22.
- Development of full CIP, Q2 2021/22.
- Monitoring of new H2 financial guidance released from NHSE/I in relation to H2 and refresh financial plan in Q2 2021/22.
- HASR Fragile and vulnerable services programme to deliver change in pathways which deliver operational efficiency, improve quality and outcomes and support recruitment of staff by 2023.
- Five Year Plan, interim Clinical Plan and Trust Recovery Plan by 2024.
- Letter from NHSE/I related to financial special measures and achievement of action plan by Q3 2021-22.
- Finailise Investment Programme 2021-22 Q2 2021.

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Recurrent COVID-19 Expenditure
- Savings Programme

Links to High Level Risk Register

- Risk of not achieving 2020-21 CIP target - family services (2733).
- Unable to meet CIP delivery - surgery (2599).
- COVID-19 Expenditure (ref: Financial Plan 2021-22)
- Savings Programme (ref: Financial Plan 2021-22)

Strategic Threats

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

Gaps in Controls

- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on H2 Financial Framework 2021-22.
- Finance Strategy

Gaps in Assurance

- Integrated Performance Report - Finance.
- Delivery of Cost Improvement Programme Plan.
- Management of finance risks arising from the cost of the pandemic.
- Individual organisational sustainability plans may not deliver system wide control total.

Future Opportunities

- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.

- To live within our means

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

Strategic Objective 3

Risk to Strategic Objective 3 - 3.2: 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.

Risk Rating	Initial	Current	Target
Consequence	5	4	5
Likelihood	2	3	2
Risk Rating	10	12	10

Iniital Date of Assessment: 1 May 2019

Last Reviewed: July 2021

Target Date: 31 March 2024

Lead Committees:
Finance and Performance Committee

Risk Owners:
Chief Financial Officer

Current Controls

- Capital Investment Board
- Agreed Capital programme and allocated budget 2021/22
- Financial Special Measure Meeting with NHSE/I

Assurance (internal & external)

Internal:
- Minutes of Trust Management Board, Finance and Performance Committee, Capital Investment Board.

External:
- NHSE/I attendance at AAU / ED Programme Board
- Financial Special Measure Meeting with NHSE/I

Planned Actions

- Develop core capital programme in conjunction with long term financial strategy by Q2 2021/22.
- Financial requirements for HASR Q3 2021/22 (link to SO1-1.3 and SO4).

Future Risks

- COVID-19 third surge and impact on finance due to the lack of supplies or inflation
- National policy changes.
- Challenges with estate major capital.

Links to High Level Risk Register

- AAU / ED Business Case

Strategic Threats

- ICS Future Funding.
- Government funding allocations

Gaps in Controls

- Systems plans may not address individual organisational sustainability.
- Challenges with Estate.

Gaps in Assurance

- Delivery of Cost Improvement Programme Plan.
- Individual organisational sustainability plans may not deliver system wide control total.
- Committees in Common

Future Opportunities

- Provider collaboration
- System wide collaboration to major capital development needs.

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale 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.

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

Risk Rating	Initial	Current	Target
Consequence	5	4	4
Likelihood	3	3	2
Risk Rating	15	12	8

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021
Target Date: March 2025

Lead Committees:
Finance and Performance Committee

Risk Owners:
Director of Strategic Development

Current Controls

- Audit Risk & Governance Committee.
- Trust Management Board (TMB).
- Finance and Performance Committee.
- Capital Investment Board.
- HAS Executive Oversight Group.
- Humber Coast and Vale (HCV) Health Care Partnership (HCP).
- Integrated Care System (ICS) Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HASR and HASR Programme Director appointed.
- NHS Long Term Plan (LTP).
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common (Trust Board approved 1/6/2021)

Assurance (internal & external)

Internal:
- Minutes of HAS Executive Oversight Group, HCV HCP, ICS Leadership Group, Wave 4 ICS Capital Committee, Audit Risk & Governance Committee, Finance & Performance Committee, TMB, Capital Investment Board.
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.

Planned Actions

- Continuous HAS communication and engagement
- HAS two year programme (current to March 2022) - 12 month rolling.
- Options appraisal for HAS Capital Investment to be approved by Q4 2021/22.
- Identification and approval for management time within existing consultant management Pas (Clinical Leads), approach to be agreed with Chief Operating Officer / Divisional Clinical Directors by September 2021

Future Risks

- National policy changes.
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.

Links to High Level Risk Register

- Clinical Strategy (RR no. TBC).
- HASR political and public response to service change (RR no. TBC).

Strategic Threats

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

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Interim Clinical Plan with Humber to be progressed.
- Governance arrangements for HAS, clinical leadership, clinical engagement and approval of plans.
- Strategic capital investment options appraisal in progress for HAS for N Lincs and NE Lincs.
- Engagement with the wider system in the clincial strategy, capital and service developments, including attendance at programme boards / clinical sign off of propose plans.
- Local Authority, primary care, cmmunity service, NED and Governor engagement / feedback.
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Hosting of HAS clinical services to support planning.
- Lack of integrated plan and governance structure.

Future Opportunities

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

Strategic Objective 5 - To provide good leadership

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

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

Risk Rating	Initial	Current	Target
Consequence	4	4	4
Likelihood	4	3	2
Risk Rating	16	12	8

Iniital Date of Assessment: 1 May 2019
Last Reviewed: July 2021
Target Date: March 2022

Lead Committees:
Workforce Committee and Trust Board

Risk Owners:
Chief Executive

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS.
- CQC and NHSE/I Support Teams
- Board development support programme with NHSE/I support.
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments.
- Development programmes for clinical leaders, ward leaders and more programmes in development.
- Communication with the Trust's senior leaders via the monthly senior leadership community event.
- NHSI Well Led Framework.
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement.
- Joint posts of Trust Chair and Chief Financial Officer, with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, HCV HCP and CCG.

Assurance (internal & external)

Internal:
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Letter from NHSE/I related to financial special measures and achievement of action plan.
- Chief Executive Briefing (bi-monthly) to Trust Board

Positive:
- Letter from NHSE/I related to financial special measures and achievement of action plan.

External:
- CQC Report - 2020 (rated Trust as Requires Improvement).
- Financial and Quality Special Measures.
- NHS Staff Survey.

Planned Actions

Planned Actions:
- Compliance and performance improvement to be monitored at PRIMS by 31 March 2022.
- Development of Trust Priorities quarterly report, by Q2 2021 and supporting People Plan which outlines plans to scope out a Leadership Development Programme for leaders at all levels by December 2021.

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.

Links to High Level Risk Register

- None

Strategic Threats

- Non-delivery of the Trust's strategic objectives;
- Continued quality/financial special measures status;
- CQC well-led domain of 'inadequate'.
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives;
- Failure to obtain support for key changes needed to ensure improvement or sustainability;
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.

Gaps in Controls

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

Gaps in Assurance

- Integrated Performance Report
- Financial Special Measures
- Quality Special Measures

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)170

DATE OF MEETING	3rd August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Jug Johal – Director of Estates & Facilities
CONTACT OFFICER	As above
SUBJECT	Annual Fire Report
BACKGROUND DOCUMENT (if any)	HTM 05-01 – Managing Healthcare Fire Safety
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Estates & Facilities Governance Group Trust Health, Safety & Fire Group Audit, Risk & Governance Committee
EXECUTIVE SUMMARY	Key highlights of the report include: • Significant investment to commence replacement of fire alarm system commencing DPOW • No enforcement actions during period • Number of unwanted fire signals reducing • Training at 84% at end of period

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
	✓			

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment	✓	**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Strategic Objective 1 – 1.4 : The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Annual Fire Report – Trust Board

Period – 1st April 2020 to 31stMarch 2021

1.0 Introduction

1.1 This report is for the period 1stApril 2020 to 31st March 2021. It is based on a rolling programme of fire risk assessments across the Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) estate in accordance with the Regulatory Reform (Fire Safety) Order 2005 [RR(FS)O] and the Healthcare Technical Memorandum (HTM) known as "Firecode" which applies to all Trusts.

1.2 The rolling programme is such that all areas of the Trust's estate have undergone an initial risk assessment which is then reviewed on a risk category basis of low, medium and high risks. High risk areas are revisited at least annually. These risk categories are based on definitions contained in guidance documents within the RR(FS)O or Firecode (e.g. patient areas with sleeping facilities are automatically designated as high risk whereas out-patient departments would be designated medium or low risk).Premises occupied or managed by the Trust are also accounted for inclusive of community locations. Some fire risk assessments are out of review date due to covid-19, this has been discussed with Humberside Fire and Rescue Service. It is agreed that these assessments will be reviewed remotely from the area involved and their review dates extended. If there are any potential problems identified then attempts will be made to get the area reviewed taking into account suitable precautions.

1.3 Compliance issues across the estate is monitored on a regular basis by the Finance & Performance Committee. These documents are live and current work is ongoing to ensure that risks are appropriately identified on the risk register to ensure that those which could result in statutory enforcement and/or pose a risk to the safety of staff, patients and visitors. The risk register means that issues such as condition and connections to Fire Ring Mains, Coronation Block etc. can be considered where they may be linked to the Critical Infrastructure (CI) risks and also the Back Log Maintenance (BLM) programme. Some of these risks have been reviewed in the light of the updated Six Facet Survey Report, Critical Infrastructure Board, Capital allocations etc.

1.4 It should be noted at the time of compiling this report a number of significant projects are underway which will result in a number of fire risks being removed from the risk register. The most significant of these are the outstanding issues in relation to the Coronation Block and the replacement of the fire alarm system at DPOW.

2.0 Administration

2.1 The regulatory landscape is changing and the direction of fire safety management has been impacted by the Covid-19 pandemic. This has resulted in anticipated regulatory reforms being delayed as some are related to the outcomes of the ongoing Grenfell public enquiry (currently the technical enquiry has yet to conclude). There are a number of potential regulatory changes such as the relationship between landlords/owners, the management company (where there is one) and local authorities interaction (i.e. Building Control, enforcing authority etc.).

2.2 There have already been some regulatory changes made to the RR(FS)O meaning that the fire brigade have now more enforcement options for accommodation buildings of multiple occupancy to ensure that regulatory requirements & responsibilities are complied with. This may result in more enforcement action within NHS Trusts who have staff accommodation premises on their sites. In addition the Fire Authorities are now involved with Building Control Applications from when they are submitted for approval and are able to regulate prior to the commencement of work (as opposed to only able to enforce on completion of the work).

2.3 Fire safety generally, within healthcare, still remains an area of concern especially where patient safety is considered as being at high risk. Additional risks arising from the Covid-19 pandemic have also been highlighted due to increased oxygen usage and the potential risk of enriched oxygen atmospheres. It should be noted, however, that in the UK there have been no significant fires where increased oxygen has contributed to the fire. This is not the case in other parts of the world and this may be in part to the standards in use in the UK and the level of awareness and training.

2.4 At the Northern General Hospital in Sheffield, the Sir Robert Hadfield Wing – which had opened in 2005 – has been closed since November 2018, with the four wards of 120 beds shut due to poor construction practices. The building constructed under a Private Finance Initiative (PFI) was found to have potential fire compartment breaches which could result in unexpected fire spread and the Trust was served with a prohibition notice and required to empty the wards of patients and not to occupy the wing until the issues have been resolved.

2.5 Currently there are 19 NHS Trusts with enforcement notices still in force for various issues such as inappropriate emergency evacuation routes, lack of fire risk assessments, staff accommodation (prohibition notice served a number of years ago), insufficient fire fighting equipment, lack of training etc.

2.6 A wide range of other trusts have complained about the ‘lack of capital’ and its effects on fire safety provision, while others still have had fire safety notices ‘in place for several years’ including Doncaster and Bassetlaw Teaching Hospitals Foundation Trust, were not able to occupy their Women & Children’s Block and their East Ward

Block at Doncaster Royal Infirmary. These notices have now been complied with but the work to done to do this is estimated to be in the region of £20m.

2.7 In addition, United Lincolnshire Hospitals Trust has had a number of enforcement notices on both Lincoln County Hospital and the Pilgrim Hospital in Boston from mid-2017, still outstanding. Significant funding has been given to be allocated to comply with building regulations, but these issues have still not been resolved and potentially could result in further enforcement action.

2.8 This activity by fire enforcement authorities highlights a more interventionist strategy being adopted post Grenfell and there is likely to be more activity when the second inquiry into Grenfell publishes its full and final report.

2.9 In terms of our enforcing authority it should be noted that whilst audits with Humberside Fire and Rescue Service (HFRS) were suspended due to Covid-19 NLaG a number of telephone assessments will be completed. There still remain occasional incidents of concern relating to compartmentation, detection change of use of areas/wards etc. This could potentially result in enforcement action although the working relationship is such that this has not occurred up to now. Although there is still somewhat an evident culture that fire safety is an estates and facilities function exists in relation to local management of fire safety more engagement is being actively encouraged.

2.10 During the year the incumbent fire safety advisor left their post to pursue a career development opportunity and this has resulted in a review of how fire safety is considered. Due to the large number of capital funding that has been awarded the responsibilities regarding projects and operation fire safety management is in the process of being split and recruitment has been made to the operational side

3.0 Training

3.1 Compliance for fire training in this period stood at 84% which is the same as previous years. A breakdown can be seen below:

Chief Nurse	88%
Trust Management	96%
Digital Services	92%
Estates & Facilities	95%
Finance	94%
Medical Directors Office	78%
People & Organisational Effectiveness	93%
Strategic Development	89%
Operations Overall	82%

- Clinical Support Services	89%
- Family Services	76%
- Medicine	78%
- Operations Management	71%
- Surgery & Critical Care	79%
- Therapy & Community Services	88%

3.2 These figures are taken from the reports produced at the end of March 2021 and it should be noted that due to Covid-19 all face to face training was suspended and a number of staff were identified as requiring to shield, stay at home etc. This effect will cause some distortion in the figures which will also be evident in subsequent reports.

3.3 There should be some acknowledgement that despite having to deal with significant pressures arising from the Covid-19 pandemic the Trust managed to maintain the level of fire safety training.

4.0 Fire Calls

4.1 During 2020/21 there were no primary fires on Trust property. There were a number of smaller fire incidents which were promptly dealt with by staff.

4.2 A comparison of Unwanted Fire Signals (UwFS) at the Trust is tabulated below.

	UwFS 2014/15	UwFS 2015/16	UwFS 2016/17	UwFS 2017/18	UwFS 2018/19	UwFS 2019/20	UwFS 2020/21
SGH	3	7	4	3	10	10	7
DPOW	4	9	8	9	8	17	3
GDH	0	0	2	2	0	1	0

4.3 The recent trend of increasing UwFS has been reversed across all three sites. This is primarily due to better notification and call challenge internally with NLAG.

4.4 The number of UwFS at DPOW is a combination of system or unknown faults and cooking incidents. The system/unknown faults should be addressed in 21/22 as the replacement of the existing fire alarm system commenced in Q4 of 20/21 and will be completed in Q2 of 21/22.

4.5 More analysis of the alarm activations (of which there were 123 in total) has been introduced but there is not a full set of data for 20/21 so that information will be reported in future reports.

4.6 The risk relating to the failure of the auto fire detection system (AFD) at DPOW will be removed from the risk register when the replacement system is installed and commissioned in Q2 of 21/22. Some remedial work at SGH has been completed to reduce the risk of failure of the AFD system but the this system is also planning to be replaced in 21/22 with the same system as currently being installed at DPOW. This may allow linkage between the sites and monitoring of alarms from a central location at some point in the future.

5.0 Maintenance

5.1 With the critical infrastructure funding being used to address the AFD issues there has been no allocation within the BLM for fire issues. However, where required damaged fire doors have had to be replaced and this is usually funded by the revenue funding streams.

5.2 The issues in relation to fire compliance within the Coronation Block are nearing completion of the work to address them. This is part of the enabling works to allow the ED/AAU project to move forward. When the work has been completed the building will be used for administration purposes apart from the fracture clinic which at present cannot be relocated. Agreement with Humberside Fire & Rescue Services (HFRS) on what is required to allow occupancy was obtained and there has been regular contact with HFRS and the contractor undertaking the work to ensure that when completed the requirements will be met.

5.3 In relation to fire detector head replacement programmes the AFD replacement project at DPOW means that all new heads will be installed at DPOW and the same will occur at SGH when the replacement scheme commences.

5.4 Consideration is now being given to the other main area of maintenance which relates to the fire doors. The requirement to inspect the doors at regular intervals is not fully compliant with the frequency needed and records need to be more comprehensive. A recognised inspection regime and recording system is now being reviewed and a business case developed to implement such a system. In addition to this authorised repairer schemes are being reviewed to allow authorised repairs to be undertaken for minor damage rather than having to replace the whole fire door set.

6.0 Maintenance-Passive Fire Protection Update

6.1 A number of inspections and testing requirements have slipped in frequency due to the impact of Covid-19 and the implementation of red zones at SGH and DPOW. These will be picked up as the number of zones return to green and allow easier access to the companies used.

6.2 Fire dampers and dry risers will continue to be tested at the required frequency if accessible (i.e. not in red zones) and a full regime of testing will be reintroduced as the clinical impact of Covid-19 lessens.

6.3 A check of fire stopping has been undertaken during the AFD replacement at DPOW with some areas highlighted as requiring work. Currently the information is being collated to allow costs and options to be developed and implemented to address those areas. In addition fire stopping information within projects currently underway is being more robustly managed to ensure that appropriate information and evidence is retained on where fire stopping has been carried out and certified as adequate in accordance with an accredited scheme. It is noted that some nearby Trusts have been subject to enforcement action on this issue and this will continue to be progressed comply with the requirements

6.4 The programme of annual fire extinguisher checks continues and the inventories are all up to date.

7.0 Maintenance-Active Fire Protection Update

7.1 As previously mentioned the AFD replacement project at DPOW will mean that all the detector heads will be replaced so no replacement programme is required for this year. As the SGH replacement programme will also occur in 21/22 then these head will also be replaced. This will leave a small amount of heads at GDH to be replaced

7.2 The new AFD system at DPOW will allow an appropriate location to be identified on the panel and will relate to the door codes which are now on each door. This will address the issue where wards rename areas without notification so any alarm activation message may give a correct location. Also the new system will allow estates staff to reconfigure the text string address where required which is currently difficult due to the age of the systems

7.3 The cause and effect of the AFD systems will be reviewed as part of the replacement programme and will ensure that this still meets the requirements of the HTM.

7.4 Work has been carried out in the last year to reinstall a number of fire hydrants at SGH which were not operating correctly. That work has been completed and further work on the fire ring main is continuing to remove the connections currently supplying water to the outbuildings directly from the ring main. This has implications in relation to legionella risks and the requirement to have a dedicated ring main. Hydrant testing has identified a number of hydrants where the flowrate is below the required level and ongoing work in 21/22 will look to identify and resolve these issues.

8.0 Investment during the period

8.1 Funding was obtained (circa £2m), during the period to commence the replacement of the fire alarm systems within the Trust. Commencing with DPOW the tender process resulted in MNCN being awarded the contract and at the end of March most of the Family Services block and North Side had been completed with work commencing on the main building in April.

8.2 The work for the whole of DPOW is scheduled to be completed by the end of July. The fire alarm at SGH is the planned next phase of the process although detailed planning has not yet been finalised.

9.0 Conclusions

9.1 There has been a significant move by the Trust to address some of the main issues in relation to fire compliance. This has been assisted by funding being made available to the Trust to allow this work to be undertaken. Whilst this work will (when completed) reduce the number of high risks in relation to the risk from fire and/or compliance with fire safety legislation, further work will still be needed to address issues such as fire stopping, fire door inspections and repairs.

9.2 There should be a recognition of the advancements made and this is somewhat reflected in that whilst other Trusts have been subject to enforcement action, HFRS have

worked with the Trust to allow the issues to be resolved to the satisfaction of both the fire authority and NLAG.

9.3 Further improvements can be made and these are reflected in the recommendations shown below.

10.0 Recommendations

10.1 The following recommendations are made:

a) Estates & Facilities to produce a business case to seek funding to implement an accredited fire door inspection scheme which will then ensure that all fire doors are inspected as required and appropriate records are maintained..
b) Estates & Facilities to ensure that the current work on the fire ring mains and hydrants is completed and all hydrants are tested to ensure appropriate flows are obtained.
c) To undertake a feasibility in relating to training staff to undertake approved repairs to fire doors to reduce costs as this could prevent the need to fully replace.

11.0 Annual Statement

11.1 This report confirms that for the period stated all relevant fire risk assessments have been completed as required by the Regulatory Reform (Fire Safety) Order 2005 except where noted due to current pandemic.

11.2 Reasonably practicable control measures identified (via the risk assessments) have been implemented during the course of the above period or where this has not been possible have been incorporated into an appropriate action plan and progress monitored via the relevant forums. Where progress is not being made to reduce the risks the relevant forum will escalate this in accordance with Trust policies and procedures.

Signed By

……..…….……Signature ……..……Signature

……..Print Name ……Print Name

Chief Executive Fire Safety Manager (as designated under HTM)

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)171

DATE OF MEETING	3rd August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Jug Johal – Director of Estates & Facilities
CONTACT OFFICER	As above
SUBJECT	LSMS Annual Security Report 20/21 & Workplan 21/22
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Security Group Estates & Facilities Governance Group Trust Health, Safety & Fire Group Audit, Risk & Governance Committee
EXECUTIVE SUMMARY	Key highlights of the report include: • Collaborative work with Humberside Police • No overdue actions • New projects in progress to reduce risk of harm to staff and patients A new set of NHS Security Management Standards (Violence Prevention and Reduction Standard published December 2020)

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
	✓			

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Strategic Objective 1 – 1.4 : The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	Approval	Information	Discussion	Assurance	Review
	✓				

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Estates and Facilities

Annual Report for Security Management 2020/21

Report Date:	15th April 2021
Number of Pages:	15
Report Author:	Ashley Leggott, Emergency Planning and Accredited Security Management Specialist
Director Sign-Off:	Jug Johal, Director of Estates and Facilities (Security Management Director (SMD)

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Executive Foreword

Security affects everyone who works within the NHS. The security and safety of staff, patients, visitors and property are a priority to enable the effective delivery of healthcare services. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has continued to develop its security management arrangements as part of a structured work programme identified in last year's Annual Report. This has included the:

- Implementation of the Joint Working Agreement between NLAG, Humberside Police and the Yorkshire and Humber Crown Prosecution Service
- Development of the 6 Point Promise for victims of intentional physical assaults whilst at work due to be rolled out late 2021
- Improved sharing and analysis of crime data between NLAG and Humberside Police
- Review of the existing CCTV provision across all three hospital sites and exploration of new technology options to replace and ensure it is fit-for-purpose
- A proactive approach to the issuing of informal warning letters to aggressors of violence and abuse against staff

There have been several criminal sanctions and Trust policy sanctions applied during 2020/21. The criminal sanctions include convictions against offenders for verbal and physical assaults. The Trust has issued 8 informal warning letters which were sent to patients and visitors warning them of inappropriate behaviour towards staff. The Trust issued 4 formal warning letters to patients due to the severity of their behaviour towards staff but has not excluded any patients or visitors during 2020/21. The Trust also issued one exclusion order to a repeat offender and severity of their behaviour.

The announcement in October 2018 from the Secretary of State for Health and Social Care detailed a renewed approach to tackling violence and abuse against NHS staff coupled with the potential for a new national lead for security management within the NHS. A new national lead (NHSE/I) and associated standards were released late 2020. It is hoped that this will close the gap that was created by the disbanding of NHS Protect, and allow for NHS Trusts sharing key security information and the central collection and analysis of security incident data.

Jug Johal
Director of Estates and Facilities (Nominated Security Management Director)

1.0 Background and Introduction

This report covers all aspects of Security Management at a local level and provides an update on the work streams that have been completed between the 1st April 2020 and the 31st March 2021.

The Trust is committed to improving the provision of a secure environment for staff, patients and visitors and the security and protection of its premises and assets, whilst recognizing the need for accessible clinical services and the desirability of a welcoming non-threatening environment. The Trust aims to achieve this objective through the implementation of appropriate systems and arrangements which meet national, legislative and code of practice requirements issued from various bodies.

In accordance with the NHS Standard Contract, in respect of services provided to NHS Commissioners and the Standards that were previously set by NHS Protect, the four priority areas for the Trust to develop a secure environment are:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

The Trusts Security Strategy, which is coordinated at a local level by the Local Security Management Specialist (LSMS), focuses on seven generic areas for action:

- **Creating a pro-security culture** – to promote a culture in which the responsibility for security, including timely reporting of security incidents, is accepted by all
- **Deterrence** – Identifying and implementing ways to deter security incidents and breaches
- **Prevention** – Identifying and implementing ways to prevent security incidents and breaches
- **Detection** – Ensuring security breaches are detected and appropriate reporting systems are in place

- **Investigation** – Initiating post incident reviews and criminal investigations
- **Sanctions** – Providing advice on relevant sanctions and utilising Trust policies
- **Redress** – Support the Trust to seek redress in all appropriate circumstances and assessing the true cost of security incidents to the NHS

2.0 Security Management Structure

The Trust's security management structure sits within the Directorate of Estates and Facilities and consists of the nominated roles of Security Management Director (SMD), held by the Director of Estates and Facilities, and the Local Security Management Specialist (LSMS) role held by the Emergency Planning and Local Security Management Specialist (figure 1). These roles work closely with the operational security functions that are managed by the Associate Director Facilities & Sustainability Facilities Services Management and delivered through the ISS security contract.

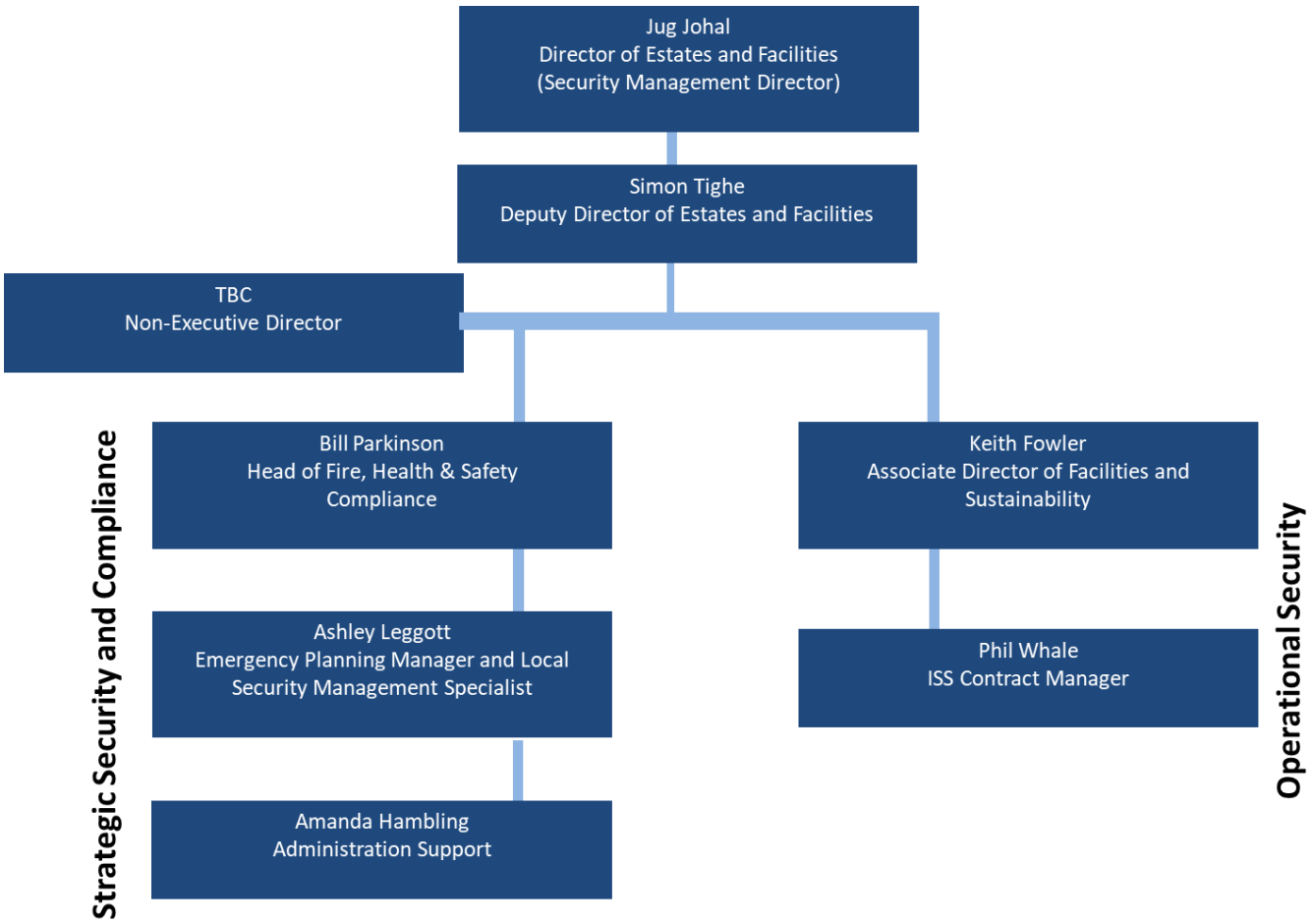


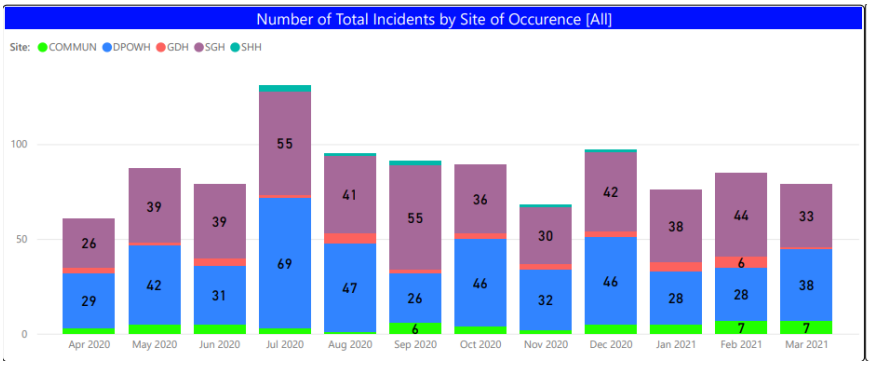
Figure 1 – Security Management Structure

2.1 Violence and Aggression against Staff

The number of reported incidents of security coded incidents during 2020/21 was a total of 1038 incidents Trust wide. This is broken down by 462 at DPOWH, 478 at SGH, 37 at GDH and 53 in the Community. This includes all incidents that are now coded as security including behaviour that is related to medical condition, absconding from wards and is not just coded to violence and aggressive behaviour. This appears to of had a significant increase on the figures that was reported during 2019/20. The year period of 2020/21 is a very difficult period to show similarities to other years due to the effect of the Covid-19 Pandemic and the impact this has had on the National Health Service nationally and locally.

The chart below (figure 2) shows the number of incidents per month by site. The reported numbers show that there has been a steady numbers of incidents reported at both DPOW and SGH though out the year, with July seeing the largest number of incidents reported at DPOW and similar with SGH this is likely to have been caused by the lifting of restrictions that had been in place for a number of months in relation

to the Covid-19 pandemic, with visitor numbers into the local economy at their highest for that year.



Calendar Month	COMMUN	DPOWH	GDH	SGH	SHH	Total
Apr 2020	3	29	3	26		61
May 2020	5	42	1	39		87
Jun 2020	5	31	4	39		79
Jul 2020	3	69	1	55	3	131
Aug 2020	1	47	5	41	1	95
Sep 2020	6	26	2	55	2	91
Oct 2020	4	46	3	36		89
Nov 2020	2	32	3	30	1	68
Dec 2020	5	46	3	42	1	97
Jan 2021	5	28	5	38		76
Feb 2021	7	28	6	44		85
Mar 2021	7	38	1	33		79
Total	**53**	**462**	**37**	**478**	**8**	**1038**

Figure 2 – Number of incidents per month by site

It should be noted that of the total 850 behaviour incidents reported during 2020/21, 51.93% related to behaviour that included violence or aggression, of this 32.11% was classed as Inappropriate /Aggressive Behaviour towards staff by patients and 25.31% was classed as Inappropriate/ Aggressive Behaviour towards staff by staff this is a slight decrease on the percentage that was reported in the year 2019/20 which was 27.13%.

The next chart (figure 3) shows the percentage of incidents per category for the year.

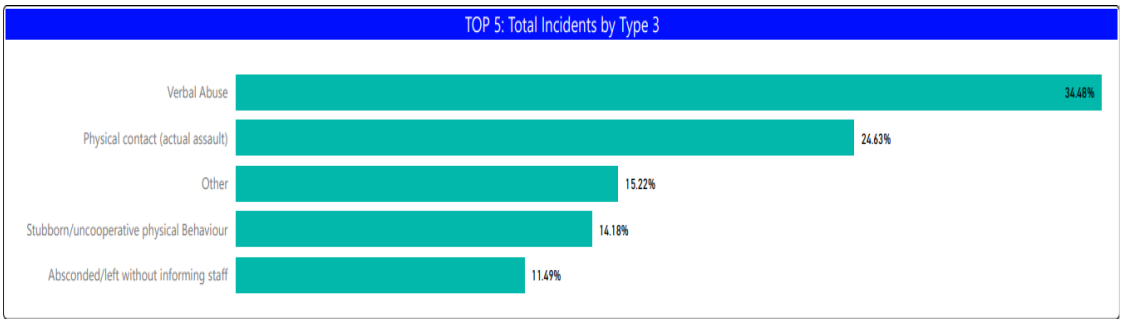


Figure 3

The percentage of reported physical assaults is 24.63%. The type of physical violence ranges from pushing and lashing out to punching and kicking. A number of

these incidents will relate to patients that are suffering from a medical episode so lack capacity to understand their behaviour so no action is taken by the LSMS but should be reviewed by the medical team in charge of their care to ensure correct care package is been provided to support the patient and staff.
The majority of incidents that are reported relate to both of the Emergency Care Centres this could be due to the patient and visitors they have within their departments and the acute treatment and care been delivered. The incidents that don't include clinical factors the LSMS and Police will endeavour to take strong action to try to prevent these incidents reoccurring.

Work is undertaken to support victims of these incidents and to put relevant actions in place against the aggressors in the hope of positive outcomes and to try and prevent reoccurrence. Details of some of the work in progress are included in other sections of this report.

2.2 Joint Working Agreement

The Joint Working Agreement (JWA) between the Trust, the Yorkshire and Humberside Crown Prosecution Service, and Humberside Police underwent a full review and rewrite and was re-launched in March 2018. The LSMS has worked closely with Inspector Richard Mirfin from Humberside Police to implement the JWA and ensure it makes an impact at frontline services. Work has continued with the implementation and awareness of the JWA and its principles to frontline policing and NHS staff. A 6-Point Promise has been agreed between NLAG and Humberside Police that details the six key points that NLAG staff will receive should they become a victim of an intentional physical assault whilst at work. These include the support that will be made available to them and that NLAG and Humberside Police will work together to achieve a positive outcome for the victim wherever possible. The 6-Point Promise was due to be launched during 2019 alongside a joint media release for awareness but there has been a delay in this been signed off by Senior Officers within Humberside Police and we are hoping for a new launch later in 2020. Due to the on-going Covid-19 pandemic the role out of the 6 point promise has been further delayed with a provisional role out date for late 2021.

2.3 Warning Letters for Unacceptable Behaviour

The Trust does not tolerate any acts of criminal violence and aggression against our staff and in support of this the Trust has the Policy for the management of Violent, Aggressive and Intimidating Behaviour which contains an exclusion procedure. The exclusion procedure consists of four stages, verbal warning, informal warning letter, formal warning letter and then an exclusion letter.

The LSMS has taken a proactive approach to challenging unacceptable behaviour as an early intervention to try and prevent the escalation of behaviour and reoccurrence of incidents. This proactive approach has led to 8 informal warning letters being sent to patients and visitors warning them of inappropriate behaviour towards staff during 2020/21. The Trust also issued 4 formal warning letters to patients due to the severity of their behaviour towards staff. The Trust excluded one patient during 2020/21 due to continues unacceptable behaviour having been issued with both an informal and formal warning within a short time period. The types of behaviour that led to the informal and formal warning letters include being verbally aggressive, threatening staff, physically assaulting staff and racial abuse.

Previous monitoring of the number of incidents that occurred prior to the warning letter and after the warning letter, the data showed that in the majority of cases there has been no reoccurrence of incidents involving the individuals after the letter has been issued.

2.4 Community Lone Working

There are approximately 549 staff that have received face-to-face training and been issued their new device. Currently there is 399 active devices assigned to staff with a mixture of individuals and pooled units. The devices contain the latest lone working technology, are linked to a 24/7 specialist alarm receiving centre and feature GPS locating technology that can be directly linked to the Police Command Centre Dispatchers during an emergency to ensure the quickest response possible for staff requiring help. The feedback received from staff has been positive regarding training, service provided by People-Safe and the new device functionality.

Due to the change in working practices caused by the Covid-19 pandemic the usage of the devices fell sharply during the year, as less staff where working in lone working situations. As lockdown restrictions begin to be lifted and working practices change this usage will be monitored and actions taken to ensure usage of the device increases.

2.5 Surveillance Systems

The Trust currently operates 3 Security Surveillance Systems, CCTV, Body Worn Video (BWV) devices and non-recording patient cameras and monitors. The Trust also has Automatic Number Plate Recognition (ANPR) in use on our car park barriers which, although not a security system, is still classed as a surveillance system.

The current CCTV system is analogue at DPOWH and GDH, whereas SGH has dual digital/analogue capacity recorders, but analogue cameras. The systems at DPOWH and GDH regularly fail with issues associated with the hardware, including the recording units, the cameras and the controller units. Much of the current system is out-dated, no longer supported or replaceable from the manufacturer and does not offer the modern functions found as standard on many CCTV systems. The current CCTV system often results in a lack of evidential quality footage to provide to the police, the inability to provide footage post-incident due to system failures, or the inability to record the minimum 30 days of footage due to recorder storage constraints.

A full review of the Trust's CCTV systems was completed during 2018 and an independent CCTV surveyor commissioned to provide a feasibility report for system replacements and upgrades. A tender process for a new Security provider has taken place and included in this tender there was a requirement for CCTV investment, discussion will be held with the awarded party regarding the requirements of upgrade to the CCTV system. No covert cameras were deployed during this year financial year.

2.6 National NHS Security Management

NHS England and NHS Improvement department released a new set of Standards for security management late 2020 which have replaced the previous ones issued by NHS Protect before they was disbanded in 2018. The Trust has reviewed these new standards to ensure they are meeting the requirement set out within them.

2.7 NHSE/I Standards

In December 2020 NHSE/I released a new set of standards for security management, Violence Prevention and Reduction Standard to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

The Trust will work to these standards and the work plan for the coming year is line with the standards attached Annex A.

2.8 Counter Terrorism

The many terrorist incidents that have occurred in the UK over the past few years reminds us of the continued need to ensure our sites and staff are prepared to respond to an incident and to be aware of the warning signs leading to an event. The Trust has worked closely with the National Counter Terrorism Policing: North East Counter Terrorism Unit in providing appropriate training sessions for Trust staff. The Trust was in the process of arranging new counter terrorism training for all staff using the new SCAN training provided by our local counter terrorism officers, this was unfortunately affected by the Covid-19 pandemic and had to be cancelled, this will be relooked at hopefully for late 2020 or early 2021. Due to the severity of the Covid-19 pandemic this training could not be completed within the stated time period and will hopefully be relooked at in late 2021 depending on the pandemic and operational pressure been experienced by the Trust.

3.0 2021/22 Work Plan for Security Management

The 2021/22 Work Plan for Security Management, which outlines the key actions against each security management objective, has been attached at Appendix A.

4.0 Summary and Next Steps

In summary, there continues to be a considerable amount of work in developing the Trust's security management arrangements to improve the safety of our services for staff, patients and visitors, and to protect NHS property and assets. The focus areas incorporated into the 2021/22 Work Plan for Security Management are continuing the close collaborative working with partner agencies to increase incident reporting and investigation outcomes, support for staff who become victims of crime, and progressing new technology and improvements to surveillance systems. The renewed national focus on reducing violence against NHS staff is likely to see a new set of security management standards and improved sharing of incident data and analysis across NHS organisations.

5.0 Trust Board Action Required

The Trust Board is asked to:

- Note the contents of the report
- Note the 2021/22 Work Plan for Security Management at Appendix A

Appendix A

2021/22 Work Plan for Security Management

Standard	Area	Task / Objective	Target Dates	Completed Date
Strategic Governance				
1.1	A member of the Executive Board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation. This person is nominated to NHS England	• LSMS to meet at least quarterly with SMD or as required • Quarterly Security Group Meeting • Investigation or management reports to be provided as required • Security Management Annual Report to the Trust Board	Quarterly Quarterly As required June 2021	
1.2	The organisation employs or contracts a qualified, accredited and nominated security specialist(s) to oversee and undertake the delivery of the full range of security management work	• LSMS to attend relevant conferences and CPD events • LSMS to attend Regional LSMS Forum	As required Quarterly	
1.3	The organisation allocates resources and investment to security management in line with its identified risks	• Funding is allocated to security issues as identified through security risk assessments and incident reporting • LSMS to support the Trustwide CCTV review	Ongoing In progress	
1.4	The organisation reports annually to its Executive Board, or equivalent body, on how it has met the standards set by NHS England in relation to security management, and its local priorities as identified in its work plan	• Self Review Tool (SRT) against the NHS Protect Standards completed and submitted to Security Group • Results of SRT against NHS England Violence Prevention and Reduction Standards to be included in Security Management Annual Report to the Trust Board	Awaiting new standards Awaiting new standards	
1.5	The organisation has a security management	• Review Policy and Strategy for	February	

	strategy aligned to NHS England Violence Prevention and Reduction Standards. The strategy has been approved by the executive body or equivalent body and is reviewed, evaluated and updated as required	Security in line with review schedule • Security Management Annual Report to the Trust Board	2022 June 2021	

Standard	Area	Task / Objective	Target Dates	Completed Date
Inform and Involve				
2.1	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets	• Joint Working Agreement in place with Humberside Police and CPS • LSMS meets with senior Police representative to progress collaborative working • LSMS attends relevant Community Safety Partnership work groups	Completed Quarterly Bi-Monthly	**2018**
2.2	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff. As part of this, the organisation participates in all national and local publicity initiatives, as required by NHS England Violence Prevention and Reduction Standard, to improve security awareness. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective	• LSMS to update all security related posters throughout the Trust with latest contact details • Security bulletins and alerts to be published in the weekly all-staff team brief newsletter • LSMS to provide security stands on each site during national security awareness month	June 2021 Ongoing November 2021	
2.3	The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises. The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external stakeholders to discuss security weaknesses and to agree a response	• LSMS to liaise with project teams of new builds and refurbishments • LSMS to liaise with Humberside Police Safer by Design Officer • LSMS to conduct security assessments on existing buildings as required	As required As required As required	

2.4	All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary	• LSMS reviews all security incidents reported through the DATIX reporting system, coding and grading where appropriate • Feedback provided to incident reporters • Awareness campaign to be launched to provide guidance to all staff on which incidents should be reported to the Police	Ongoing Ongoing 2021/22	
2.5	All staff who has been a victim of a violent incident have access to support services if required	• Victims of physical assault while at work to be sent a letter from CEO that contains the contact details of the LSMS and support on offer • LSMS proactively contacts those identified as victims through DATIX reporting	Ongoing Ongoing	
2.6	The organisation uses the Security Incident Reporting System (SIRS) to record details of physical assaults against staff in a systematic and comprehensive manner. This process is reviewed, evaluated and improvements are made when necessary	• Trust DATIX incident reporting system includes SIRS reporting, however these are no longer submitted externally since NHS Protect was disbanded • LSMS to review all reports of physical assaults • LSMS reports physical assault data to the Trust Security Group	N/A Ongoing Quarterly	
Prevent and Deter				
3.1	The organisation risk assesses job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the level of training on prevention of	• Training compliance to be monitored through the Trust Security Group • Another Project Argus exercise (Now SCAN) to be delivered by Counter Terrorism Unit Officers to senior managers and key decision makers and	Quarterly Late 2021/22	

	violence and aggression is delivered to them in accordance with NHS guidance on conflict resolution training. The training is monitored, reviewed and evaluated for effectiveness	security officers		
3.2	The organisation ensures that staff whose work brings them into contact with NHS patients are trained in the prevention and management of clinically related challenging behaviour, in accordance with NHS England Violence Prevention and Reduction Standard. Training is monitored, reviewed and evaluated for their effectiveness	• Training compliance to be monitored through the Trust Security Group • LSMS to link in with clinically challenging behaviour restraint training project • New project launched to develop to risk assess patients on admission for risk of violent/aggressive behaviour and security incidents – VAS Score	Quarterly In progress Delayed will look at early 2022	
3.3	The organisation assesses the risks to its lone workers including the risk of violence. It takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness	• Issuing and training staff in the lone working devices • Community lone working device usage to be monitored through the Trust Security Group	In progress Quarterly	
3.4	The organisation distributes national and regional NHS alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored reviewed and evaluated	• LSMS to review alerts received from other NHS organisations and partner agencies and disseminate within the Trust as appropriate • LSMS to receive alerts from the Cross-sector Safety and Security Communications (CSSC) and disseminate as appropriate	Ongoing Ongoing	
3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds	• LSMS to advise on access control as areas are refurbished or risks identified • LSMS to support the Trustwide CCTV review • LSMS to complete annual audit of CCTV releases	As required In progress Completed	

		• Review Policy for Use of Directed Surveillance		
3.6	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal	• Review of the Policy for the Security and Management of Assets	April 2022	
3.7	The organisation operates a corporate asset register for assets worth £5,000 or more	• Review of the Policy for the Security and Management of Assets	April 2022	
3.8	The organisation has departmental asset registers and records for business critical assets worth less than £5,000	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.9	The organisation has clear policies and procedures in place for the security of medicines and controlled drugs	• Any breaches of medicines security are notified to the LSMS	Ongoing	
3.10	The organisation has policies and procedures in place to ensure prescription forms are protected against theft and misuse. These policies and procedures are reviewed, evaluated and updated as required	• The Medicines Code and associated policies are in place	N/A	
3.11	Staff and patients have access to safe and secure facilities for the storage of their personal property	• Patient lockers / SAMPOD digital lock upgrades being installed at DPOWH	Completed	
3.12	The organisation records all security related incidents affecting staff, property and assets in a comprehensive and systematic manner. Records made inform security management priorities and the development of security policies	• The Trust uses the DATIX incident reporting system for all incidents and security related incidents are reviewed by the LSMS	Ongoing	
3.13	The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is included in the organisation's policies and procedures	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.14	In the event of an increased security threat level, the organisation is able to increase its	• ISS Contract Review meetings • Review of Policy for Bomb Threats and	Quarterly July 2021	

	security resources and responses	Suspect Packages		
3.15	The organisation has suitable lockdown arrangements for each of its sites, or for other specific buildings or areas	• Review the Policy and Procedure for Lockdown	March 2022	
3.16	Where applicable, the organisation has clear policies and procedures to prevent a potential child or infant abduction, and these are regularly tested, monitored and reviewed	• A test of the child abduction procedures to be completed at DPOWH and SGH	Completed	2021

Standard	Area	Task / Objective	Target Dates	Completed Date
Hold to Account				
4.1	The organisation has arrangements in place to ensure that allegations of security related incidents are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated	• LSMS reviews all security incidents reported through the DATIX reporting system, coding and grading where appropriate	Ongoing	
4.2	The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents	• LSMS to assist Police with investigations and be primary police liaison for the Trust • LSMS to attend court, case conferences and other sanction hearings • LSMS to manage the warning letter system for unacceptable behaviour as part of the Trust's exclusion process • LSMS to send formal warning letters on behalf of the Trust and support managers in sending informal warning letters	Ongoing As required Ongoing Ongoing	
4.3	Where appropriate, the organisation publicises sanctions successfully applied following security related incidents	• Criminal sanctions to be published internally and externally as appropriate	As required	
4.4	The organisation has a clear policy on the	• Standing Financial Instructions are	Ongoing	

	recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness	due review by the Finance Directorate		

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)172

DATE OF MEETING	2nd August 2021
REPORT FOR	Trust Board
REPORT FROM	Shaun Stacey, Chief Operating Officer (Accountable Emergency Officer)
CONTACT OFFICER	Graham Jaques, Head of EPRR and Operational Flow
SUBJECT	**EPRR Annual Report**
BACKGROUND DOCUMENT (if any)	Annual Report 2020/21
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report provides assurance on the Trust's Emergency Preparedness, Resilience and Response arrangements including the work programme for 2021/22. The Trust's Emergency Preparedness, Resilience and Response arrangements are in place to ensure the Trust is complaint with: • Statutory obligations under the Civil Contingencies Act 2004 • NHS England EPRR Framework 2015 • NHS Standard Contract SC30 In summary, there continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the Trust must be prepared for. It is essential that there is a continued focus on the Trust's Emergency Preparedness and Business Continuity arrangements. It is important that the Trust maintains and continues to advance its reputation within the EPRR arena and contributes towards the Region's Preparedness. The Board is asked to: • Note the current compliance against the NHS England Core Standards for EPRR • Note the training and work programme for 2020/21 (Appendix B and C) • Note the national learning lessons from the first wave of the pandemic of the recommendation of bolstering and expending EPRR teams to ensure resilience for future incidents and reduce the impact of such incidents

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓			✓	

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response	✓	**Workforce and Leadership**	**N/A**
Quality and Safety	✓	**Strategic Service Development and Improvement**	**N/A**
Estates, Equipment and Capital Investment	**N/A**	**Digital**	**N/A**
Finance	**N/A**	**The NHS Green Agenda**	**N/A**
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	**N/A**				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓	✓		

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Clinical Support Services

Annual Report for Emergency Preparedness, Resilience and Response 2020/21

Report Date:	09 June 2021
Number of Pages:	17
Report Author:	Graham Jaques, Head of EPRR Ashley Leggott, Emergency Planning Manager Stacy Kirby, Emergency Planning Officer
Director Sign-Off:	Shaun Stacey, Chief Operating Officer

1.0 Background and Introduction

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), in common with other NHS organisations, needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could range from extreme weather conditions to an infectious outbreak, a major transport accident or an act of terrorism. As a Category one responder under the Civil Contingencies Act 2004, the Trust has a legal obligation to plan for and respond to these risks and threats working in partnership with other parts of the NHS, the emergency services and local authorities.

2.0 NHS Emergency Preparedness, Resilience and Response (EPRR) Assurance

NLAG is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR. These core standards cover all aspects of the Trust's EPRR work, including the Trust's statutory obligations under the Civil Contingencies Act 2004.

Due to the impact of the Covid-19 pandemic the self-assessment process was adjusted to represent the impact that the response to covid-19 was having within the field of EPRR. It was requested that organisations showed how they had made progress on their standards they had reported as partially or non-compliant in the 2019/20 process, the process of capturing and embedding the learning from the first wave of the COVID-19 pandemic and how the inclusion of progress and learning in winter planning preparations has been implemented within the organisation.

There was one standard that the Trust was partially compliant; this is standard 59 – Decontamination capability and availability. Compliance with this standard continues to be an issue with the number of ED staff trained to respond to a CBRN incident. This has been further compounded by the limitations that Covid-19 has brought to training been provided due to strict Government social distancing measures. To support this, the Emergency Planning Team alongside the emergency department CBRN link nurses have introduced an "E learning" training package. This allows easy access to the knowledge elements of the training for ED teams and includes the "Step 123+", "Initial Operational Response (IOR)" and the recommended dry decontamination processes for non-caustic contamination. The practical elements of the training including the donning of the powered respirator protective suits (PRPS) continue to be a training gap. The Emergency Planning Team has arranged 11 practical training days at DPOW and 10 practical training days at SGH for the second half of 2021. More training days will be added for the first half of 2022 when required then there will be a rolling programme of training for the ED's to ensure all staff receive their training and refresher training.

The process of capturing and embedding the e-learning from the first wave of the covid-19 pandemic and how the inclusion of progress and learning in winter planning preparations has been implemented within the organisation, was detailed in how the ICC was implementing the learning on a daily bases with sharing of information through the Strategic Management Meeting held weekdays at 09:30 to ensure that the trust is managing the oversite of the operational response and strategic forward looking management of the Covid-19 response. All strategic meeting key decisions and actions have been captured on a central incident log. All actions are captured by the loggist with a daily sign off process. All actions are monitored until closed. The Trust has engaged in Regional Health Test exercises to ensure lessons learnt from the first wave where implemented correctly.

The inclusion of progress and learning being implemented in the Trusts Winter Planning preparation was ensured by the set-up of the winter planning group for 2020/21. This was established during June 2020 and met regularly to ensure preparedness for managing the challenges that winter brings. It is recognised that as winter approaches there are significant challenges with weather, Covid-19 and seasonal flu. An action plan was closely monitored as

part of the winter planning group with escalation into the Incident Coordination Centre strategic coordination group meetings

The self-assessment against the NHS England Core Standards for EPRR 2020/21 will commence during July 2021 when released by NHS England and is expected to have a submission deadline of October 2021. The Deep Dive subject for 2021/2022 is yet to be confirmed.

3.0 Testing, Training and Working Together with Local Partner Agencies

As a Category one responder, NLAG must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agencies' emergency plans. The EPRR Training Programme (Appendix C) lists the internal and external training and exercises completed during 2019/20 and those currently planned for 2020/21.

Emergency plans must be validated through an exercise every three years as a minimum unless a live incident occurs when the emergency plan is implemented. Section 5.0 within this report refers to live incidents that have occurred over the past 12 months.

3.1 Live Decontamination Exercise

The EPRR team carried out a Live Decontamination Exercise in 2018 at Scunthorpe General Hospital (SGH) to test the Trust's response to contaminated casualties self-presenting at the Emergency Centre. The team had a further Exercise planned for 2020 at Diana Princess of Wales Hospital (DPOW) but due to the COVID-19 Pandemic this had to be cancelled and will be re-scheduled for 2021. Due to the impact of COVID-19 Pandemic this has been further delayed and the EPRR team is now looking at focusing a live decontamination exercise to be held as a multi- agency exercise looking at the Humber area as a whole.

3.2 CBRNe/HAZMAT Training

Emergency Care Centre staff are required to complete CBRNe/HAZMAT training annually. This includes the Initial Operational Response (IOR) and Step 123+ principles for contaminated self-presenters and the use of dry decontamination. The training also includes practical elements such as the fitting and use of the Powered Respiratory Protective Suits (PRPS) and the deployment of the decontamination tent for both wet and dry decontamination in order to maintain patient dignity.

EMAS conducted a CBRNe/HAZMAT audit at DPOWH and SGH during October 2020 to assess the Trust's preparedness to respond to an incident. The audit included serviceability and maintenance of equipment, emergency plans that were in place and the specialist training provided in house. NLAG successfully passed the audit with no gaps in planning identified. An EMAS Audit has been arranged for September 2021. A potential barrier that was noted was the difficulties in releasing operational frontline Emergency Care Centre staff to undertake the specialist training required. This barrier has become more apparent as the number of staff who have not completed their annual refresher training has remained high. The risk this presents to staff safety and the Trust's ability to respond to contaminated self-presenting casualties has meant this has been added to the risk register. Training has significantly reduced due to the COVID-19 Pandemic and due to Social Distancing Restrictions that have been implemented by the Government. During June 2020 actions were taken with the EPRR team and Emergency department CBRN leads to develop a virtual training program. This does not cover the practical aspects of donning and doffing Powered Respirator Protective Suits but training videos have been developed to support this aspect. With the restrictions starting to be eased it is hoped that the practical training will commence early July 2021 with an increased level of training for each Emergency

Department been provided by the EPRR team, this will be alongside the Emergency Departments Lead CBRNe/HAZMAT Nurses.

3.3 Bank Holiday Preparedness

Continuing with the approach to the planning for the operational impacts associated with Bank Holidays, this is now embedded for every Bank Holiday. This involves the check and challenge of medical rotas, nursing rotas, senior management cover and service provisions through a multi-directorate planning group. An assurance spreadsheet is distributed within the Trust and to the gold and silver on-call teams.

3.4 Working with Local Partner Agencies

In respect of partnership working with Local Partner Agencies, the Trust is represented at the Local Resilience Forum (LRF), the Local Resilience Forum's Sub-Groups, and the Local Health Resilience Partnership. In addition NLAG locally attend the Emergency Preparedness and Resilience Group in Northern Lincolnshire which has recently been attended by North Lincolnshire CCG Emergency Planning lead. NLAG participates in joint planning and testing of regional plans and regularly attends multi-agency exercises to evaluate response plans and identify lessons to be learned that can be incorporated into NLAG plans.

3.5 Learning Lessons from Terrorist Attacks

NLAG proactively reviews its emergency plans and arrangements to ensure that any lessons to be learned from incidents across the UK are assessed, and where applicable, incorporated into our local plans. The debrief reports from the terrorist attacks (Westminster, Manchester Arena, and London Bridge) have been shared with NLAG and any identified learning opportunities will be incorporated into the Trust's emergency plans and training. The initial Salisbury Incident findings have been shared with the Trust however a full review will be conducted when the final report is published.

4.0 Emergency Preparedness, Resilience and Response - Work Programme

The EPRR Work Programme (Appendix B) provides a high level overview of the work to be carried out that ensures compliance with the NHS England Core Standards for EPRR. The EPRR Work Programme will continue to develop in line with the ever changing guidance and legislation to ensure the Trust maintains its compliance and readiness to respond to an incident.

5.0 Incidents – Implementation of Emergency Plans

Between 1st April 2020 and 31st March 2021, the Trust activated its emergency plans to support the response to four live incidents.

Description of Incident	Date	Emergency Plans Activated
NLAG COVID-19 Pandemic	Jan 2020 - Ongoing	• Business Continuity Plans • Pandemic Influenza Response • Patient Flow, Escalation and Surge Policy • Critical Incident Plan

		• Incident Coordination Centre Manual • Major Incident Plan • COVID-19 Pandemic Surge Plan
NLAG Oxygen Provision	07 November 2020	• Major Incident Plan • Business Continuity Plans • Patient Flow, Escalation and Surge Policy
EU Exit	31 December 2020	• Business Continuity Plans • EU Exit NLAG Plan

5.1 Incidents

EU Exit

On December 31st 2020 the UK left the EU with a deal in place. Due to the ongoing pandemic certain key points of the deal where delayed to ensure a smooth transition process is achieved. Key dates are now forecasted for April and June 2021. There is not expected to be large port distribution that had been forecasted if a No Deal exit had occurred. A further delay with implementing the full port regulations has been forecast due to the ongoing pandemic.

Covid-19

At the end of January 2020 the trust received the first email relating to an emerging situation in the Wuhan region of China in relation to Wuhan Novel Coronavirus Virus that was infecting large numbers of the population. The EPRR team held a teleconference with local CCG's to establish the risk to our local Health and Social Care services could possibly face should the virus arrive within the UK. In February it was established that cases where emerging within the UK, so planning was prioritised to ensure an appropriate and proportionate response was established. The situation with Covid-19 (Wuhan Novel Coronavirus) increased as the pandemic escalated in the proceeding months with a large number of patients presenting to the Trust with Covid-19. An Incident Coordination Team was established to deal with the demands of the pandemic and in March 2020 the Trust set up physical Incident Coordination Centres to centrally manage the on-going incident. The Trust experienced the highest number of inpatients related to Covid-19 during November 2020, which placed the Trust under extreme pressure. During this month a Major Incident was declared due to the demand on the oxygen provision at both DPOW and SGH sites. A number of ward moves had to be implemented to ensure oxygen provision was maintained and patient safety was not compromised. Lessons learnt from this incident have now been embedded within the Trust's planning documents for the pandemic and the estates team have embedded learning into their oxygen work programme and maintenance. The pandemic has been ongoing for over a year which is the longest response required to an incident experienced within the Trust and the NHS. The pandemic is still on going at present though with lower numbers of cases presenting and now the planning is been focused on the challenges that will be faced during Winter 2021. The impact and management of the incident is captured in the NLAG Phase 3 response.

National learning lessons from the first wave of the pandemic identified the need for organisations to bolster and expand their EPRR teams and should not rely on just one individual or part of an individual, as this has caused extreme fatigue and unpresented workloads for these individuals and restricted the flow of the specialist knowledge these roles have when dealing with emergency situations and the planning for such never events.

6.0 Summary and Next Steps

In summary, there continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the Trust must be prepared for. It is essential that there is a continued focus on the Trust's Emergency Preparedness and Business Continuity arrangements. It is important that the Trust maintains and continues to advance its reputation within the EPRR arena and contributes towards the Region's Preparedness.

7.0 Trust Board Action Required

The Board is asked to:

- Note the current compliance against the NHS England Core Standards for EPRR
- Note the training and work programme for 2020/21 (Appendix B and C)
- Note the national learning lessons from the first wave of the pandemic of the recommendation of bolstering and expending EPRR teams to ensure resilience for future incidents and reduce the impact of such incidents

Appendix A

Action Plan for Compliance with NHS England Core Standards for EPRR 2019/20

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline / Progress
59	CBRN	CBRNe/HAZMAT training is provided to all EC Centre medical, nursing staff, HCA's, receptionists and flow coordinators. There have been delays in training staff at one of the sites due to operational difficulties in releasing ECC staff to attend training; the other site has increased their trained staffing level significantly.	Increase numbers of A&E staff attending CBRNe/HAZMAT Training Sessions to increase 24/7 operational response cover, by: • Additional training sessions offered • EPRR Team have stepped in to deliver training • Cross-site training promoted to reduce pull from each A&E	31/03/2020 – Two training sessions held in 2020 at DPOW resulting in 15 staff being trained. The 6 planned session at DPOW and 3 planned sessions at SGH were cancelled due to the COVID19 Response. With a further 9 planned sessions between Jul 2020 and Dec 2020

Appendix B

Emergency Preparedness, Resilience and Response Work Programme 2020-21

Emergency Preparedness, Resilience and Response Work Programme 2021				
Subject	**Task**	**Deadline**	**Status**	**Notes**
Adult Critical Care Services Surge Procedures				
Management of surge and escalation in critical care services SOP for Adults Critical Care	National Policy	**01/03/2022**	**Completed**	2013 - no updated version available
Management of surge and escalation in critical care services SOP for Adults Respiratory ECMO	National Policy	**01/03/2022**	**Completed**	2020 - updated and on the Hub
Adverse Weather Response Tools				
The Cold Weather Plan for England	Ensure relevant actions can be activated during Cold Weather Alerts	**01/10/2022**	**Completed**	National Plan updated Oct 2020
Adverse Weather Coordination Template	Excel Spreadsheet	**01/06/2021**	**Completed**	For Review prior to Winter 2021
Cold Weather Assurance SITREP Example	Excel Spreadsheet	**01/06/2021**	**Completed**	For Review prior to Winter 2021
Emergency Accommodation for Staff on DPOWH Site Template	Word Template	**01/06/2021**	**Completed**	For Review prior to Winter 2021

Hotel Accom near DPOWH Template	Word Template	**01/06/2021**	**Completed**	For Review prior to Winter 2021
Redeployment of Admin Staff Availability Sheet	Word Template	**01/06/2021**	**Completed**	For Review prior to Winter 2021
Redeployment of Admin Staff Process v3	Word Document	**01/06/2021**	**Completed**	For Review prior to Winter 2021
Volunteer Drivers and Additional Vehicles Details Template	Excel Spreadsheet	**01/06/2021**	**Completed**	For Review prior to Winter 2021
Burns Plan				
Burns Major Incidents and Burns Mass Casualty Incident Plan - Draft 16 July 12	Regional/National Plans	16/07/2012	**Completed**	May 21 - to review updated regional Plans
Management of Surge and Escalation in Critical Care Services - SOP for Burns Services	Regional/National Plans	01/11/2013	**Completed**	May 21 - to review updated regional Plans
Business Continuity Plans				
Business Continuity Policy **DCP219**	Review policy	**01/03/2022**	**Completed**	Reviewed and updated. Next review due 2022
Business Continuity Plan Template	Update BCP template to provide additional detail on preparedness	**01/03/2022**	**Completed**	Updated template agreed and rolled out to all service-level BC plans
Guide to Completing the Business Impact Analysis	Guide to completing Impact Analysis section within BC Plan	**28/03/2022**	**Completed**	
Business Continuity Plans	BC Plans circulated to be reviewed - Updated by Divisons	**Monthly**	**Ongoing**	BC plan compliance reported at the EPRR Steering Group and monthly to divisions upon request.
Business Continuity Critical Services Overview	Updated following the return of BC Plans from the divisions	**Monthly**	**Ongoing**	
Training and Exercise Section	To develop training sessions for managers	**To Do**	**To Do**	June 2021 - to develop a training session for BC Plans and BIA's
Business Continuity Plan Tests	Validate BCPs through scenario testing	**Ongoing**	**Ongoing**	2020 - Live testing during the pandemic.

CBRN/HAZMAT				
CBRN/HAZMAT Plan **DCM109**	Review and update plan	**01/11/2021**	**Ongoing**	Minor Changes made Sep 2019
DPOW Exercise	Live Decontamination exercise at DPOW	**TBC**	**Ongoing**	
SGH Exercise	Live Decontamination exercise at SGH	**TBC**	**Ongoing**	
CBRN/HAZMAT Training	Deliver 'train the trainer' sessions to A&E trainers and assist in improving compliance by supporting training delivery	**Ongoing**	**Ongoing**	**2017** - 'Train the trainer' session delivered at DPOWH and SGH. EP Training Officer supporting A&E training sessions. **2020** - Requested EMAS train the trainer training to be delivered to a set amount of staff across the Trust **2021** - EMAS to provide a train the trainer session - Refresher for EPRR and also new staff, awaiting confirmation date for training to be delivered within June 2021
CBRNe/HAZMAT Audit with EMAS	EMAS to complete an on-site audit of the Trust's CBRNe/HAZMAT preparedness at both DPOWH and SGH	**01/09/2021**	**Ongoing**	Due September 2021 - Complete pre questionaire which will be sent and check stock levels of PRPS
COMAH Site information	Review COMAH Site information held on the Hub	**01/12/2021**	**Ongoing**	To carry out review of COMAH Site information held within NLAG and on site visits.
EPRR Steering Group				
Terms of Reference **DCT083**	Review TOR	**01/03/2022**	**Completed**	Reviewed and updated. Next due 2022
Emergency Planning Hub Site				
Emergency Planning	All documents linked to EPRR avaliable on the Hub	**Monthly**	**Ongoing**	To Review June 2021
Fuel Plan				
Fuel Plan	National Fuel Plan utilised and available on the Hub	**Completed**	**Completed**	
Heatwave Plan				
Heatwave Plan **DCM066**	Review and update plan	**01/06/2022**	**Completed**	01/06/2020 - Reviewed with minor changes to mirror the national Heatwave Plan. Due for review June 2022.
Incident Coordination Centre				

Incident Coordination Centre Manual **DCM178**	Review and update plan	**01/04/2024**	**Completed**	**2020** - Has been updated January 2020 and not due for review until April 2021 2021- Full review and upadtes as required completed with review date of April 2024
DPOW Major Incident Cupboard	Review and ensure sufficiently stocked	**01/06/2021**	**Ongoing**	Review completed. Required maps and stationary ordered and awaiting delivery
SGH Major Incident Cupboard	Review and ensure sufficiently stocked	**01/06/2021**	**Ongoing**	Review completed. Required maps and stationary ordered and awaiting delivery
On-Call Director and Senior Manager Training	Create and deliver major incident training session to On-Call Directors and Senior Managers	**Ongoing Rolling Programme**	**Ongoing**	Sessions delivered at DPOWH and SGH 2020 - sessions being held virtually 2021 - sessions being held virtually
Neighbouring Hospitals Info Pack	Create info pack on neighbouring hospitals for the ICC	**01/06/2021**	**Ongoing**	Created and on website for easy access, to be reviewed and updated 2020 **2021 - To do**
Loggist Training Refresher Sessions	Relaunch Loggist role and deliver training sessions for loggists	**Ongoing Rolling Programme**	**Ongoing**	New system for loggists introduced which moves away from volunteers in favour of nominated inidivudals from non-operational Directorates. Several training days completed and more arranged for new loggists on both sites 2020 - Different approach taken due to the Covid-19 Pandemic 2021 - to arrange sessions
Switchboard Cascade Test	To test Switchboards Major Incident Response	**01/05/2021**	**6 monthly**	2020 - Live incident Nov 2020 2021- March 2021 Tests completed at DPOW and SGH
Switchboard Major Incident Familiarisation Session	To familiarise Switchboard staff during a Major Incident	**01/06/2021**	**yearly**	2021 - to create a training session utilising the loggist training sessions
Investigations, Action Plans, Assurance Frameworks and Submissions				
NHS England Core Standards for EPRR Self-Assessment and Submission	Complete 2020-21 self-assessment, gain Trust Board approval and submit to NHS England before deadline	**TBC**	**Future Development**	Awaiting release of 2020/21 core standards
Lockdown Policy				
Policy & Procedure Lockdown **(DCP195)**	Review and update plan	**01/03/2022**	**Completed**	For Security (LSMS) to review and update

Major Incident Plan				
Major Incident Plan **DCM176**	Review and update plan	**01/12/2022**	**Completed**	Updated January 2020 and not due for review until December 2022
Critical Incident Plan	Review plan	**01/12/2022**	**Completed**	Reviewed and updated. Next review due December 2022
Major Incident Plan Table Top Exercises	Create an MIP table top exercise and organise a date for delivery at both DPOWH and SGH	**TBC**	**Ongoing**	**Nov 2019** - Multiple MIP table tops have been delivered on both sites and others arranged - Completed **2021** - to arrange MIP table top exercises at both SGH and DPOW
Major Incident Plan Trust Wide Table Top	Trust wide table top to cover all Directorates	**01/11/2023**	**Completed**	**17 Sep 2020** - Implementation of plan during live incidents means a Trust wide exercise is not yet required - Completed **6 Oct 2020** - NLAG Concur rant Exercise - Completed - superseded by Live incident Nov 2020
Mass Vaccination / Treatment				
NLAG Plan to Support Mass Vaccination/Treatment **DCM156**	Review and update plan	**01/07/2022**	**Completed**	01/07/2019 - Reviewed and updated. Next review due July 2022
NLAG Plan to Support Evacuation in Community (inc. Rest Centre Support and Identification of Vulnerable Patients) (DCM007)				
NLAG Plan to Support Evacuation in Community (inc. Rest Centre Support and Identification of Vulnerable Patients) **DCM007**	Review and update plan	**01/06/2024**	**Completed**	18/07/2018 - Changes completed and new review due 2021 10/05/2021 - Plan updated awaiting on SystemOne for update on DCM007A prior to submission to Document Control 04/06/2021 - Submitted to Doc Control
Pandemic Flu Plan				
Pandemic Flu Plan **DCM147**	Review plan	**01/09/2022**	**Completed**	01/02/2020 - Reviewed and updated. Next review due September 2022 2021 - to have as a Pandemic Plan review in June 2021
Yorkshire and Humber LRFs and LHRPs Pandemic Influenza Framework	Review plan	**03/10/2017**	**Completed**	to review

Partial or Total Site Evacuation				
Hospital Full and Partial Site Evacuation Plan **DCM171**	Review and update plan	**01/09/2022**	**Completed**	01/09/2019 - Reviewed and updated. Next review due September 2022. To be reviewed sooner due to ECC Building works
Site Evacuation Exercise	Organise and conduct a Site Evacuation Tabletop Exercise	**To Do**	**To Do**	
Resilience Direct				
Trust Access to Resilience Direct	Gain relevant accesses to RD	**Completed**	**Completed**	EPRR Advisor roles have access to Resilience Direct during an incident
Trust Emergency Plans on Resilience Direct	Upload relevant plans to RD	**01/06/2021**	**To Do**	Latest plans uploaded to Resilience Direct 2021 - To be reviewed
Surge and Escalation Management				
Patient Flow, Escalation and Surge Policy (including Full Capacity Protocol) **DCP301**	Review policy	**01/08/2022**	**Completed**	Aug 2018 - Next review due in 2018 Dec 2020 - Reviewed
COVID-19 Pandemic Surge Plan **DCM418**		**01/08/2022**	**Completed**	April 2020 - review in April 2023
EMAS Ambulance Divert Request Form	Available on the Hub	**01/06/2013**	**Completed**	To check for updated version
YAS Ambulance Divert Request Form	Available on the Hub	**23/01/2020**	**Completed**	
NEY FINAL Major Trauma Regional Escalation Framework V1.0 19012021		**01/02/2023**	**Completed**	April 2020 - review in April 2023
Training Needs Analysis				
Training Needs Analysis	Review TNAs	**To Do**	**Ongoing**	Reviewed in late 2019 2021 - To be reviewed

Trust EPRR Risk Register				
Procedure for EPRR Risk Assessments	Review procedure	**To Do**	**Completed**	Next review due in 2020
EPRR Risk Assessments	Complete additional risk assessments	**To Do**	**Completed**	All risks reviewed July 2019 May 2021 - to be reviewed
EPRR Risk Assessment Annual Summary Report	Provide summary report to EPRRSG	**To Do**	**Completed**	To be submitted to July 2019's EPRR Steering Group 2020 - Submitted 2021 - to be reviewed

Appendix C

Emergency Preparedness, Resilience and Response Training Programme – 2020-2021

Key:	Completed	Planned	Cancelled due to lack of attendees	Cancelled due to Major Incident

Date	Training	Training Type	Provided By	NLAG Attendance	Multi-Agency
01/04/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
15/04/2020	Major Incident Training	Training	NLAG	SGH	NLAG
20/04/2020	L3 Education and Training 12weeks	Training	External Trainer	Stacy Kirby	Individual
22/04/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
24/04/2020	Loggist Training Course	Training	NLAG	SGH	NLAG
24/04/2020	Loggist Training Course	Training	NLAG	DPOW	NLAG
18/05/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
26/05/2020	Loggist Training Course	Training	NLAG	SGH	NLAG
27/05/2020	Loggist Training Course	Training	NLAG	DPOW	NLAG
03/06/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
16/06/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
24/06/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
25/06/2020	HEPRR Award – Unit 1	Training	PHE	Ashley Leggott	Person specific
14/07/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
15/07/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
23/07/2020	HEPRR Award – Unit 1	Training	PHE	Ashley Leggott	Person specific
27/07/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
28/07/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
10/08/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
13/08/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
14/08/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
21/08/2020	Concurrent Emergencies	Training	Humber LRF	EPRR Team	LRF Mulit-agency
21/08/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
07/09/2020	L3 Education and Training 12weeks	Training	External Trainer	Stacy Kirby	Individual

09/09/2020	HCV ICS System Resilience Workshop	Training	External Trainer	EPRR Team	Multi Agencies
18/09/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
22/09/2020	Full and Partial Evacuation Exercise HUTH	Exercise	HUTH	EPRR Team	Multi Agencies
25/09/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
02/10/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
05/10/2020	Live Decontamination Incident	Live incident	NLAG	ECC DPOW	NLAG
06/10/2020	NLAG Concurrent Incident	Training	NLAG	NLAG Staff	NLAG
20/10/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
23/10/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
28/10/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
16/11/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
24/11/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
25/11/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
26/11/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
10/12/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
14/12/2020	Loggist	Training	NLAG	NLAG Staff	NLAG
16/12/2020	CBRNe/HAZMAT	Training	NLAG	ECC DPOW	NLAG
23/12/2020	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
06/07/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
09/07/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
12/07/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
28/07/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
03/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
04/08/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
09/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
19/08/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
20/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
25/08/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
26/08/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
17/09/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
20/09/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
08/10/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
13/10/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
01/11/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG
04/11/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
11/11/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG

16/11/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
01/12/2021	CBRNe/HAZMAT	Training	NLAG	EC DPOW	NLAG
21/12/2021	CBRNe/HAZMAT	Training	NLAG	EC SGH	NLAG

NLG(21)173

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Dr Peter Reading, Chief Executive
CONTACT OFFICER	As above
SUBJECT	North East Lincolnshire Health & Care – Memorandum of Understanding
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The purpose of this Memorandum of Understanding (MOU) is to set out the commitment of all key partners in the North East Lincolnshire health and care system to work together to improve the health, care and wellbeing of the population of North East Lincolnshire. The Parties to this Memorandum of Understanding (MOU) are: (1) North East Lincolnshire Council (the Council) (2) NHS North East Lincolnshire Clinical Commissioning Group (the CCG) (3) Humber Coast and Vale Health and Care Partnership (the ICS) (4) North East Lincolnshire Integrated Care Partnership, through its constituent members (the ICP)

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓			✓	

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working	✓		

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	N/A				
BOARD ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
	✓				

NORTH EAST LINCOLNSHIRE HEALTH AND CARE SYSTEM

Memorandum of Understanding

Dated xxxxx

The Parties to this Memorandum of Understanding (MOU) are:

(1) North East Lincolnshire Council (the Council)
(2) NHS North East Lincolnshire Clinical Commissioning Group (the CCG)
(3) Humber Coast and Vale Health and Care Partnership (the ICS)
(4) North East Lincolnshire Integrated Care Partnership, through its constituent members (the ICP)

1. Introduction and context:

1.1 The purpose of this Memorandum of Understanding (MOU) is to set out the commitment of all key partners in the North East Lincolnshire health and care system to work together to improve the health, care and wellbeing of the population of North East Lincolnshire.

1.2 The parties to this MOU are committed to the greatest and most sustainable health, care and wellbeing improvements and outcomes by focusing on an agreed set of priorities, based on a collective commitment to a set of principles and a governance model that fosters integration, innovation, transformational change, infrastructure development and early intervention to address the wider determinants of health.

1.3 This MOU creates a framework for subsidiarity as between the Humber Coast and Vale ICS and North East Lincolnshire, the Place.

1.4 This will be overseen and governed by a Joint Committee hosted by North East Lincolnshire Council, informing the priorities and focus of the Health and Wellbeing Board and supporting the development and leadership of the North East Lincolnshire Integrated Care Partnership; providing the necessary assurance to the ICS regarding the effectiveness of the North East Lincolnshire health and care system.

1.5 This MOU therefore sets out the basis of and approach to collaboration, partnership and integration across the North East Lincolnshire health and care system.

1.6 All parties to this MOU agree to act in good faith to support the objectives and principles of this MOU for the benefit of all citizens, patients, and service users.

2. Whereas:

2.1 HM Government published a White Paper – Integration and Innovation: working together to improve health and social care for all (the White Paper).

2.2 The Council and the CCG operate an integrated health and care partnership under the auspices of an Agreement entered pursuant to Section 75 of the NHS Act 2006 (the Union).

2.3 The Union is governed by a Union Board, a committee in common of the Council's Cabinet and the CCG's Governing Body.

2.4 The ICP is a non-legally constituted health and care partnership in North East Lincolnshire, with membership from all health and care providers, including Primary Care Networks (PCNs).

2.5 In response to the White Paper the Council and the CCG are reviewing the Union arrangements and the implications for local health and care commissioning.

2.6 The ICP is developing a governance and partnership model to support more joined up and collaborative provision of local health and care services, working with the CCG and the Council.

2.7 The Council is statutorily responsible for the administration and operation of the Health and Wellbeing Board in North East Lincolnshire (HWB Board).

2.8 Subject to legislative implementation of the White Paper, the CCG will cease to exist from April 2022.

2.9 The Council, the CCG and the ICP are working together to develop governance, leadership and oversight arrangements for the North East Lincolnshire health and care system (the Proposition) in response to the White Paper.

2.10 The Council, the CCG and the ICP seek to work in collaboration with the ICS to develop, test and implement the Proposition in North East Lincolnshire subject to legislation, legal advice and all necessary constitutional and governance approvals of the Parties.

2.11 The Parties acknowledge that, in any event, public consultation may be required prior to the implementation of any changes signalled by the scope and intent of this MOU.

3. It is Agreed that:

3.1 The Parties support the principle of Primacy of Place as set out in the White Paper.

3.2 "Place" is agreed as the local government administrative and co-terminus CCG area of North East Lincolnshire.

3.3 In response to the White Paper the Parties support the principles set out in Annex A as the basis of the Proposition as well as the Primary Objectives set out in Annex B.

3.4 The Proposition is predicated on the establishment of a Joint Committee for Place, with proposed terms of reference and membership set out in Annex C (Governance Model)

3.5 In support of the Proposition the Parties support the high-level focus of the HWB Board set out in Annex D.

3.6 The Parties seek to operate the Governance Model in shadow form from (Date X) 2021 Subject to agreement with the ICS and NHS England.

3.7 The Council and the CCG will consider the best practicable use of Section 75 of the NHS Act 2006 to support the Proposition, subject to legal advice.

3.8 This MOU is not legally binding on the Parties but the Parties agree to both the spirit and intent of this MOU, in the interests of developing the most practicable and effective health and care system governance, leadership and oversight arrangements for the population of North East Lincolnshire.

4. TERM AND TERMINATION

4.1 This MOU shall commence on the date of signature by the Parties and shall remain in place unless terminated by unanimous agreement or a termination pursuant to clause 4.2 or because legislative change renders the purpose and intent of this MOU superfluous.

4.2 Any party may terminate this MoU by giving at least three months' notice in writing to the Council.

VARIATION

5.1 The provisions of this MOU may only be varied by written consent of the Parties.

6. **CHARGES AND LIABILITIES**

6.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their commitment's obligations under this MOU.

7. **STATUS**

7.1 Nothing in this MOU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute either party as the agent of the other party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of any other Party

Annex A

The Principles

A Local Authority hosted (place based) health and care system in North East Lincolnshire that:

(i) supports and builds on established health and care integration and collaboration, where it makes sense to do so (and reinforcing the new duty to collaborate)
(ii) brings commissioners and providers much closer together to focus on priorities that serve to improve the experiences and outcomes for the population of NEL
(iii) brings statutory bodies, partners, and the voluntary sector together to fully optimise their collective (and active) contribution to the local economic growth agenda (through the lens of the wider determinants of health)
(iv) leads and positively contributes to the development of a sustainable, fit for purpose and agile health and care workforce
(v) maximises the use of the NEL health and care £ to benefit patients, service users and residents
(vi) supports and facilitates the development of a sustainable Integrated Care Partnership, particularly the role, development, and contribution of PCNs
(vii) continues to actively support arrangements that foster public and patient involvement and community voice and clinical leadership
(viii) contributes actively and strategically to the digital, asset and wider infrastructure agenda – supporting 21st century models of health and care and service integration
(ix) positions key place based statutory responsibilities (public health, adults, children) at the heart of the health and care system
(x) is supported by an operating model that brings data, analytics, intelligence, behavioural insights and policy development together - to inform and support strategic development, resource planning and evidence-based decisions

Annex B

Primary Objectives:

(i) To support an improved focus on the prevention of ill health and the promotion of wellbeing, including collective and active engagement in the wider local economic growth and regeneration agenda.

(ii) To oversee and facilitate the role of the health and care system in support of Covid-19 recovery, learning and future planning.

(iii) To oversee effective integrated health and social care across North East Lincolnshire, including the engagement of the voluntary and community sector.

(iv) To develop medium to long term priorities for securing investment in and the development of fit for purpose health and care infrastructure (physical and digital) and the effective use of the public estate.

(v) To ensure that citizens, patients, and service users receive and access the right care at the right time and in the right place, minimising hospital admissions and maximising independence.

(vi) To collaborate to prioritise the interests and outcomes of citizens, patients and service users in North East Lincolnshire.

(vii) To conduct all activities resulting from this MOU in ways that are consistent with the Nolan principles and to take all reasonable steps to ensure that any employees, partners and associates involved in carrying out activities do likewise.

Annex C

Place Governance Model

(insert final agreed diagram and terms of reference)

Annex D

Health and Wellbeing Board areas of focus

(i) Strategic partnership direction and shaping of place
(ii) Wider determinants of health
(iii) NEL Population health
(iv) JSNA
(v) Place / system recovery post Covid

Signatories:

Peter Reading
Chief Executive
14 July 2024

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)174

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Gill Ponder, NED / Chair of F&P Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Finance & Performance Committee – Minutes of meetings held on 28 April and 26 May 2021
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Finance & Performance Committee – Minutes approved at the meetings held on 26 May & 30 June 2021.
EXECUTIVE SUMMARY	Minutes of the Finance & Performance Committee held on 28 April and 26 May 2021 are attached for information.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓		✓		

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance	✓	**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	BAF Risk SO3 (3.1-3.2) BAF Risk SO1 (1.2-1.6) & SO4				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **28 April 2021 – via Teams Meeting**

PRESENT:	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Gill Ponder	Associate Non-Executive Director / Chair of F&P (designate)
	Andrew Smith	Non-Executive Director
	Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
	Peter Reading	Chief Executive (For first hour)
	Lee Bond	Chief Financial Officer
	Shauna McMahon	Director of Digital Services
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer
	Helen Harris	Director of Corporate Governance
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Anne Barker	Finance Admin Manager (Minutes)
IN ATTENDANCE:	Angie Legge	Associate Director for Quality Governance (Item 5.2)
	Anthony Rosevear	Divisional GM, Community & Therapies (Item 5.4)

Item 1 04/21 **Apologies for Absence**

Apologies for absence were noted from: Ivan McConnell.

Introductions were made to welcome Gill Ponder to the meeting as the incoming Chair of Finance & Performance Committee.

Neil Gammon registered his dissatisfaction with the number of late papers at this month's meeting.

Item 2 04/21 **Declarations of Interest**

There were no declarations of interest made.

Item 3 04/21 **To approve the minutes from the previous meeting held on 31 March 2021**

Stuart Hall highlighted that some actions from the minutes were not captured in the action log and questioned how confident could the Committee be that actions have been completed.

The minutes were reviewed for all actions and all appeared either on the action log or on the agenda. Stuart Hall confirmed but asked that all actions appear on the action log. The committee agreed that this approach would be adopted to ensure the highest standard of governance.

Following the review the minutes were agreed as an accurate record.

Item 4 04/21 **Matters Arising**

4.1 Action Log

The Action Log was reviewed as follows:

4 - (27 08 20) – Tender Pathology – Brian Shipley advised that LCHS was 1.5% of total Pathlinks and 5.8% of Microbiology.
9 - (27 08 20) – Bridging loan required for AAU scheme. OBC not due until October 2021 so there will be a need for financial draw down earlier. Deferred the item until May 2021 meeting.
5 - (30 09 20) – Ref Cost / SLR – Defer as on work plan for May 2021
5.4 – (28 10 20) – CDIP – Shauna McMahon to provide an update at the next meeting for information once Grant Thornton report available.

Following review the action log was noted.

Item 5 04/21 **Presentations for Assurance**

5.1 Board Assurance Framework 2021/22 (BAF)

Helen Harris presented the BAF and advised that this was for information only at it was still being revised with further work on high level risks and their scoring required. Once the BAF has been finalised, agreement will be sought on the reporting cycle to Assurance Committees.

Andrew Smith agreed that the BAF was moving in the right direction. He said that he would be interested in understanding how assurance of progress was obtained and how the BAF links with the Integrated Performance Report.

Neil Gammon asked when the final version of the BAF would be ready. Helen Harris commented that F&P Committee do have a significant number of strategic risks to monitor. She had considered quarterly reviews but it may be that the Committee would want to conduct deep dives more frequently so she suggested bi-monthly may be more appropriate. It was anticipated that the BAF would be reviewed by all sub-committees before seeking approval from Trust Board. It was agreed to add this matter to the Highlight Report.

5.2 CQC Progress Report

Angie Legge presented the report and highlighted the appointment of a new member of staff due to commence on 14th June to replace Lucy Kent. Angie Legge noted that whilst progress continues to be made, there were nine actions that remained rated red.

In response to the question of whether CQC provide a letter following their taking part in meetings with the Trust, similar to that received in Finance, Angie Legge confirmed that a more informal approach is taken, usually with verbal feedback or emails containing further questions if required.

Neil Gammon referred to the KPIs for waiting lists asking what the difference was between ‘managing patients not seen within the timescale’ and ‘monitoring the management’ of those patients. Angie Legge advised that whilst the initial task can be achieved there is a need to ensure that through cultural change revised processes become embedded, on an upward trajectory and thus business as usual

Stuart Hall suggested that it was getting late to turn red rated actions to green to support exit from special measures and reinforced the need to focus on mitigations for the red actions and their impact. Angie Legge confirmed this was being undertaken.

Andrew Smith suggested that the report should be shorter and by exception. Angie Legge confirmed that this was planned work involving a re-format to ensure that mitigations are clear.

Shaun Stacey stated that the IPR should be used for 90% of the information as trajectories for improvement are shown in that document.

Following review the report was noted.

5.3 Final Ops Plan 2021/22 – Update on Progress

Shaun Stacey advised that the first draft of the H1 (Apr to Sep 2021) Operational Plan had been submitted to the ICS the previous day. Once finalised, it would form part of the integrated care plan. The threshold for delivery was not met with activity below target for inpatients for 3 months and work was being carried out with the clinical teams on that. The appendix in the IPR shows that the Trust does well with inpatients and day cases but he wants a plan that demonstrates the trajectory and builds on that through efficiencies and improvements. Some concerns existed around workforce which is a challenge as staff return from shielding and long and short term illness. This, combined with outstanding leave, presented a significant challenge. Work was underway to mitigate the impact but he noted that appropriate leave and rest must be taken to ensure that front line staff can recover.

The final challenge is the financial resource and Shaun Stacey stated that whilst the Plan hit milestones in the submission to deliver income for 6 months (H1) this was not so clear cut for the full year.

He commented further that the Trust would be able to manage an infection control outbreak in the year without impacting on the plan however if a further pandemic occurs this would not be the case.

Stuart Hall asked how staff wellbeing could be measured and wondered if some of the Plan's output was predicated on insourcing and outsourcing and whether we are seeking additional enhanced payments for over delivery. Shaun Stacey confirmed that there were earning opportunities which would assist the wider health economy.

Brian Shipley added that the main part of activity recovery is hitting the minimum activity thresholds within existing resources. It was unclear if the total overall ICS position would also include York and Harrogate so meetings were currently taking place to determine this aspect.

5.4 Community Services, Community Response Team GP

Ant Rosevear attended to present the very comprehensive, positive report and talked through the slides that had been provided.

Ant Rosevear highlighted that the service was implemented in April 2020 in response to Covid-19 to support patients at home and complex discharges; the service was provided by Safecare Ltd and commissioned by NL CCG. Funding is reviewed on a 3-monthly basis and has been agreed until June 2021 utilising discharge to assess funding. The model is based on senior clinical presence working with the single point of access where

acute care is required.

When the service was established no KPIs were in place but demonstrable impact on the provision of healthcare to the North Lincolnshire system could be seen within the report. Ant Rosevear acknowledged that whilst it is difficult to quantify there had been significant service development since inception and he would like to see the ICS consider the evidence and continue with the current funding, with particular focus on planning guidance and what can be achieved.

Ian Reekie was encouraged to hear that the initiative is feeding into improvements in unplanned care performance but only in the North Lincs area and asked if there were any plans for similar in North East Lincolnshire. Ant Rosevear stated that there were no current plans in that area. However, planning guidance promotes consistency across the region and nationally. Discussion was underway, including at the A & E Delivery Board, to draw up plans in accordance with planning guidance, for submission to the ICS to incorporate such a proposal.

Stuart Hall asked how confidence was obtained that benefits were attributable to this programme. Ant Rosevear acknowledged that it was difficult to quantify but within the community services there are benefits being seen i.e. a large cohort of patients would be going through A&E and that is not happening. One of the key developments is the continued building of ever more productive relationships with EMAS.

Neil Gammon was concerned that funding was reviewed on a 3-monthly basis rather than there being a long term commitment. Brian Shipley explained that now there is more certainty on the numbers it will raise the profile of what we do and get funding for but he suspected that the timing of national planning guidance may have been a driver in the need to review that often.

Shaun Stacey referred to the Gateway to Care project (page 5) describing the work undertaken this year with Hospital at Home as transformational. Whilst he appreciated it was just North Lincolnshire at present, work was underway with NEL CCG to commission similar aspects as highlighted within the paper. He said that the impact on families that this service has had should not be underestimated and he would be keen to maintain this service for the local population.

It was agreed that this was a good news story that should also be included within the highlight report to the Trust Board.

Action: Neil Gammon

Neil Gammon thanked Ant Rosevear for attending and asked him to pass on thanks to Dr Naveen Samuel for the clear briefing paper.

Item 6 04/21 **Integrated Performance Report (IPR)**

Shaun Stacey presented the report and asked the Committee to consider if assurance could be gained with the new format of the IPR.

Shaun Stacey briefly highlighted a number of areas to note including:

- In the EDs, zoning routes and the need to swab patients prior to admission causes delays with care.
- Improvement in 12hr performance, compared with Nov 20 to Jan 21, was encouraging however any breaches can be linked directly to patient flow within ED and inpatient exit blocks, compounded by increased patient acuity requiring longer

stays. There was thus still more to do.

- Small improvement seen in ambulance handover between 15 – 30 minutes but other handover measures have worsened.
- Access and flow is helping urgent and emergency flows at both sites and work is on-going with the integrated units.
- Continued increase in patients waiting, so demand and the ability to treat remains difficult.
- Still comparably high performance within the region for cancer treatment.
- Further increase in 52 week waits with improvement expected as more operating theatres are opened and GDH as well as independent sector are used more; anticipated to get to zero 52 week waits by the end of the year
- Still challenges with diagnostics as demand exceeds capacity. Diagnostic hub to be opened up later in the year and NLAG are also bidding for additional, mobile MRI scanners and whilst gained two CT scanners trained staff are required.
- Workforce remains a challenge particularly with carry-over leave being a risk.

Neil Gammon commented that the report contained the detail with clearly understandable slides which bring the picture to life. The Committee would like to see continued emphasis on recovery during the planning and would benefit from seeing the plans put in place now as operational services are “ramped up”, but also further down the line as they progress. Shaun Stacey explained that currently Ops are trying to understand the recovery trajectory at service level, which can then be aggregated to divisional level; adding there would be internal and constitutional trajectories.

Ian Reekie referred to the lack of progress with outpatient risk stratification and wondered how much of this is reliant on primary care. Shaun Stacey explained that the report shows an historical position, with current statistics actually slightly better. Family Services were making good progress although he acknowledged that Medicine and Surgery have ground to make up.

Shaun Stacey added that risk stratification is important but it has to be balanced with the need to create capacity to undertake the treatment requirements needed by patients. There was a need for greater Primary Care involvement but it was important to remember that this was not just an administrative exercise but a clinical assessment of the patient. The eventual aim was to ensure that the right plans are in place within the funding available.

Stuart Hall commended the format of the report and highlighted the 12hr trolley breaches. Shaun Stacey explained that these were directly related to flow through the hospital and referred to ward outliers and the need to recognise the work that is being done with the management of beds as a result of Covid-19 i.e. regraded beds to manage the Covid risk which is not able to be reflected in the report but would settle down as business as usual is resumed.

Neil Gammon referred to Phase 3 Summary (page 53) and the elective and day case cardiology being significantly below plan and asked if there was a link with this and the success of the cardiology Connected Health Network at the Immingham Roxton Practice PCN. Shaun Stacey explained that they were two separate issues. The problem is lack of sufficient access to laboratories and having available monitored beds and capacity. The plan was to open up SGH and DPOW facilities 7 days a week to enhance this capacity.

Neil Gammon also asked about the local indicators shown as TBC on the Scorecard (Page 8). Shaun Stacey explained that these had been put forward as part of the planning last year and still need to be agreed with the ICS. Once agreement is reached it will potentially reset the targets but they would continue to be local ones. He added that NLAG were well ahead as planning started in November 2020 but cannot be finalised until negotiations with commissioners are complete.

Andrew Smith stated that the Committee were assured that clear trajectories are in place and he would like to see contextual, forward looking tracking to give an holistic approach.

Neil Gammon agreed that the report was a much better representation of operational performance with greater clarity and it showed that plans and actions were moving in the right direction, acknowledging the clear challenges around workforce and finance The committee clearly felt assured that planning is well underway but having sight of trajectories for the remainder of the year would ensure that the Committee can see how well, or not, the trajectories were being met, and are likely to be met, over the coming months.

Item 7 04/21 **Finance**

Brian Shipley presented the end of Month 12 report and briefly highlighted issues to note, including:

- £162k surplus ahead of the breakeven position.
- At month 11 forecast surplus £2.5m
- Month 11 annual leave provision £7m reduced to £5.37m from actuals and the Trust received full income for that amount. Also included provision for “Flowers” legal case based on guidance received with income slightly below full value. £3.3m included in year- end position for non-A4C but not income backed so potential risk to the Trust
- Non clinical income improved with additional HEE funding and the highest Pathlinks activity to date
- Increased bad debt provision primarily linked to overseas visitors bills which continue to be chased so notional provision included
- Other adjustments include pension contributions and donated equipment throughout the year that had to be recognised in the accounts
- Still incurring additional costs to combat Covid-19 whereas had a balanced position under the financial regime for the first six months to ensure breakeven position
- Savings – had good delivery given the context of last year with a slight surplus achieved
- Capital - £23m received over plan and spent full capital programme for the year
- Achieved financial plan for second year running acknowledging the financial regime helping achieve that
- Ongoing Covid-19 expenditure will need to be one focus in 2021/22

Neil Gammon commended everyone involved in the timely spending of in year capital funds and also for the second year of delivering against the control total.

Jug Johal advised that Nicola Parker in the Finance team maintained oversight of capital spend and was in daily contact with his teams to ensure spending was in line with profiles and he wanted to acknowledge that effort.

Neil Gammon referred to the nursing agency costs that continue to rise despite bank incentives and Brian Shipley explained that some of the costs were because of staff shielding and sickness absence with a high proportion of staff, identified through risk assessment, who were not able to work in clinical areas therefore needed to be back filled. Family Services have a relatively high proportion of BAME staff.

Shaun Stacey highlighted the issues with overseas recruitment for registered nurses that did not have the required capabilities to immediately start work productively on the wards. This resulted in doubling up of staff to provide necessary supervision. The Trust was continuing overseas recruitment with a national drive to improve the standard as this is not just a local position. In addition, sickness absence and high levels of annual leave require managing, so if it was possible to drive recruitment figures up recruiting to the vacancy rate, this would translate into a reduced requirement to use agency staff over weekends and nights.

Brian Shipley explained that they are reviewing on-going Covid-19 expenditure with divisions who have been asked to produce plans for the second part of the year. Neil Gammon asked for an update, jointly, between Finance and Operations teams to explain how they intend to drive down Covid-19 spend to achieve parity with the amount received.

Action: Brian Shipley / Shaun Stacey

7.2 Financial Special Measures – Letter

The latest letter received from NHSI/E had been provided for information and was noted.

7.3 Financial Planning Update

Brian Shipley presented the report which outlined the Trust's approach to budget setting for the first six months of 2021/22 and contained the proposed trust wide budgetary allocations for that period.

Brian Shipley drew the Committee's attention to Appendix 1 – Financial Gap Bridge Analysis which outlined the main changes since the original assumptions were made prior to the planning guidance being received.

Following review the draft budgets were approved by the committee and the remaining financial planning updates were noted.

7.4 Capital Plan 2021/22

Brian Shipley presented the report which outlined the Trust's draft capital programme for 2021/22 and the corresponding funding streams. The programme is ambitious and involves a number of risks, for example, timescales of spending cash and requirements for ongoing AAU Business Case.

Jug Johal referred to support of £1.5m from the ICS to improve the oxygen system at the Trust and additional infrastructure improvement funding, targeting fire and water systems. Energy funding of £1.3m for Goole and £40.3m Public Sector Decarbonisation Scheme Grant funding which is the biggest across the country with the next highest at £27m in London. Jug Johal advised that a condition of the funding is for it to be spent by the end of September 2021. He has written to request a formal extension of that requirement to March 2022. The spending of the allocation will feature in the usual finance report over the year.

Following the review the report was noted.

Item 9 04/21 **Digital Services**

9.1 Annual Priorities

Shauna McMahon presented the report for information and explained that the digital priorities include the upgrading of devices; upgrading of PAS and modernising of the Data Warehouse for improved reporting. The PAS upgrade is currently in the costing phase and also linking with HUTH; a meeting is arranged with suppliers for the Data Warehouse in order to scope the spec; and Robotic Processing Automation (RPA) to reduce repetitive data entry which is being done in conjunction with the ICS.

A governance structure was also provided within the report for information.

Post Meeting Note: Shauna McMahon had advised that one of the groups within the structure had changed their name from Digital Services Delivery Group to Digital Solutions Delivery Group.

Neil Gammon suggested adding the Governance schedule to the F&P work plan to have a quarterly update on how Digital Strategy is progressing, major projects and finance/benefits. He also suggested adding to the highlight report that we now have an agreed way forward through this Committee for Digital Strategy assurance purposes.

Item 8 04/21 **Strategic Development Update**

Neil Gammon advised that there was no update this month and proposed suggesting to Ivan McConnell that whilst an update should be provided on a regular basis it does not necessarily need to be every month.

Item 10 04/21 **Estates & Facilities**

10.1 BAF Risk – Deep Dive – Ventilation

Jug Johal presented the report and highlighted that the Technical Memorandum 03-01 – "Specialised ventilation in healthcare premises" is published in two parts i.e. 'design and installation of ventilation systems'; and 'operational management and planned maintenance'. He advised that as a result of Covid-19 a number of HTM are being reviewed.

Jug Johal highlighted the Premises Assurance Model outlined within the report and advised that the ventilation systems are on the risk register as red, due to the age of the infrastructure, unless refurbishment or rebuild with major funding is available.

There were no major concerns to be highlighted to the Committee and Jug Johal advised that the one outstanding action was being addressed with the remainder due for completion during the year

Andrew Smith referred to the red ratings and suggested that the mitigation plans described did not appear to still warrant a red rating and asked why, if any changes were made, would it still remain a significant risk. Jug Johal explained that the concern in reducing the risk was that it could affect the ability to allocate capital which is based on risk, so if a lower risk rating prevailed, then the capital funding may not be allocated. He added that with the pandemic, it is not the right time to reduce the risk relating to ventilation systems.

Andrew Smith agreed with the pandemic explanation but not the funding aspect as this was not an appropriate use of risk management and asked if there was some way to aggregate the two. Jug Johal explained that the equipment is well beyond the expected lifespan and could fail at any point. Neil Gammon also agreed that this use of the Risk Register was not an appropriate way to seek capital funding.

Stuart Hall added that the ventilation system is a major concern with functionality and if looking to increase activity say in Ophthalmology, they are heavily dependent on air systems.

Following the discussion the update was noted.

Item 11 04/28 **Draft F&P Workplan 2021/22 (V1)**

Discussed earlier on the agenda

Item 12 04/21 **Items for Information**

12.1 PRIMS Governance Flowchart

The Governance Flowchart was noted.

12.2 Performance Letters to Divisions following PRIMs meeting

No letters were available due to business planning discussions taking place with Divisions.

Item 13 04/21 **Any Other Urgent Business**

There was no other urgent business raised.

Item 14 04/21 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues to raise with other Committees

Item 5 04/21 **Matters for Escalation to the Trust Board**

The following issues were agreed to highlight to the Trust Board:

- Allocation of Salix funding and formal request to extend spending requirement deadline to March 2022
- Board Assurance Framework
- Final Operations Plan for 2021/22
- Finance Report
- Digital Services
- Good News Story – Community Response Team GP

Item 16 04/21 **Date, Time of next meeting**

Wednesday, 26 May 2021 – 9.00am-12.00pm

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Neil Gammon	✓											
Gill Ponder	✓											
Linda Jackson	Apols											
Stuart Hall	✓											
Andrew Smith	✓											
Lee Bond	✓											
Peter Reading	✓											
Shaun Stacey	✓											
Jug Johal	✓											
Ivan McConnell	Apols											
Shauna McMahon	✓											
Helen Harris	✓											
Brian Shipley	✓											
Ian Reekie	✓											
TOTAL ATTENDEES	**12**											

MINUTES

MEETING: **Finance & Performance Committee**

DATE: **26 May 2021 – via Teams Meeting**

PRESENT:	Neil Gammon	Non-Executive Director / Chair of F&P Committee
	Gill Ponder	Associate Non-Executive Director / Chair of F&P (designate)
	Andrew Smith	Non-Executive Director
	Linda Jackson	Vice Chair, NLAG / Associate NED, HUTH
	Stuart Hall	Associate NED, NLAG / Vice Chair, HUTH
	Shauna McMahon	Director of Digital Services
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer
	Ivan McConnell	Director of Strategic Development
	Brian Shipley	Deputy Director of Finance
	Diana Barnes	Governor Representative
IN ATTENDANCE:	Chris Evans	Associate Director of Information Systems (For item 9.1)
	Anne Barker	Finance Admin Manager (Minutes)

Item 1 05/21 **Apologies for Absence**

Apologies for absence were noted from: Lee Bond, Chief Financial Officer (Brian Shipley Deputising); Ian Reekie (Diana Barnes attending)

Item 2 05/21 **Declarations of Interest**

There were no declarations of interest made.

Item 3 05/21 **To approve the minutes from the previous meeting held on 28 April 2021**

The minutes from the meeting held on 28 April 2021 were reviewed. Jug Johal noted on page 9 the sentence …. *Jug Johal explained that 'the equipment is well below expected lifespan…'*should read *'the equipment is well beyond the expected lifespan' …*

Subject to this amendment, the minutes were accepted as a true record.

All actions from the minutes were included either on the agenda or captured on the action log.

Item 4 05/21 **Matters Arising**

4.1 Action Log

9. – (27 08 20) – Capital Spend – Jug Johal advised that a bridging loan would not now be required due to the delay with the scheme therefore this item could be closed.

5.4 (28 10 20) – Clinical Data Improvement Programme – It was noted that an update was being brought to this meeting but this element goes back to October 2020 when Lee Bond suggested looking at a comparison with HUTH. It was suggested that Shauna McMahon liaise directly with Lee Bond and advise if this item could be closed and the Committee receive regular updates as per the workplan.

Action: Shauna McMahon

Following review the action log was noted.

Item 5 05/21 **Presentations for Assurance**

5.1 Board Assurance Framework 2021/22 (BAF)

The BAF had been provided as work in progress and Neil Gammon explained that the Committee were being asked to decide on the frequency each of the strategic risks should be considered by the Committee. The final version of the BAF would be presented to Trust Board in August for final approval.

Jug Johal noted some overlaps, explaining that Estates & Facilities provide reports each month which include the risks as highlighted in the BAF. Therefore, the E&F BAF Risks deep dives were already brought to the F&P Committee each month for discussion.

Andrew Smith suggested that the red ratings should be considered more frequently as only seeing them on a quarterly basis seemed too infrequent. Neil Gammon did not think more frequently would be necessary as there would likely be no movement in the rating month on month. However, if the risk referred to a statutory requirement or patient safety this would need to be more frequent.

Stuart Hall suggested that some methodology would need to be in place to be able to increase the frequency should the risks creep up.

Shaun Stacey referred to SO 1.2 (performance targets) and advised that there would be an opportunity to review each month through the IPR where trajectories and performance against constitutional targets would be clear but this was not available at the current time. Shaun Stacey asked Andrew Smith how this information could be triangulated in the IPR document and it was suggested that they meet outside of the meeting to discuss further.

Action: Andrew Smith / Shaun Stacey

Stuart Hall observed that seeing this information within the IPR would negate some of the concerns.

SO1.6 (business continuity arrangements). Shaun Stacey stated that this was high as a consequence of Covid on routine work; noting that the statutory requirement is included as part of EPPR and signed off annually. Shaun Stacey suggested a review on a quarterly basis to account for any heightened Covid risk. Once the Trust was running more as business as usual the frequency could revert back to twice a year if deemed appropriate.

Neil Gammon agreed with Shaun Stacey's comment on the links with the IPR and suggested that each Director should review the areas under their remit and determine when these should be brought to the Committee which would add to the richness of the workplan; this would not exclude ad hoc items during the year.

Linda Jackson explained that it had been agreed that the BAF would be presented to the Trust Board every four months and therefore would be brought to F&P the month before and the Committee need to determine the risk ratings and the need to exceed or decrease the frequency of review. It was noted that Estates & Facilities are already planned in for the year and both Ivan McConnell and Shauna McMahon are planned for regular updates; Shaun Stacey to identify areas for review across the year.

Action: Shaun Stacey

9.32am Gill Ponder joined the meeting due to connection difficulties at the start of the meeting.

It was agreed that Neil Gammon, Gill Ponder and Linda Jackson would discuss the workplan outside of the meeting.

Action: Neil Gammon / Gill Ponder / Linda Jackson

5.2 CQC Progress Report

Neil Gammon advised that given there were no attendees available for this item he had spoken with Dr Kate Wood who had suggested that any questions could either be directed to her or held back until the upcoming Board briefing on improvements made since the last CQC inspection.

Linda Jackson queried the current status of the five business cases as these were quite integral to the Trust being compliant.

Shaun Stacey updated as follows:

- Third Tier Anaesthetic cover – Approved and out to recruitment. Currently using locums both middle and consultant grade.
- 16hr Consultant Cover in EDs – Achieving but not consistently and covered by locums, overtime and agency cover. Some gaps in rotas so business case outstanding for approval as needs some adjustment for VFM; having two A&Es means below the national standards
- Medical Staffing out of hours – completed
- RSCNs in Urgent Care – National problem getting RSCNs in EDs. Have bolstered Paediatrics and Medicine training to look after children should be finalised in June.
- Community Nursing Staffing – Completed and presented. Needs further nursing review.

Brian Shipley advised that it was anticipated the outstanding business cases would be finalised at the 21 June Business Case Review Group (BCRG) and then to TMB for consideration to approve.

Stuart Hall referred to section 4 – areas of learning (page 2) i.e. *Ongoing learning about what is evidence* and asked what the evidence looked like; how it would be reflected in the inspection which would be a well led theme; and did planning going forward reflect this? Shaun Stacey explained the work that had been undertaken including Execs 360 degree reviews, development and board sessions; Divisional leadership level work with Elaine Criddle; Clinical Leads undertaking robust leadership training with leadership academy with consultant body; and a recently commenced programme for junior and staff grade consultants.

Ivan McConnell also highlighted the need to reflect on having two sites and the cost drivers of that; as well as looking at the future as part of Humber Acute Services with a number of clinical personnel involved, noting that the model of care today would not necessarily have the same requirements in the future.

5.3 National Cost Collection Process and use of SLR.

Brian Shipley presented this item and explained that there were some gaps against the national standards, some old as previously highlighted through Internal Audit recommendations and some new. A proposal was presented, and agreed, at TMB to form a Costing Steering Group. This would be a clinically led steering group, led by the new Information Officers. The information would feed into the model hospital and GIRFT

programmes to ensure a consistent approach to costing within the NHS.

Neil Gammon raised the timescales noted within the document as the end of July which he suggested would be a lot of work and asked what the ramifications were of not achieving by that time. Brian Shipley explained that some of the actions had been outstanding for a number of years, which the costing team had had to work around in the absence of specific data, but this proposal would give the actions some traction to enable some recommendations to be closed. Any potential risks to timeframes would be escalated back through the F&P Committee.

Gill Ponder queried the comparator organisations and asked if there were any plans to go beyond the region and look at other neighbouring organisations. Brian Shipley explained that within the model hospital there was an ability to pick and choose who to benchmark against rather than always at ICS level. If there was a specific service to benchmark then it would be possible to pick a similar sized organisation with similar service design.

Ivan McConnell observed that it was difficult to benchmark 'apples with apples' and asked if there would an opportunity to use the small hospitals framework, which Brian Shipley agreed. It was noted that unless trauma was stripped out, HUTH would not be an appropriate comparison.

Stuart Hall agreed with the formation of the costing steering group and referred to the costing processes within the report (4.2) in terms of post and pre-Covid costs and suggested that the current data may not be all encompassing to achieve the correct data and asked if this could be enacted on a site, and not just service, specific basis. Brian Shipley confirmed that sites were always looked at first so that was included.

Following review the report was noted.

Item 6 05/21 **Integrated Performance Report (IPR)**

Neil Gammon highlighted that in discussions with Helen Harris it had been suggested that if performance targets were being met or exceeded on a regular basis the reporting could be by exception. He asked the Committee to consider if they wished to adopt that approach.

Shaun Stacey highlighted that the report did not show the current status of the recovery trajectories and that this would be built into the information presented going forward. Shaun Stacey highlighted issues to note as follows:

Planned Care

- RTT – Continued to deliver but not within constitutional standards. Also recovery against day case improvement.
- DM01 – Some improvement made but continued to be a challenge. Ultrasound biggest concern despite using all capacity within organisation and exploring additional capacity from the independent sector and community diagnostic hubs. Working on productivity of DM01 with help from Community Hubs from July.
- Cancer 62-day - Showing improvement trend and for the first time in three years seeing change in colorectal conversion and treatment which continued to drop
- Outpatients - Still a challenge with follow-ups.
- Waiting list position - Continued to rise but expected a downward trend by end of September which was forecasted to continue to the end of the year

Gill Ponder observed that the narrative in some of the sections of the report had been pasted from section before and therefore the reasons for the drop in performance were not clear.

Neil Gammon also noted some areas where narrative was not included and advised that Helen Harris' team aggregated the information before it was sent to the Ops team and due to time constraints it was not always possible to complete fully. He therefore referred back to his earlier question if the Committee wished to see only by exception.

Shaun Stacey also explained the difficulty in getting a 64 page document completed across four divisions in the timeframes. He acknowledged that access to theatres and the number of surgeons because of BAME should have been explained in more detail.

Neil Gammon highlighted that there was no mention of risk assessment and staff isolating within the Exec summary. Shaun Stacey explained that risk assessments continued to be reviewed and more staff were returning to do face to face care and therefore undertake surgical operations. There was still prevalence risk in the NL patch which had not been fully addressed.

Unplanned Care

- A&E performance – Averaging 70% performance. Data showed an exceptional period i.e. 500 attendees which was becoming a regular occurrence. Undertaken two audits, in conjunction with system partners, i.e. retrospective missed opportunities and real time point prevalence audit with evaluations presented to teams. Also seeing growth of type 3 patients in A&E who could have been dealt with by another health service.
- Non-elective LOS – Constantly improved and helping to keep lower level of bed requirements

Stuart Hall raised a number of questions including frailty pathways and testing, upskilling ambulance attendees; breach analysis how many related to same day attendances; progress in SDEC (Same Day Emergency Care); was paeds an issue as part of that; and having sight of SEDIT for comparators and performance in that area.

Shaun Stacey responded and advised that a pilot frailty service was being done within the cost envelope. In terms of improvement to pathways, there was an issue around people being able to walk in and how to control that, noting that a review of activity and performance was undertaken by regional COOs, with 3900 appointments in ED but attendances at a much higher number so there was more work to be done.

SDEC – More patients were seen per day but breaching the 4hr standard. Arrival to assessment was attributable to flow. Paeds was also challenging but was being addressed but again went back to workforce, although the new A&E would address that issue. Demand workforce flow should be included in the next report where a much better performance should be seen as part of assurance for CQC.

Linda Jackson raised the Statistical Process Control (SPC) charts in A&E noting that the first few months' performance had not changed given the high number of attendees and suggested bringing the audit information to the next meeting for assurance on outcomes. Shaun Stacey suggested that it would be more meaningful as a system rather than A&E on two sites and proposed including this in the July 2021 meeting, which was agreed.

Action: Shaun Stacey

Gill Ponder raised the delays in ambulance handover due to lack of IT interface between NLAG and EMAS. Shaun Stacey explained that the EMAS system did not "talk" to the Symphony system without a separate "patch" which required national agreement. The position reported was accurate, although disappointing.

Shauna McMahon added that work was ongoing with EMAS and Symphony to get that exchange of information.

Ivan McConnell commented that SPC charts could be useful if used appropriately but there was a need to understand the drivers and be able to document those. They were only useful if mapped against trajectories.

10.45am Peter Reading had joined the meeting

Peter Reading agreed and suggested it might be appropriate to ask Sam Riley from NHSI/E to come back to do further sessions and suggested that as he was meeting with Elaine Criddle later that day he would take that action forward.

Action: Peter Reading

Following review and discussion the Committee noted the report. It was also agreed that going forward the IPR should be by exception only.

6.3 Operational Plan 2021/22

Shaun Stacey presented the report which outlined the operational plan for H1 of 2021/22. The submitted plan demonstrated an ability to hit thresholds in terms of value in all areas. Informal feedback received was that it was an ambitious plan but well thought through with no request to revisit.

Gill Ponder noted that the CIP savings were not underpinned by the delivery plan and asked what the plan was, given we were already two months into the year.

Brian Shipley explained the delays in scoping the savings plans due to Covid and added that ERF was not considered as part of the current plan and an additional income stream of £3m could potentially underpin CIP shortfall but reducing the Trust cost base should be the main focus as any ERF would be non-recurrent. Brian Shipley also referred to page 20 within the report which outlined the base threshold without additional resource from ERF.

In response to questions raised by Stuart Hall regarding bed modelling and finances, Shaun Stacey explained that the organisation did not have a formal modelling tool and a manual process was in place and outlined the considerations made within that process including Christmas and other Winter related illness that reduced ability to attend, complex work undertaken at Goole, noting that in-patient format was around seasonal variations. In terms of Covid patients there was a need to be isolated with DPOW ward having side rooms and SGH currently using redirooms.

Linda Jackson raised questions in respect of the total number of 837 beds and asked if this was more or less than previously; had the bed base for the next 6 months been communicated; and what was the new model of OPD service across both NEL and NL; and asked if this was the Connected Health Model.

Shaun Stacey explained that the bed base would be confirmed in June and a paper produced, in conjunction with Nursing and Finance, which would show all elements and would be seeking approval to recruit to all vacancies if numbers increased. This would not necessarily mean more nurses but would explain where beds were required. In terms of Connected Health Shaun Stacey explained the outputs from Cardiology were included in the plan. There was no clarity at present on H2 funding but it was anticipated that a strong driver to deal with patients would be the Connected Health network.

Item 05/21 **Finance Update**

7.1 Finance Report M01

Brian Shipley presented the report and highlighted issues to note:

- Month 1 slightly behind plan by £14k
- Over delivery of minimum base threshold
- Concern over clinical pay overspend (£0.08m) due to overspend on medical and nursing staff
- Covid expenditure – reduced in April to £1.2m compared to average spend last year of £1.6m per month. Expectation that Covid income would reduce, particularly in H2
- Bank incentives to be stopped at the end of June 2021
- Potential for ongoing costs of recurrent Covid virtual ward and SPA
- Savings delivery – marginally over delivered due to non-recurrent back office vacancies rather than use of temporary staffing. Still have gap in CIP savings of £1.3m which needed to be a focus
- Capital – slippage on ED schemes potentially mitigated the need for a bridging loan
- Balance Sheet – Cash reduced due to paying a month in advance now back to normal
- Invoices – still meeting better practice target of 90%

11.25am Peter Reading left the meeting

Stuart Hall noted the surprising overspend in the surgical division when comparing the paper previously discussed at 5.3 and asked how robust the figures were i.e. clinical activity, job planning and Covid etc.

Brian Shipley explained the actual numbers for M01 so nothing contentious and does not include ERF. Stuart Hall agreed to collate the information that requires clarification and to send through to Brian Shipley and report the outcome back to the next Committee meeting if required.

Action: Stuart Hall

Shaun Stacey explained the anaesthetic funding which related to improvement in performance and response to those needs; the overspend was attributable to BAME risk position. There were eight vacancies in anaesthetics related to additional posts for improvements required, which was causing pressure.

Gill Ponder referred to Appendix 2 and the variance against budget of £1.6m for excluded items which Brian Shipley explained was grant income (EPC capital schemes).

Following review and discussion the report was noted.

7.2 Financial Special Measures Update

The FSM letter from NHSI had been received late the day before and had been uploaded to the Sharepoint site for information.

Item 9 05/21 Strategic Development

9.1 Clinical Data Improvement Programme

Chris Evans attended the meeting to present this item and highlighted areas to note including, a significant improvement over the last two years; a stabilised SHMI improvement position which came from collaboration of internal teams. Also contained within the report was a summary of coding and the HSJ Awards with the teams shortlisted into the top three.

11.35am Shaun Stacey left the meeting

Jug Johal commented that whilst he had not been involved since November 2020 when Shauna McMahon commenced in post, one of the biggest risks was reversal of the SHMI score when consultants left the Trust but it had stabilised over the last quarter so credit to teams who did the work.

Chris Evans highlighted the clinical audits undertaken which resulted in only 3% difference between coding and audit. Grant Thornton would still be in place for Q4 when a full audit for CDIP would be undertaken, which would be reported to this Committee.

Chris Evans explained that there were no set financial targets due to Covid but was on target against the original plan. There was a positive continuation of effort but there were still some risks around service and managing with a few key members of staff. There was a collaborative approach with HUTH across clinical coding and IG and they were working towards a sustainable service model.

The Committee noted the update with no further questions.

11.40am Chris Evans left the meeting.

Item 8 05/21 Strategic Development

8.1 HASR Programme Update

Ivan McConnell presented the report which outlined progress on the Humber Acute Services Programme 1 which included a review by HUTH and NLAG Chief Executives resulting in a revised, agreed schedule. Key issues were Ophthalmology and Urology requiring OD support and pushed to later in the year; Clinical Leadership recruitment through open competition and in place for key specialities by the end of Q2.

Programmes 2 and 3 would see a programme relaunch by the Chair and two CEOs to take place in mid-June with a series of weekly events to the end of October; establishment of development board through Committee in Common; capital pre-SOC to be published; opportunity to lobby on capital when Amanda Pritchard visited the Trust in mid-June.

Linda Jackson referred to the clinical services within the clinical plan and asked for an update on the recruitment of clinical leads. Ivan McConnell advised on the priority services and highlighted that Ophthalmology and ENT would be in place by December; Urology and Respiratory pushed back to March.

Ivan McConnell proposed an update at a NEDs briefing if it would help.

Action: Ivan McConnell

Item 10 05/21 **Estates & Facilities**

10.1 BAF Risk – Deep Dive – Back Log Maintenance Programme (BLM) and Premises Assurance Model (PAM)

BLM – Jug Johal presented the report which gave an update on the BLM programme delivered in 2020/21 and outlined the 2021/22 programme. Jug Johal highlighted specific areas to note including the core funding of £1.8m and the additional funding for critical infrastructure (£3.5m); critical care (£1.4m); and Infection prevention & control (£1.3m). Capital revenue of £97k used for survey work and feasibility studies. Jug Johal noted that a limited number of schemes (section 4) had been identified due to a number of schemes still being completed from 2020/21 and overlapping with the major capital programme.

PAM – Jug Johal presented the report and explained that this is now a mandatory requirement referring to the six domains for self-assessment; workshops were held throughout the year. The E&F Directorate had undertaken the PAM self-assessment process and the Trust was represented at a national level consulting at the NHSE/I PAM development steering group.

Jug Johal referred to the summary of findings (page 6) and highlighted that there were no areas found to be inadequate and several areas were outstanding, where improvements were identified these were minimal.

The newly released National Cleaning Standards would move to a similar scoring mechanism as food hygiene scores and Jug Johal advised that this would be reported through Q&S as working with project director through the Chief Nurse Directorate; highlights would still be brought through this Committee.

Jug Johal also referred to the recommendations (page 8) and advised that most of the work was completed or due to be completed with specific dates identified and there were no areas of concern that required highlighting to the Committee.

There were no questions raised and the BLM and PAM updates were noted.

Item 11 05/21 **Draft F&P workplan 2021/22 (version 1)**

Neil Gammon explained that the current workplan was still to be finalised and suggested that discussion could continue after the meeting between Linda Jackson, Gill Ponder and Neil Gammon.

Item 12 05/21 **Items for Information**

12.1 Performance Letters to Divisions following PRIMs meetings – no letters available for this meeting.

Item 13 05/21 **Any Other Business**

There was no other business raised.

Item 14 05//21 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues to raise to other Trust Board Assurance Committees

Item 15 05/21 **Matters for Escalation to the Trust Board**

The following were agreed to highlight to the Trust Board:

- Further development work on use throughout the Trust of SPC charts
- Considerable ED pressures
- Improvement seen in BAF documentation
- Two audits by ECIST to be brought back to the Committee in July.

Gill Ponder highlighted that this was Neil Gammon's last F&P meeting and wished to place on record the Committee's thanks for all the excellent work that he had done for this Committee over the years.

Item 16 05/21 **Date and Time of next meeting**

Wednesday, 30 June 2021 – 9.00am-12.00pm via Teams

Attendance Record 2021/22

Name	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Neil Gammon	✓	✓										
Gill Ponder	✓	✓										
Linda Jackson	Apols	✓										
Stuart Hall	✓	✓										
Andrew Smith	✓	✓										
Lee Bond	✓	Apols										
Peter Reading	✓	✓										
Shaun Stacey	✓	✓										
Jug Johal	✓	✓										
Ivan McConnell	Apols	✓										
Shauna McMahon	✓	✓										
Helen Harris	✓	Apols										
Brian Shipley	✓	✓										
Ian Reekie	✓	Apols										
TOTAL ATTENDEES	12	11										

NLG(21)175

DATE OF MEETING	Tuesday 3 August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Mike Proctor, Non-Executive Director & Chair of the Quality & Safety Committee
CONTACT OFFICER	As above
SUBJECT	Quality & Safety Committee Minutes April - June 2021
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report includes the minutes of the Quality and Safety Committee held between April and July 2021

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓				

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)					
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 16 April 2021**
Time: **9.30am – 11.30am**
Venue: **Virtual meeting via MS Teams**

MINUTES

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Andrew Smith	Non-Executive Director
Angie Legge	Associate Director for Quality Governance
Ellie Monkhouse	Chief Nurse
Andrew Smith	Non-Executive Director
Colin Farquharson	Deputy Medical Director
Michael Whitworth	Non-Executive Director
Peter Reading	Chief Executive

In attendance

Ian Reekie	Governor
David Cuckson	Governor / Observer
Anne-Marie Hall (item 79/21)	General Manager, Medicine
Sarah-Jayne Thompson (item 77/21)	Assistant General Manager, Surgery & Critical Care
Debbie Bagley (item 78/21)	Head of Nursing, Surgery& Critical Care
Mr Naeem Nabi (item 77/21)	Consultant & Clinical Lead, Ophthalmology
Jane Warner (item 80/21)	Head of Midwifery
Jenn Orton (item 78/21)	General Manager, Surgery & Critical Care
Laura Coo	PA to the Medical Director **(for the minutes)**

70/21 **Apologies for Absence:** Kate Wood, Shaun Stacey, Jeremy Daws, Jan Haxby,

71/21 **Chair's opening remarks:**

Mike Proctor advised that the BAF and IPR were not on the agenda due to the timing of this meeting and the reporting schedule not being aligned. The BAF was still in development and both reports were progressing well. In order to ensure the committee were looking at an up-to-date IPR it might be necessary to change the Quality and Safety Committee meetings to be held on the fourth Friday of each month but that decision would be made later and the group would be involved in that decision. Mike also planned to meet with the NEDs separately to discuss this option.

72/21 **Declarations of Interest**

There were no declarations of interest.

73/21 Minutes of the previous meeting held on 19 March 2021

The minutes were approved as an accurate record of the previous meeting.

Matters Arising

74/21 There were no matters arising.

75/21 Review of action log

Ophthalmology would be discussed today and the CLIP report was due on 28th April.

Regular Reports

76/21 Clinical Harm report

Colin Farquharson referred to the report distributed which was taken as read. This report was provided every two months in this format however this would be changed going forward. The key findings identified an improvement in patients on the confirmed or suspected cancer pathways (section six of the report) and there had been progress in historical harm. There had also been an increase in what used to be categorised as stage one on the RTT process, those patients who had been waiting longer than 52 weeks. These were now being scrutinised through different systems.

There had been an overall reduction adjudication of moderate harm which was a positive step.

Debbie Bagley & Jenn Orton joined the meeting at 9.45am.

There was a small increase in the number of patients requiring clinical harm review with regards to the non-cancer pathways however there had been an actual decrease in the number of patients who had come to moderate harm which was positive in terms of patient safety.

Colin referred to the top of page nine of the report. It had been suggested for the next Clinical Harm Assurance report to this Committee that the data should be reported on a different set of metrics in line with the KPIs. Colin felt they now had a handle on what they were doing with these patients. The numbers had dropped; 71 patients had been on that pathway for more than 104 days which had improved from 179 patients previously.

Colin invited any questions or comments.

Peter Reading asked two questions, whether Colin was getting full cooperation from the relevant clinicians across the span of specialties, and secondly because of covid and the growing waiting lists, Peter asked what was being learnt from others or what others were learning from us in regard to risk stratification. Peter referenced that lessons had to be learnt whilst acknowledging the high numbers and the volume of work across the ICS. Peter noted that other organisations had higher numbers of long waiters. NLaG were ahead of the game in some aspects and some will learn from us. Colin was pleased with the degree of cooperation received from the majority of clinicians although some required ‘encouragement’ to contribute as required.

Naeem Nabi joined the meeting at 9.50am

Andrew Smith felt it was a really helpful report and that the pressure of clinical harm reviews was directly proportional to the waiting lists. Andrew asked if it was correct to say that the root solution was to resource effort on reducing waiting lists. In response Colin commented that in an ideal world that would be the case however that was not the case at the moment. The processes were aligned in the first place as it was identified that the patients on the waiting lists would have to be risk stratified due to the impact of Covid. NLaG was the first trust in the region to suggest that. This had then led to a discussion that where risk stratification was being done, it would be more efficient to undertake any clinical harm review at the same time to avoid duplication.

Ian Reekie asked if the relevant representatives of the CCGs had been involved in the talks for the different priority areas and were very supportive of the process. With those patients who had a relatively minor diagnosis but still needed to be monitored, could the GP's take on that workload. Colin agreed, and noted this had been the case and GPs were supportive of the process.

Mike summarised the key points. This Committee looked forward to seeing a single process and the timescales for full implementation and an evaluation of effectiveness. Mike also suggested it would be helpful to occasionally look at a single specialty and at what low and moderate harm meant to those patients. It was, overall, a very helpful report.

Colin added that further assurance should come from internal audit, who had been tasked with auditing clinical harm and risk stratification in the first two quarters.

Anne-Marie Hall joined the meeting at 10am

77/21 Ophthalmology Update

Naeem Nabi personally thanked Peter Reading for his leadership and investment into Ophthalmology and thanked Angie Legge for the support.

Sarah-Jayne Thompson referred to the report distributed which was taken as read and asked for any comments or questions.

Mike Proctor noted that the report did not answer the specific questions that the Committee had asked. The committee wished to have an update on whether the overdue follow up waiting list could be filtered and reported by patient condition, how long the overdue patients had been waiting beyond the planned time of their review and also the potential or actual harm of being overdue and not being reviewed. The committee therefore requested a further paper for the next meeting.

It was noted that the number included in the report was for all non RTT, overdue follow up patients booked and un-booked, the reason they included the booked overdue patients, was that at any point the patient could cancel and until they were seen, their appointment remained overdue. With regards to the conditions, Sarah advised that the system was unable to filter to sub- specialty detail. A manual work-around was for a diagnosis code to be added onto the system, the service were working hard to add this to the current patients on the waiting lists and had completed 50%.

Mike posed an example to illustrate the concern, it was anticipated that a number of the patients overdue would be glaucoma patients, the committee wanted to know how long they had been waiting past their due date, and if some were at risk of permanent sight deterioration or loss. Sarah advised that the system would not be able to currently identify this sub speciality. Sarah also advised that HUTH were currently able to provide sub speciality data as they had a specific ophthalmic system called Medinet. Currently the NLAG PAS system was unable offer this functionality and that was for all specialities within the Trust not just this particular speciality. Peter Reading advised that he was not aware of that issue or the software issue and would like to discuss with Sarah outside of this meeting. Naeem Nabi asked to be involved in those conversations. Mike suggested for those conversations to be completed outside of this meeting and for an update to be provided at the next meeting including discussing what mitigation was in place.

Naeem Nabi added there were different subsets within glaucoma; the vast majority of glaucoma cases were asymptomatic and those patients were very risky because an issue may not be visible to the consultant on a virtual consultation. Sarah further clarified, in reference to the immediate investment for Ophthalmology that the IT investment was to support the transfer of images for mobilising virtual clinics and releasing capacity. The investment in dedicated ophthalmology software to support data being provided at sub speciality level was featured in the medium term section of the business case. The rationale for this was to ensure that discussions were held with HUTH and a system wide decision with regards to software investment was reached prior to investment.

The Committee was grateful for the discussion and understood the difficulty of obtaining the information requested but looked forward to hearing greater clarification regarding risks and mitigations for this group of patients.

Action: The Division to provide a further paper to the next QSC in May and Mike Proctor would highlight to the Board the ongoing lack of assurance related to potential harms resulting from long waits in Ophthalmology but this may be modified following receipt and review of the further information requested.

Sarah-Jayne Thompson and Naeem Nabi left the meeting at 10.15am

78/21 Surgery Update

Debbie Bagley referred to the report distributed which was taken as read. Debbie drew members attention to the significant improvements made within Surgery with regards to complaints and PALS, the Divisions had worked really hard to achieve that position and only had 16 complaints outstanding.

In terms of document control, as of 31st March the Division only had one document outstanding compared to over 100 this time last year.

Work was ongoing to mitigate the risk relating to mandatory training with deterioration in compliance. All workbooks and e-learning had been supplied to deliver a quick turnaround where possible. Confirm and challenge meetings continued as well as review of compliance. They were working very closely with the Clinical Leads and Ward Mangers to achieve compliance. There had also been some work on MEWs

and deteriorating patients. Options were being looked at to try to get everybody to be able to attend the Alert course which was a real difficulty due to covid.

Andrew Smith pointed out that he appreciated a lot of work had gone into producing the report but felt that it did not give a clear picture of what was being done to address the critical issue of cancer pathways / wait times. He felt that a more unified presentation was required with a clear emphasis on what was being done to address the issue so that progress could be tracked in governance committees. Work to manage and reduce waiting lists had featured in the Board meeting when they looked at the IPR, as a NED Andrew felt the work they were doing in this area was somewhat fragmented. He knew there was a Cancer Project Lead but asked if there needed to be somebody looking at what was being done in those areas to focus on the waiting lists etc. Debbie had been successful in securing some funding from Humber Coast and Vale so would be appointing more people to address those issues. Jenn Orton added that with regards to cancer on a positive note Colorectal was now at 86.7%.

The Division was working with CSS colleagues to look at a colon capsule. Instead of a CT taking three spaces the capsule would take just one which would help them to manage that pathway better. Clinical harm reviews were being carried out for anybody waiting over 104 days but they were shared with HUTH and they then sat on their system. Jenn was working with Denise Gale to go through them.

Peter Reading asked about hip fractures as that was something that was raised by CQC in 2018 and asked for some assurance around that. In response Debbie advised there had been a lot of work and significant improvements made in that area, they had also looked at how they were doing as a national outlier. Work was ongoing with ECC to make sure they were managing that episode of care from the front door to discharge.

Mike summarised the discussion. The Committee acknowledged the substantial and significant improvement made particularly with regards to document control and complaints. Mike praised the CQC summary within the report and felt that it was helpful. Mike thought there was a lot of information about the position of the Division in relation to constitutional standards however this Committee was particularly interested in the patient safety and quality issues and would like reports to be focused more on that going forward.

Debbie Bagley and Jenn Orton left the meeting at 10.27am

79/21 Diabetes Management Report

Anne-Marie Hall referred to the report distributed which was taken as read and summarised the key points. There had been zero clinical harm instances but there had been issues with the Paediatric element highlighted through the PEWs audit. Anne-Marie thought that was linked to a lack of clarity for the standards and monitoring of that which had now been resolved. The nursing staff were meeting their target for mandatory training at 85% but the medical staff were not meeting their target so more work was needed to drill down and raise the level with the doctors.

Peter Reading was troubled by the figures that were presented, for BM testing for children following the death of two children and asked if there was a problem related to compliance with the policy which indicated a clinical risk. Anne-Marie responded to

clarify that the issue was that when the Paediatric team was introduced into ED they used a clinical judgement for glucose and blood testing to avoid unnecessary distress with the children. What the clinicians needed them to do was to document why they chose not to use the policy described for required testing which would improve the assurance. This should also be reflected in the data collection.

Colin Farquharson had been involved with one of the families of the two children, had visited the parents at their home and thought perhaps there needed to be a change reflected overtly and explicitly documented to enable the Trust to demonstrate that there was a good mitigation of what we were doing now. This needed to include an explanation as to why the protocol had been changed. Peter requested for Kate Wood to be involved in those conversations.

Action: Anne- Marie Hall to involve Kate Wood in the discussions as to assurance on the Paediatric BM score in A&E.

Ellie Monkhouse added that they had invested heavily to have the Paediatric nurses and needed to recognise that it might have been a good decision at that time but noted, having been an A&E nurse herself that not everybody needed their blood sugars testing. Mike agreed that we needed to comply with the standards set but if we did not we needed to explain why that had changed.

Anne-Marie Hall left the meeting at 10.37am

80/21 Maternity Update, including CNST

Jane Warner attended the meeting at 10.25am

Jane Warner referred to the report distributed which was taken as read. The report reflected the up to date position of where the Division were with CNST. Dates had changed on a number of occasions in the last few months, but now needed to be submitted in July. Great strides had been made with the saving babies' lives element with a pre-term birth clinic commencing on 26th April at both sites. The new consultant obstetricians had done considerable work with the uterine Doppler scanning. There had been challenges with the Anaesthetics staff undertaking PROMPT training.

Towards the end of report, Jane highlighted the current position with regards to the Ockenden report, noting that as part of that there was a requirement that the Trust met the CNST standards. As well as the work going on within the Trust the LMS were very involved and had oversight. Their processes had been written and were being followed with regards to any new incidents also working closely with our local chair. Jane highlighted the informed consent around personal care plans, which were now in use which was positive for our women and the midwives had said they were useful. Overall it was a very positive report.

Jane invited any comments or questions.

Mike Proctor noted the confidence that the Trust were on track to achieve CNST. As actions six and eight were yet to be achieved, Mike asked if there was any specific support the Committee could provide. Jane would appreciate the support for the PROMPT training and helping them to achieve it. It was agreed that this should be highlighted to the Board of Directors.

81/21 Key SI Update, including Maternity

Colin Farquharson referred to the report distributed which was taken as read. As chair of the SI panel Colin gave an overview of the key points; the report was kept as brief as possible and the first part of the report was about how SI's were scrutinised in the organisation and how they were signed off. The maternity serious incidents were shown in the table of the report as well as four others that had been completed and were documented in the report. With regards to non-maternity incidents there were some key SI's that were been investigated. One was a stop the clock confidential police enquiry and the other was regarding the oxygen supply. As mentioned in the report the SI related to the Never Event was a joint report in with St Hughs. Another was an inadvertent paracetamol overdose resulting in a death, the Trust had highlighted that to HSIB given the potential wider learning and HSIB had commenced this investigation.

In respect of learning there had been a learning event planned from a HUTH oncologist and HSIB would be attending on 13th May for a workshop about the learning generated from a national investigation into drugs left in cannulas which anybody was welcome to attend.

Mike Proctor asked in terms of the maternity SI where a root cause for that particular incident was not found if it was difficult to put actions in place. Jane Warner agreed it was unusual to not be able to find a cause but there could still be actions and things to be learnt.

Angie Legge added that both internally and with HSIB the process involved looking at all the gaps where the policy was not met, the investigations tried to establish a root cause, but would still unpick all the potential gaps along the pathway and consider what might need to be tightened up and what learning could be generated even when a root cause could not be identified.

Mike Proctor to highlight the maternity SI to the Board of Directors.

Jane Warner left the meeting at 10.51am

82/21 CQC Progress Report

Angie Legge referred to the report distributed which was taken as read. Angie highlighted that the report mentioned there was nothing specific under Quality and Safety however there were a couple of reds under mandatory training which had a quality impact.

The report was noted by the Committee.

Mike Proctor commented that having seen this report at various committees he wondered if this Committee could receive some sort of simplified highlight report. Andrew Smith and Ellie Monkhouse supported that suggestion rather than the Committee receiving the full report.

83/21 Deviations NICE Guidance

None this month

84/21 Nursing Quality Report

Ellie Monkhouse referred to the report distributed which was taken as read. Ellie advised that the report was work in progress as they were trying to change the style of the report although the team had continued to produce this report it did come with a huge caveat that some of the areas worked in a completely different way to how they used to. In addition to that there was an overwhelming struggle with staffing issues made worse during the pandemic. They were not able to release staff for mandatory training due to low numbers and some people had to complete their mandatory training in their own time.

Ellie invited any comments or questions.

Mike Proctor noted that there were some formatting issues within the report. Ellie noted there was an ongoing discussion as to what should be included in this report and what was included in the IPR, they hoped to avoid any duplication. Ellie thought it was important to maintain some of the triangulation and some of the softer elements.

In terms of the summary Mike noted the concerns around staffing and would flag that with the Trust Board through the highlight report.

85/21 Nursing, Midwifery and AHP Strategy

Ellie Monkhouse referred the long awaited Nursing, Midwifery and AHP strategy distributed which was taken as read. This was originally launched in February 2020 but was then put on hold due to Covid. The strategy now took into account the post Covid world. It was already well know and embedded across the organisation and some of the actions within that were already taking place. This was approved by TMB but was not quite the final version but they were hoping to do a formal launch with Comms mid-May time.

Mike Proctor thought it was a great piece of work and it was really a clear and accessible document to read. The Committee would recommend approval of the Strategy to the Board.

Highlight reports

86/21 Mortality Improvement Group (MIG)

Colin Farquharson referred to the highlight report distributed which was taken as read. The last MIG was a positive meeting but one ongoing negative was that the SHMI had stayed stable at 106.8, although the Trust had now had over a year of sustained stability and improvement and was still within 'as expected'. The mortality report had been presented by Jeremy Daws and showed a significant improvement of screening deaths, which was above the target.

Post meeting note for clarification from Dr Kate Wood; The one negative was the ongoing out of hospital SHMI which was felt to be due to the lack of palliative care input and identification of early alternative options for treatment and place of care when approaching the end of life.

Clinician coding accuracy had been maintained post Grant Thornton. The one negative was the ongoing out of hospital SHMI which was due to secondary care not appropriately coding the patients for palliative care. This had been escalated to NHSE/I and as a result they were doing a collaborative piece of work with NLaG and CCGs to see if they could find anything that would have an effect on the out of hospital SHMI. This trust had been flagging this for a considerable amount of time but asked if the out of hospital SHMI had been flagged.
Mike Proctor thanked Colin for turning this report around so quickly.

Mike to highlight the ongoing issues related to out of hospital SHMI to the Board

87/21 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed which was taken as read. Angie highlighted the report received from the Medicine division on risk stratification, which indicated the collaborative working with GPs to achieve the risk stratification on all patients.

88/21 Patient Safety Champions

Angie Legge referred to the report distributed which was taken as read. The only thing to highlight was the update given in terms of the national training, Angie was keen to get that training rolled out.

Items for Information

89/21 Quality Governance Group (QGG) minutes

90/21 Mortality Improvement Group (MIG) minutes

91/21 Register Ext. Agency Visits

92/21 Annual Clinical Audit Programme

93/21 Any Other Business

Nothing raised

94/21 Matters to Highlight to Trust Board or refer back to QGG

To refer to the Trust Board;

- Ophthalmology – still time to refine that but the lack of assurance was concerning
- Diabetes and difficulties with the PEWS
- Maternity SI's
- Staffing issues mentioned in the Nursing Quality report
- The Committees support for the Nursing, Midwifery and AHP Strategy
- Ongoing support for MIG

95/21 Meeting review

May be changing the date of the next meeting to the 28th May

Date and Time of the Next Meeting:

Friday 21 May 2021 at 9:30am - 11:30am to be held virtually

The meeting closed at 11.14am

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 21 May 2021**
Time: **9.30am – 11.30am**
Venue: **Virtual meeting via MS Teams**

MINUTES

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Abdi Abolfazl	Deputy Chief Operating Officer
Andrew Smith	Non-Executive Director
Angie Legge	Associate Director for Quality Governance
David Cuckson	Non-Executive Director
Ellie Monkhouse	Chief Nurse
Kate Wood	Medical Director
Linda Jackson	Vice Chair
Maneesh Singh	Non-Executive Director
Michael Whitworth	Non-Executive Director
Peter Reading	Chief executive

In attendance

Sarah-Jayne Thompson (item 102/21)	Assistant General Manager, Surgery & Critical Care
Jo Loughborough (item 109/21)	Patient Experience Lead
Kelly Burcham (item 112/21)	Head of Risk & Clinical Audit
Helen Harris (item 106/21)	Trust Secretary
Laura Coo	PA to the Medical Director **(for the minutes)**

96/21 **Apologies for Absence:** Ian Reekie, Shaun Stacey,

97/21 **Chair's opening remarks:**

Mike Proctor noted the difficulty in getting papers in a timely manner for this month's meeting which made it a challenge to have enough time to read through the papers prior to the meeting. On this occasion Mike had reluctantly accepted some late papers but had also refused to accept a late paper which came through yesterday. Mike noted that it was essential papers were provided on time going forward.

98/21 **Declarations of Interest**

There were no declarations of interest.

99/21 **Minutes of the previous meeting held on 16 April 2021**

The minutes were approved as an accurate record of the previous meeting.

Kate Wood clarified a point on page six. Essentially, after the Serious Incident a process was implemented which defined a strict threshold to indicate when a blood sugar measurement should be taken. It was now agreed that there should be some flexibility in the decision making on the need for this investigation supported by a senior decision maker with paediatric training. This new process was currently being established to ensure patient safety.

Andrew Smith commented that with regards to page three the question was whether the root solution adequately supported the waiting lists. Andrew asked for it to be corrected to say 'the root solution was to resource effort on reducing waiting lists'.

On page eight, the last paragraph, Kate clarified that the Palliative care coding did not impact on SHMI but did impact on HSMR. Kate to forward a post meeting note to Laura Coo to add to the minutes for clarification.

Ellie Monkhouse clarified that Colin Farquharson had solely presented the paper on Serious Incidents and not herself.

Matters Arising

100/21 There were no matters arising.

101/21 Review of action log

There were not any actions to review

102/21 Ophthalmology Follow up patients

Sarah-Jayne Thompson attended the meeting at 9.45am

Sarah-Jayne Thompson referred to the report distributed which was taken as read and highlighted the key points. Mike Proctor summarised what he believed the report identified; that because the system did not identify the diagnosis for patients on the waiting list, the list therefore could not then be filtered by diagnosis making risk stratification and the identification of patient harms impossible.

Sarah-Jayne agreed, and noted that the focus within the specialty was to ensure all patients had sub speciality codes to support risk stratification. 68% had been completed and the trajectory was that by 21st June, all overdue follows ups would have a diagnosis code. The specialty was trying to manage the situation proactively so that all patients coming through the door had a diagnosis code and in parallel the consultants were risk stratifying those on the list.

The overdue follow ups were categorised by those greater than 50 days overdue

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Andrew Smith commented that he had a slight concern that this was only being established now and secondly his understanding was that our risk stratification approach across had been across the board within the organisation but took comfort from that process. Andrew went on to ask if this issue was the same across other areas. Kate Wood added that it was discussed at the Surgery and Critical Care PRIM in depth. As Sarah-Jayne had clearly articulated the diagnosis codes had been added at DPoW but there was a difference in how it had been done at SGH and further work

was needed there. At the PRIM it was agreed that they would present the level of detail and trajectory next Friday.

Peter Reading commented that he had mentioned at the last meeting that if the software was hindering the process, to raise it with him, and that while this may have already happened, he was not aware of it. Sarah noted that they were in discussions across the care system to try to ensure a universal approach.

Going back to the risk stratification Linda Jackson suggested that any concerns needed to be flagged to the board.

Mike Proctor summarised the discussion. Mike believed this should be escalated to the board, but needed to understand which of those patients were at higher risk and at the moment they could not do that. The positive from the update was that the thrust had identified a problem and was actively pursuing actions to rectify the issue. Mike thanked Sarah for a very honest report highlighting the issues within Ophthalmology. He noted that as the risk stratification was implemented that Serious Incidents, including sight deterioration and loss might be discovered and we needed be honest with those. Although there might be barriers for change Mike felt this could be used as lever in working with the Ophthalmologists by citing the concern of the board and this committee. In general the risk stratification had highlighted an issue which needed mitigation and actions putting in place.

Mike thanked Sarah-Jayne for the report and asked her to provide a further update in July and a fuller report in October when the new process was fully implemented.

Sarah-Jayne commented that it was a challenging specialty but there were some consultants who were very engaging and were willing to work with change.

Action: MP to escalate the issue to the Board as a significant gap in assurance. Reports in July and October to be identified in the action log.

Sarah-Jayne Thompson left the meeting at 10.04am

103/21 Discussion re referral from ARG re Cancer Waits

Andrew Smith explained the reason for this item being on today's agenda. At present NED's did not believe that they had absolute clarity about the cancer waiting times or that the mitigating management was effective in managing clinical harm. Andrew asked if everybody was comfortable that there was no harm in the patient waiting lists we were dealing with. Mike Proctor thought there was an underlying concern that if there was a significant number of patients waiting longer than they should be then the assumption would be there would be some harm there and believed it would be helpful to have a more detailed review at those patients through a future clinical harm review paper to the Committee.

Kate Wood advised that the clinical harm process was set up for 52wks and 104 day cancers and was totally embedded in the organisation and still is. The clinical harm review for cancers was already there but a bespoke report could be easily produced for visibility. It was already within the clinical harm report that Colin produced but maybe not articulated in the detail required.

Action: Kate Wood will provide a report focussing on risk stratification and potential clinical harms for cancer patients for the next meeting.

Andrew asked if the performance element in terms of recovery on waiting list would be looked into as well.

Action: Abdi Abolfazl to produce an update for the performance side of things.

104/21 Outbreak behaviours

Item deferred to the June meeting and Maurice Madeo would provide the paper/update.

Regular Reports

105/21 Community & End of Life update

Item deferred to the next meeting.

106/21 IPR

Helen Harris joined the meeting at 10.10am

Helen Harris referred to the reported distributed which was taken as read. Work was ongoing in the background with Kate Wood and Angie Legge around quality priorities and working those into the IPR but the main focus really was looking at those hotspots areas such as VTE as there was a slight dip in performance.

Kate added that the IPR was still very much a work in progress and they were working together with the information team to ensure the data triangulated across all the reports. Kate appreciated it was a very lengthy report and would prefer to focus on the areas where they was some deterioration rather than looking at the areas where we were already assured through our SPC charts.

Peter Reading left the meeting at 10.16am

Mike Proctor asked about MRSA. Ellie Monkhouse updated that there had actually only been one case detected which was hospital acquired and had been reported to the IPCC. Ellie had a concern about the timings of data provision as it had not allowed for IPCC validation of the case, so therefore were not accurate figures , Ellie thought the way that some of the data was presented could be changed.

Linda Jackson thought the IPR was starting to look good, and it was mentioned that some of the SPC charts could be dropped where we had the assurance. Linda asked about the number of SI's, this time last year we had between 10 to 12 SI's a month whereas now there was only one a month. Linda asked if that was because reporting had stopped or if it was a positive improvement. Angie Legge clarified the Trust that this was not about failing to declare but there was an element previously that NLaG had been over declaring SI's in comparison to other trusts. The patient safety incident framework suggested that if where an organisation focused on between 20 and 30 serious incident investigations per it enabled uncovering the system failing and lead to genuine learning and change, otherwise the process was consumed with too many investigations of a lower standard which did not get to the root of the issue. The other

aspect was the 'Covid effect', noting generally and there was less theatre and elective work which reduced some potential serious incidents.

Kate Wood added that SI panel meetings were held weekly and attended by a wide membership including the multi-disciplinary teams which was well minuted and the feedback was that it was a very robust process. HUTH would be starting that process in approximately three weeks' time.

Kate's real concern for the organisation with regards to VTE was that our risk assessment as per the reporting deteriorated. The most important thing was about keeping our patients safe. There had been a number of wards that had changes due to Covid and Kate was not convinced we had the reporting, escalating and treatment right. There were some long discussions at the Medicine PRIMs that week. Junior doctors and nursing teams were working together; this was predominantly working on the acute admissions area which was where VTE performance deterioration was identified. The team were working through it. Kate had just received an email from Medicine about VTE confirming that would be rolled out in the next couple of weeks. Kate acknowledged that the reduced position on VTE risk assessment was a patient safety concern.

Linda Jackson asked what the position was with agreeing bed base post covid, when would there likely to be a post covid model. Abdi Abolfazl noted that the Operations teams had been working on that model as part of the 21/22 plan. It was noted that the escalation and establishment was aligned with ED and AAU. There was also consider but there had already been discussions with Lee Bond and Peter Reading in relation to the financial side to

Kate Wood informed the committee that the concern relating to Structured Judgement Reviews (SJR's) came back to how data was collated and this report was still work in progress. SJRs had a time delay as clinicians had 6 weeks to complete the review and the data then needed to be collated. A patient could die in March but the SJR might still not ready in May. Kate added that SJRs were becoming a challenge, it had not been a problem whilst people were shielding as they were carrying out the SJRs at home but with the lack of shielding during the second wave of Covid pressures, it had been a challenge.

Mike summarised this report was still work in progress but felt it always would be as it was constantly evolving and improving. He noted that the Board had planned a further review of the IPR in July.

Action: MP to highlight to the Board the concern regarding VTE assessment performance and the potential for serious patient complications. The Committee to continue to monitor this important indicator of patient safety

107/21 BAF

Helen Harris and Kate Wood had gone through the BAF which was also submitted to Ellie Monkhouse for comment. It was still work in progress, but now had the new format, new structure and a plan on how to move forward with this. There were some considerations for reviewing strategic risks in the future. The other part was for the committee to agree the reporting of the BAF to the Committees monthly presentations

did not give sufficient time to close the gaps. Helen proposed to bring the BAF back in July.

Linda Jackson fully supported the BAF coming here less frequently to avoid review overload. It was looking better but Linda had a query on risk, something that Hull had done was they were not happy with the risk of patients who were left on their waiting lists and potentially coming to harm. Linda asked how that risk was being extracted (in 1.1). Mike Proctor thought that the wording for 1.2 needed to be reviewed.

Similar to Linda, Ellie Monkhouse was quite exercised with the numbers in our work force, she worried we talked too much performance in a QSC and not about patients. This was discussed a lot in other places, and felt the patients should be discussed rather than the numbers. Some of the parts that Ellie had put in were around her concerns for workforce as that impacted everything. Ellie was concerned about the scoring of the quality risk at 15.

Mike felt as though we had focused on the patients today but the committees cannot work in complete isolation and needed to make sure they worked together in terms of identifying and focusing on key patient safety and quality issues.

Kate commented that to have condensed the BAF down from what it was to this was testament to the work that had been done but it was not there yet. The comments and discussion within QSC were helpful in how to move forwards. Angie Legge was doing work with the Divisions on the understanding of risks within the organisations and what the risks meant. Ellie and Kate were doing that same piece of work through the PRIMs.

Kate and Ellie had spent a number of years looking at the quality metrics and the mitigation. Kate thought what we had done in quality had come up with so much mitigation that it had reduced our risk rating. Workforce worried Kate too and maybe the conversations could be what the other committees did to ensure they had robust mitigation in place to reduce the risk score; Kate thought the mitigation for the Quality risk was probably correct and hence the scoring appropriate.

Mike Proctor would like further conversations about the risks and whether it was clear. One of the things that struck him was that there was a significant gap between where the organisation had declared it wanted to be, as articulated in the risk appetite statements and score and where it stood at the moment indicated by the current risk score.
In the health service our priority responsibility was looking after our patients and he thought we needed to have a level of language and understanding of risk across the organisation for each of the committees. The new BAF was enabling us to have that conversation.

All members were content with the proposed 4 monthly reporting frequency starting in the Jul meeting.

Helen Harris left the meeting at 10.52am

108/21 Quality Account progress update

The guidance and deadline for this year's Quality Account had been produced this week so it would be impossible to have this done with the required six weeks consultation before 30th June. Hence a plan with a trajectory had been produced and Quality and Safety Committee were invited to support that timescale and plan. This was agreed.

109/21 Combined Patient Experience Report

Jo Loughborough referred to the report distributed which was taken as read and highlighted the key points

Q4 was a very pivotal time coming from the old complaint process to the new. The timeliness and quality of the responses had improved. There was still a lot of work to do which now involved a lead investigator role. There was a lot of cultural work to do within the divisions as well and they had a family liaison team supporting the wards.

The meeting was recorded from this point due to connection problems for the minute taker.

Ellie was concerned that some of the patient experience staff who had been vital to improvements in this area were moving to other roles within the organisation and had hoped to make these roles substantive and permanent. The committee agreed and would do what they could to support the case.

Mike thought this was a really positive report, the performance around getting complaints sorted was very positive and was sure that would make a great difference in terms of people being satisfied with the responses they get. Mike thanked Jo Loughborough for the update.

Jo Loughborough left the meeting

110/21 Nursing Quality Report

Ellie Monkhouse referred to the report distributed which was taken as read. Ellie highlighted the key points; staffing remained a challenge and we were still seeing the impact of that in some of the previous discussions at the meeting today. The fill rates continued to fluctuate but the negative blip in March was probably due to people trying to get their leave in last minute. There was a phase where trying get bank and agency to cover shifts for fill rates to a decent level had been problematic. The organisation was currently working on an establishment re-set because all the demographics of the wards had changed and the staff had changed, patient need had changed so they were on week 4 of data collection. This would be ready to go to the Board in July/August time.to the Trust was maintaining a 60/40 qualified ratio which Ellie thought was a great achievement but she was still monitoring the substantive fill rates over night as they did still cause Ellie some concern. 73 overseas nurses had joined the organisation and another cohort had started at the beginning of May. The Nursing and AHP strategy would be launched on May 12th for international nursing day.

Ellie invited any comments or questions

Mike asked in terms of establishment figures how many more nurses the Trust needed to recruit. . Ellie advised that this was why the reset was going ahead and why she had asked Shaun Stacey to re-set the bed base. More data about the acuity of the patients, and richer data about the acuity and needs of the patients would help clarify the skill set required. It would be difficult to give a figure but in terms of recruitment this trust had always struggled but Ellie was trying to ensure she was making best use of all available avenues at the central team had looked at career pathways and were starting to attract from out of area because we work with three universities not just one. The geographic location remained a problem.

This report would be coming to this committee every month, although it would be refined slightly.

Action: MP to highlight to the Board the ongoing concerns about nurse staffing and the potential impacts on quality of care.

111/21 Key SI Update, including Maternity

Angie Legge referred to the report distributed which was taken as read. Angie gave a summary of the key points; of the maternity incidents already declared the two by HSIB had been discussed at SI panel and they had found that there were no issues with the care however these did fall under the HSIB. Panel had fed back to the teams as it could feel concerning for staff on the front line as they had done everything they could and therefore the team had stressed that this was not about an error but this was that HSIB were doing a lot of learning work nationally but we welcomed if there was any learning that came out of those.

Action: Mike Proctor will refer to the Maternity SI within the highlight report to the Board.

112/21 CLIP

Kelly Burcham referred to the report distributed which was taken as read. Kelly highlighted the key areas to note; alterations to the table on page three, the table on page four contained the overarching triangulated themes and provided details of where each of those themes was recorded, an indication of the risk and then key comments including whether it was a quality priority. Four of the themes, EoL, medication care and discharge were linked to quality priorities. This report could be used to inform future QP as well.

Kelly highlighted the learning from themes on page three, the CLIP at a glance, two learning events held recently which had been very successful, HSIB attended for one and a consultant oncologist presented a session. Angie Legge added that we had our first learning group as part of the learning strategy work and the team were taking that forward to share key messages and better embed it in people's minds. The two learning events were really good and there was great opportunity for a lot of people to attend due to it being virtual.

Kelly hoped the changes been made to date had made the report easier to follow. Angie added for awareness that the team were looking at a risk management system with a view to more focused themes which better articulated the concerns.

Linda Jackson thought the report was very easy to read and thought the triangulation was excellent.

Mike Proctor thanked Kelly for the report and attending.

Kelly Burcham left the meeting

113/21 Deviations NICE Guidance

There were no deviations to discuss

114/21 CQC Update

The report had been reduced with the appendix removed at committee request. AL had focused on trying to identify where we were with business cases but was a little concerned about the impact the block contract was having on progressing improvements in community nurse staffing.

Mike Proctor found the report very helpful and Linda Jackson commented that she preferred the streamlined report but had a question around business cases requesting more detail in respect of the section 31 issue from the last inspection. Kate Wood responded that the board development day in the middle of June would address the section 31.

Highlight reports

115/21 Mortality Improvement Group (MIG)

Kate Wood referred to the report distributed which was taken as read.

Congratulations were noted about the sustained improvement on the SHMI.

116/21 Quality Governance Group (QGG)

Angie Legge positively highlighted the new SOP for photographing wounds.

117/21 Serious Incident Review Group (SIRG)

Angie Legge referred to the report distributed which was taken as read.

118/21 Patient Safety Champions

Angie Legge referred to the report distributed which was taken as read. Angie noted that a governor representative had asked about the staff wellbeing and the effect of the tiredness on staff and it was really nice to have that type of question posed from one of our governors.

Items for Information

119/21 Quality Governance Group (QGG) minutes

To follow

120/21 Mortality Improvement Group (MIG) minutes

To follow

121/21 Any Other Business

Linda Jackson wondered where we were with the workplan finalisation as they had to be taken back to the board in July and secondly she watched a Panorama programme on hospital secrets uncovered it was talking about Royal College and independent reviews and the fact that they should be shared with the regulator. Linda asked whether the Trust shared any Royal College or independent reviews with our regulators.

Angie Legge noted one review from the Royal College of Surgeons looking at MDTs but the plan was to include this in the quality account.

Kate Wood added that the report was very critical but what they glossed over was the fact that it was not mandated however there was a very open relationship with the CQC in this organisation and if anything information was overshared so it was not an issue from our perspective but Angie was right we would put it in the quality account.

The question on workplan it is almost there and Angie would discuss at agenda set about bringing it here to progress. We were waiting for the trust board cycle of business before we could progress with that.

David Cuckson asked a question based on a personal interest in that his granddaughter was a student nurse at SGH and she could not find a mentor so asked if that was something we should worry about. Ellie Monkhouse confirmed it was not an issue and she would need to discuss with her Ward Manager.

122/21 Matters to Highlight to Trust Board or refer back to QGG

To refer to the Trust Board;

- Ophthalmology issue discussed and concerns
- Cancer and patient harm risk stratification
- VTE risk assessment and work ongoing to improve that
- Complaints and the improvements

123/21 Meeting review

Date and Time of the Next Meeting:
Friday 18 June2021 at 9:30am - 11:30am to be held virtually

The meeting closed at 11.34am

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

Meeting: **QUALITY & SAFETY COMMITTEE**
Date: **Friday 18 June 2021**
Time: **9.30am – 11.30am**
Venue: **Virtual meeting via MS Teams**

MINUTES

Present

Mike Proctor	Non-Executive Director **(Chair of the meeting)**
Maneesh Singh	Associate Non-Executive Director
Michael Whitworth	Non-Executive Director

In attendance

Dr Peter Reading	Chief Executive
Dr Kate Wood	Medical Director
Ellie Monkhouse	Chief Nurse
Angie Legge	Associate Director for Quality Governance
Jan Haxby	Chief Nurse, CCG
Abdi Abolfazl	Deputy Chief Operating Officer
Anne-Marie Hall (item 131/21)	General Manager, Medicine
Dr Anwer Qureshi (item 131/21)	Divisional Clinical Director, Medicine
Simon Buckley (item 131/21)	Head of Nursing, Medicine
Anthony Rosevear (item 132/21)	General Manager, Community & Therapy Services
Vicky Thersby (item 134/21)	Head of Safeguarding
Jeremy Daws (item 138/21)	Head of Quality Assurance
Ian Reekie	Governor
Laura Coo	PA to the Medical Director **(for the minutes)**

124/21 **Apologies for Absence:** *Shaun Stacey (Abdi Abolfazi), David Cuckson, Andrew Smith, Helen Harris*

125/21 **Chair's opening remarks:**

There had been discussions amongst the NEDs and Executive team about returning to face to face meetings. The national guidance will hopefully become clearer over the next few weeks. Mike Proctor recognised that the logistics would be difficult but hoped to have a face to face meeting by August/September. Mike also noted that he would not be able to attend the scheduled meetings in August and September due to other commitments and therefore proposed to move those meetings to Friday 27th August and Friday 24th September. Mike also noted that the IPC update from Maurice Madeo was deferred this month due to Maurice being on annual leave.

Action: Laura Coo to re-arrange the August and September meetings.

126/21 Declarations of Interest

There were no declarations of interest.

127/21 Minutes of the previous meeting held on 21 May 2021

Peter Reading commented for future minutes that the only members of the committee listed under present should be the NEDs, all other attendees should be noted as 'In Attendance'.

Ellie Monkhouse noted that on page four under item 106/21 it should refer to 'MSSA' not MRSA, also on page six 6, fifth paragraph it should say that Kate and Ellie had spent a lot of time looking at the quality matrix not years.

Action: Laura Coo to make the minor amendments as above.

The minutes were otherwise approved as an accurate record of the previous meeting.

Matters Arising

128/21 There were no matters arising.

129/21 Review of action log

Minute ref 25/21, Ophthalmology Performance – At the previous meeting it had been agreed for an update to be presented to this Committee in July with a more comprehensive one to follow in October, however as significant progress had been made since the last meeting Mike Proctor suggested that the comprehensive updated report should be presented in August instead.

Abdi Abolfazl informed the Committee that both Medicine and Community had spent a lot of time doing a deep dive into Ophthalmology and the team felt they would be in a position to bring an update to the July meeting.

Regular Reports

130/21 IPR

Kate Wood referred to the report distributed which was taken as read, and drew member's attention to the sustained improvement with the SHMI which continued to be monitored. VTE had been an area of consistent concern and some options had been explored in the past. Although an improvement had not been seen, there had been discussions and ongoing work with Medicine about how to move that forward with the main concern being the standard of care delivered to our patients.

There was considerable work to ensure that patients who were nearing their end of life who did not require acute care would be cared for in more appropriate settings. Kate noted that data and stats were one aspect but it was more about patients and in particular how patients were identified as being at their end of life which would facilitate more appropriate care.

Jan Haxby advised that there was an out of hospital unexpected mortality group and they were looking at that approach, end of life was just one strand, they were also

shining a light on other areas Including providing support to the cares homes and the out of hospital strategy. There were a number of work streams they were looking at including end of life, support to care homes, development of access to primary care and community frailty.

Peter Reading noted that what stood out in the recent figures was that the gap between the two sites was getting slightly worse. Peter wondered if the Committee could have some statistical analysis into what was happening, also whilst DPoW was still in the 'as expected' range for the SHMI it was still eight points higher.

Action: Kate Wood to pick this discussion up outside of the meeting and would also have the discussion at the Mortality Improvement Group (MIG).

Ian Reekie commented that clearly this metric depended on joined up working between Acute and Primary care and he thought that N E Lincs would be doing better based on the integrated work and queried why that was not the case. Jan Haxby could not really answer that directly other than to say that some of the stats and data did not always make sense but you could look at it that there were systems and processes that identified patients at end of life and you could argue that those patients were being taken out into the community which could be why people were dying out of hospital. She added that it was also worth pointing out that there was an awful lot of data to say that both ends of the patch in terms of end of life did really well in terms of their preference of where they wanted to die.

Kate Wood informed the committee that the Trust had some excellent support from NHSE/I once it had been worked through would be able to share it with the wider group.

Mike Proctor noted the beginnings of improvement with regards to VTE and possibly out of hospital SHMI but overall felt the SHMI was a really good news story. In terms of the development of the IPR that it had come on a long way and Mike thanked the people who were still developing this report in the background.

131/21 Medicine update

Simon Buckley, Anne-Marie Hall and Anwer Qureshi attended the meeting and referred to the report distributed which was taken as read.

Anne-Marie highlighted the key points;

One of the things Anne-Marie wanted to pull out was that there had been a lot of transformation work within the Division with the support from NHSI and ECIST looking at emergency care, looking at the back door, discharge to assess (D2A) and a lot of that transformation work was already making a difference.

Simon updated on the nursing plan, noting the release of the Nursing Strategy in May and through discussions with the Ward Managers and Matrons the division had put together a nursing plan for 2021-22 in line with the objectives of the Nursing Strategy. They came up with three areas of priority;

- Fundamentals of Care i.e. falls, EoL
- Development of Ward Leaders
- Introducing a standard approach to Ward based care.

This work was aligned to corporate meetings as well as divisional meetings and they looked at how pathways were aligned to deliver that care. Other things that were taken into consideration were how the wider teams were supported and what had been learnt throughout Covid. People were moved around quickly during the pandemic but through had learnt that areas did different areas did things slightly differently so had looked to align them.

Anwer Qureshi added that having the external expertise of ECIST had been an invaluable contribution.

Mike Proctor invited and questions or comments.

Kate Wood drew the committee's attention to the increase in volume of patients coming in through ED and the management of those patients as well as the flow through the organisation. It remained an absolute challenge and risk particularly with our bed capacity but Kate felt the Committee just needed to be sighted on that and thought that work to reduce attendance in ED was very important

Mike commented that it appeared to him that the joined up working between ED consultants and physicians was really top class and was something that had not always happened in other organisations he had worked in.

Anwer thanked Mike noting it had taken a long time but had happened with cooperation from both parties. Medicine had always shown presence in ED but had built confidence in the whole of the ED staff and they actually felt part of one family now and were as close ED staff as they were to the acute medics in their own team. There was a lot of mutual respect and that had helped in dealing with the front door. The bit that was most important was the cooperation that had helped immensely. Anne-Marie added that once the new build was finished it would work better although the building project was one of the things that had helped to bring the teams even further together.

Mike asked if for Anwer to pass on the Committees thanks to the team.

Anne-Marie Hall, Dr Anwer Qureshi and Simon Buckley left the meeting at 10.06am

132/21 Community & End of Life update (EoL)

Anthony Rosevear referred to the report distributed which was taken and highlighted the key points;
There had been significant progress with the CQC actions within the division and improvements of EoL with accountability and structure.

The Division continued to see pressures from a resource perspective and several of the risks had been added to the risk register. The Division had benefited from attending a 'Risk Register clinic ' which Anthony thanked Angie Legge for facilitating as that had reduced the number of risks and helped to put good controls in place.

With regards to EoL one thing that had been implemented was seven day access to Lynsey Lodge Hospice, this was originally piloted but had now been implemented so patients could be admitted on a weekend too.

Community acquired pressure ulcers prevalence was within the control limits but was not where they wanted it to be. Further work would be included in the CQC work scheduled for July.

Mike Proctor would include the link with pressure ulcers and staffing levels in his highlight report for the Board to make that link explicit. Ellie Monkhouse noted as a point of clarification that the pressure ulcers were not flagging as such it was the ability to complete the documentation which was pulling on the nurse's time which had an impact. There was also the difficulty being able to get into the care homes to carry out those assessments. Mike asked if the community nurses were fully equipped with IT or if they had to go back to base to record. Anthony confirmed they were fully equipped but connectivity was always an issue. They were exploring options and did have the ability to complete patient records in real time but it was a challenge.

In terms of investment for Community Services Ian Reekie recognised how the acute provider collaborative was likely to work but asked how that would work across the ICS. In response Peter Reading advised that his understanding was that there would be groups of hospitals with semi-formal structures but Community was going to be different in that it would develop a learning function band have a less formal structure. Anthony added that the forum they were engaged with was exactly that and there was some work ongoing to confirm the terms of reference for that group but it was still in the forming stage. Mike thought it was maybe a missed opportunity not including Community in an 'all providers' structure.

Anthony Rosevear left the meeting at 10.16am

133/21 Clinical Harm update including Deep dive into Cancer

Kate Wood referred to the paper distributed which was taken as read. The paper included a deep dive into cancer at the Committee's request. The specifics in section seven of the report detailed the deep dive. There were 154 completed clinical harm reviews and four patients were thought to have sustained at least moderate harm. One upper GI pathway patient – Kate noted that the patient did contribute to some of the delay as they wanted extended thinking time. The ongoing management was through Castle Hill but they get attributed to NLaG. There were outstanding concerns regarding whether patients at NLAG and HUTH received equitable treatment at HUTH. Ian Reekie asked if there was a real concern about patients in HUTH as he felt there was something rather amiss in terms of delays in care for cancer patients. Kate responded that as a Trust we needed to understand that detail, it raised concerns about the fact that a lot of our delays sat with HUTH which looking at the wider picture needed to look at whether or not the patients were receiving the same equitable treatment.

Peter Reading advised that they had decided to establish Committees in Common (CIC) with HUTH and the first meeting was due to be held next week. It was quite timely but in terms of Oncology there was a further crisis which was being worked on jointly with HUTH. This was a great opportunity as the CIC gave us a board level structured framework where we could take joint responsibility for those patients, there

were lots of anecdotes and the equity of access needed exploration and proper evidence was required to support or disprove impressions.

Mike found the body of the report really helpful and felt the paper answered a lot of questions and demonstrated the complexities of some of the pathways. Mike thanked Kate for the report whilst there is a struggle to meet the constitutional standards of cancer what the report demonstrated was that everything possible was being done to reduce the risk of harms to patients.

134/21 DoLs and Safeguarding update

Ellie Monkhouse introduced Vicky Thersby the new Head of Safeguarding to the group. Although Vicky had only been with the Trust for a short while she had already done a lot of work, part of that work was establishing relationships across the wider safeguarding community and Ellie wanted to thank Vicky for all her hard work. Vicky responded to say she was enjoying her role and loved embedding and changing processes and ensuring vulnerable adults and children were safe.

Vicky referred to the report distributed which was taken as read and highlighted the key points;

Team structure and Development

Vicky was trying to open up lines of communication and challenge to give more oversight. With regards to the team and the structure there had been a number of new members who had joined; they had successfully appointed a new named nurse for safeguarding adults and specialist practitioner as well as a specialist nurse for MCA DoLS. Vicky noted that a lot of the report was highlighting the key areas focused on in quarter four. During quarter one they had transferred the vulnerabilities team to work more closely with the Safeguarding team. This would help to continue the collaborative working arrangements to ensure the continued support of vulnerable adults and children in the area. Holly O'Connor had replaced Rachel Greenbeck as the new nurse for vulnerabilities. .

New Developments in Adult Safeguarding

The Safeguarding Policy had been reviewed and they had looked at the reporting measures and themes. The team had picked up themes around discharge which was probably going to be more of a focus going forward. A number of quality measures were being developed with other organisational leads which should ensure the Wards were more informed and that the concerns and referrals were consistent.

Children Looked After and Care Leavers North East Lincolnshire

Numbers remained static for notifications of children and young people coming into care over the last 12 months. There was an indication that the numbers would be reduced but that was not yet being seen. The current weekly list from children's social care identified 159 under-fives and 437 over fives. In addition there continued to be a significant pressure within the nursing team and the Designated Doctor to complete the IHA within the statutory time frame of 20 working days of a child or young person coming into care. If the team were not told within 20 days that the child has come under looked after care they could not be reviewed. This was monitored by the Named Nurse for Looked After Children and CCG Designated Nurse.

Since starting in post Vicky and the team had established a close working relationship in terms of complex young people with the North East Lincs area and locally with the children's residential homes.

Safeguarding Children

Vicky advised that there were an increased number of young people attending the Emergency Department at SGH with mental health presentation.

From a safeguarding children's perspective looking at North Lincs attendances for children in ED the attendances had increased so a task and finish group had been set up to look further into that.

The Child Protection Information Sharing (CP-IS) system had been re-embedded in the Emergency Department at both sites, this included a SOP with checks for all children and young people who attended ED as well as for women aged between 17 and 50 years when identified as pregnant. This would be audited in the future to ensure it was embedded.

The Named Nurse for Safeguarding had worked closely with Surgery to put to together a process to ensure all attendances were available for screening by the safeguard liaison team.

Mike Proctor asked in terms of children and notifications the report said 92% were received late. In terms of performance although they were not meeting the statutory requirements this Committee was more focused on the quality and safety aspects therefore asked what impact those delays would have on the individuals. In response Vicky informed that whilst they were not within timescale the information could vary it could even be that they had missed a dentist appointment but there would be a deeper dive into that information. Mike also commented that it would be helpful to hear about some examples of significant issues for children. Jan Haxby added that the performance from the Social Care Teams was not good enough which started when children and social care implemented a new IT system called liquid logic, prior to that there were no issues with performance. Social Care were aware that the CCG were not happy with the new system and were focussing on trying to fix the problem.

Ellie did not feel this was NLaG's issue to raise in a public setting as NLaG were not the provider it was Social Services, NLaG were a sub-provider of the service and this was more about how we could support Social Services. Jan clarified that the accountability sat with the CCG's who contracted to NLaG to deliver the service. Mike agreed in terms of performance but still felt the Committee had a duty of care.

It was noted that significant work, led by the CCG was being focussed in this area to improve performance and reduce risks. Peter Reading added that the history of child care suggested that we were held collectively accountable and felt the Committee needed to formally note that there was a concern. Peter suggested with the help of Ellie and Vicky that he would write to Rob Walsh the CEO of the Council noting the Committee's concerns.

Ian Reekie asked about the comment in regards to 'adults not brought to OP appointments' at the end of the report and whether that was DNAs or virtual

appointments. Vicky clarified that patients with vulnerabilities where categorised as 'not brought' rather than 'did not attend' to ensure that patients were not lost in the system and were followed up.

The Committee noted the report and thanked Vicky for attending.

135/21 Nursing Quality Report

Ellie Monkhouse referred to the report distributed which was taken as read and highlighted the key points; In April staffing had felt a bit better for all concerned but they still continued to be concerned about nights in terms of substantive fill rates. The Trust still had staff and bed stock displaced which was one of the reasons there were difficulties and had block booking of agencies.

The report included some information about quality improvement and how they were starting to develop areas to implement this initiative. It was fair to say that they were still very mindful about the effects the pandemic had on the staff although morale was quite good there were a lot of tired staff which was having an impact.

Mike Proctor asked how the 15 steps were going now that it had restarted. Throughout the pandemic teams had been carrying out mock 15 steps but the Wards were already excited to see the 15 steps coming back and that healthy competition was beginning.

Mike Proctor thanked Ellie for pulling together the report.

136/21 CQC Framework Update

Angie Legge introduced Jennifer Moverley who was the new Head of Compliance and Assurance.

Angie referred to the report distributed which was taken as read and highlighted the key points in regards to the investments relating to CQC actions:
In respect of third tier anaesthetic cover, recruitment would be commencing as soon as the job plans completed. Recruitment was also commencing to meet the standard for 16 hour consultant cover in the ED but further clarity for was being sought for middle grades. The out of hours middle grades had been recruited to with additional resource with IAAU and the RSCNs were also being recruited to. With regards to Community staffing there was some work starting to assess the acuity versus capacity gap which was going to the CCGs on 19th July.

In terms of the outstanding actions Mike Proctor noted there was some that required corporate action but the majority were with the Divisions yet Mike felt there had been massive improvements within the Divisions and them taking greater ownership for delivery. Kate Wood agreed. There had been discussions at PRIMs about whether there needed to be a Trust wide approach where the divisions could take the action and were supported but there were still challenges articulated in the paper.

Abdi Abolfazl felt the Divisions had come a long way with being able to provide evidence something that was missing previously so thought that was an achievement worth noting. In terms of the reds for mandatory training and they were taking a risk

approach i.e. the training that affected patient safety needed to be completed first which seemed a very logical approach.

Ian Reekie asked if we were still expecting a full comprehensive CQC visit this year. Kate confirmed that the Trust was expecting a series of focused visits and that the CQC would want to gain assurance on the information the Trust had been sending to them.

137/21 Key SI Update, including Maternity

Angie Legge referred to the report distributed which was taken as read. The report had been amended slightly to fulfil the Okenden requirements. As an update from SI panel yesterday Angie noted that for the most recent maternity case on page 2, StEIS 11166, HSIB had now declined to investigate. An RCA had then been undertaken in the Trust to review the quality of care in detail. That had gone to SI panel yesterday and there were no issues with regards to quality off care therefor a request to delog had been sent to the CCG.

138/21 Quality Account

Jeremy Daws referred to the Quality Account distributed which was taken as read. The Quality Account was brought to this Committee for approval for it to be released to the stakeholders. The plan was to bring the final version with stakeholders comments included back through this Committee for final approval. This year had been different due to Covid and there were some specific areas that would normally of been a focus but were not for this year. Jeremy had highlighted the key areas the Committee needed to be cited on.

The Committee agreed this could be released for external consultation.

Jeremy Daws left the meeting at 11.07am

Highlight reports

139/21 Mortality Improvement Group (MIG)

The highlight report was taken as read.

140/21 Quality Governance Group (QGG)

Angie Legge referred to the report distributed which was taken as read. Angie highlighted that they confirmed approval about the change on blood sugar monitoring in Paediatrics and the team were now analysing the data. It would be done prospectively.

141/21 Quality Review Group (QRG)

A highlight report was not received.

Items for Information

142/21 Quality Governance Group (QGG) minutes

Distributed for information

143/21 Mortality Improvement Group (MIG) minutes

Distributed for information

144/21 Any Other Business

None raised

145/21 Matters to Highlight to Trust Board or refer back to QGG

To refer to the Trust Board;

- Cancer work and risk Stratification
- Ophthalmology progress
- Community nurses staffing and links to the business case
- Relative priority of north and south bank cancer patients
- Social care notifications

146/21 Meeting review

Date and Time of the Next Meeting:
Friday 16 July 2021 at 9:30am - 11:30am to be held virtually

The meeting closed at 11.10am

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)176

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Ellie Monkhouse, Chief Nurse
CONTACT OFFICER	Jo Loughborough, Senior Nurse Patient Experience
SUBJECT	Annual Complaints Report
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Quality & Safety Committee
EXECUTIVE SUMMARY	• Summary of complaint progress through transition to new process • Outline of successes and further quality improvement plans for FY2021/22

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
✓				

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety	✓	**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or	N/A

state not applicable (N/A)					
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Feedback from compliments, complaints and concerns

ANNUAL REPORT

2020/2021

Performance for Period 2020-2021

Contents –

Northern Lincolnshire and Goole NHS Foundation Trust

Background

It is a requirement of the Local Authority Social Services and National Health Service Complaints (Regulations) 2009 to produce an annual report. The purpose of this report is to inform The Board and the general public of the effectiveness of the complaints processes within the Trust, ensuring that we remain sighted on the timeliness, quality and learning. The complaints process is supported by the Complaints Team and PALs Team at Northern Lincolnshire and Goole NHS Foundation Trust (the Trust), in collaboration with Divisions across the Trust . The process is available for patients or their representatives who wish to make a formal complaint or raise concerns on a more informal basis. Anyone who expresses a view, verbally or in writing, which can reasonably be interpreted as a representation of their views and, with the appropriate consents, will have those views acknowledged via either of these processes.

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

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

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

This report will provide information on the representations made via the PALS concerns and complaints processes in addition to the compliments received between 1 April 2020 and the 31 March 2021.

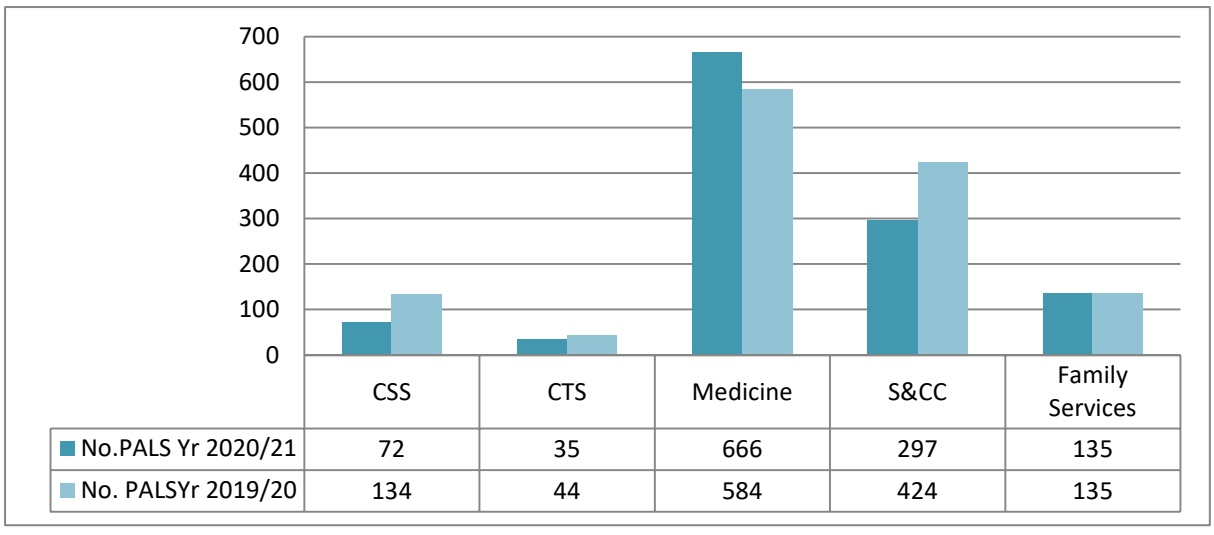
Patient Advice and Liaison Service (PALS)

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

Between 1 April 2020 and 31 March 2021, the PALS Team received **1327** concerns. This is a similar number to the previous year (2019/20 - 1338).

Response times - 194, (15%) of the concerns were resolved within one working day, with 702 (53%) closed within 5 working days. The previous year (2019/20) 48% of PALS concerns were closed within 5 working days. There is a marginal improvement on the number of PALS concerns closed within timescale, but the target of 85% still remains. There continues to be significant work being undertaken to increase Divisional ownership and improve the PALS model, this will form part of a Quality Improvement project

The below graph displays the number of PALS concerns received by the Clinical Divisions directly providing patient care. There is noted decline in recorded PALS concerns across all divisions, other than Medicine which show an increase.



	CSS	CTS	Medicine	S&CC	Family Services
No.PALS Yr 2020/21	72	35	666	297	135
No. PALSYr 2019/20	134	44	584	424	135

Complaints: New

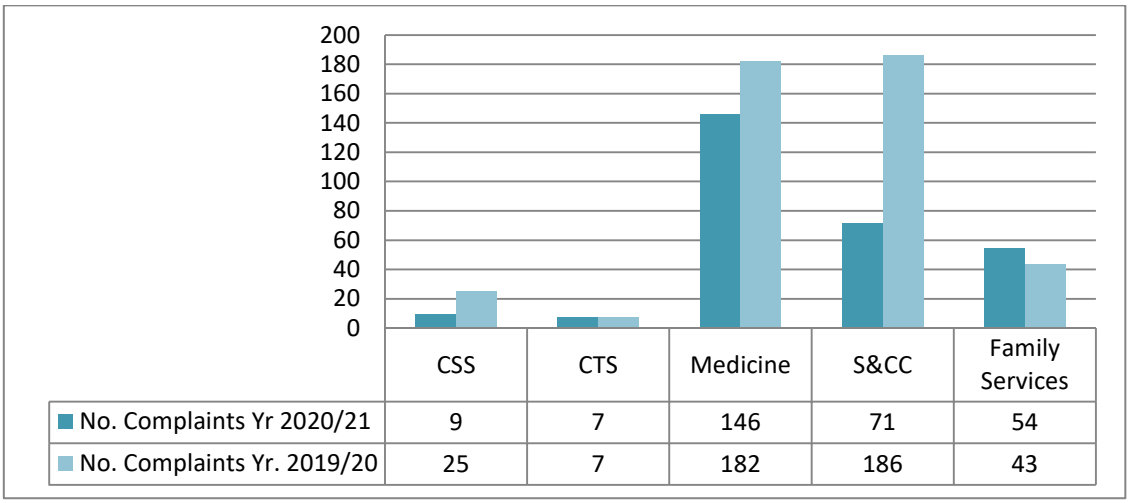
The Trust received 290 formal complaints throughout the year 2020/21This is a 26% decrease from the previous year.

In line with the Trust's new Policy and Procedure for the Management of Patient Feedback from Complaints, Concerns, Comments and Compliments, extensive quality improvement has been undertaken to ensure transition into a new process. This will help ensure that each complaint is managed with the Trust timescale, and is done so with the complainant at the centre of the process, to ensure a robust investigation with clear learning evident when appropriate and that outcomes are delivered in a compassionate manner. This is monitored through weekly Support and Challenge Meetings to ensure oversight.

Some of the specific goals of the new process are listed below:-

- Continue to embed the new complaints policy
- Divisional Lead Investigator role implemented Trust wide
- Learning to be identified and logged consistently
- Learning and themes to be discussed at monthly Divisional Governance meetings.
- Monthly oversight at Executive Challenge Meetings (PRIMS)

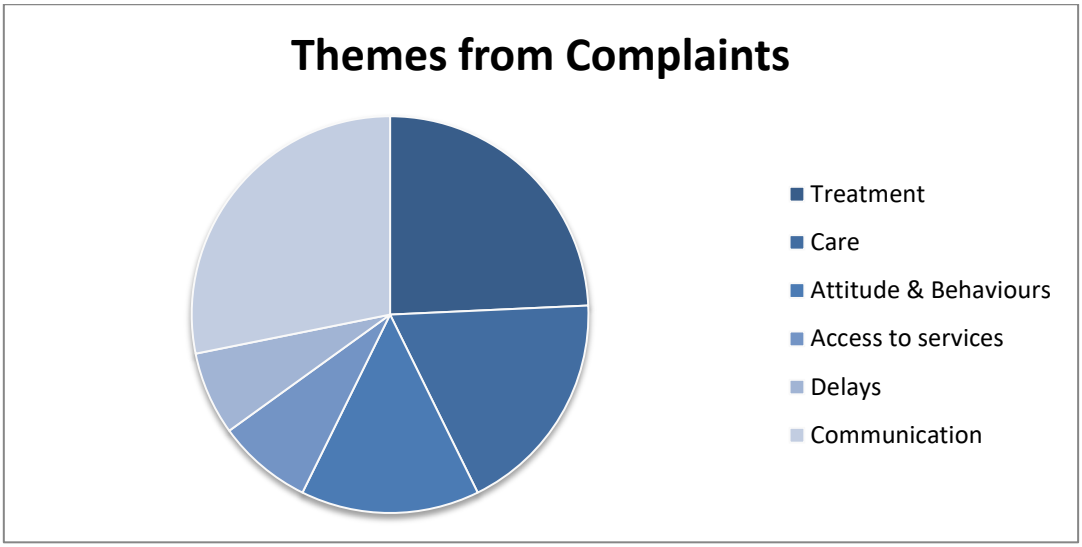
The below graph displays the number of complaints received by the division directly providing patient care:



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

Complaints : Themes

The below graph demonstrates the headline themes for formal complaints during the period of 1 April 2020 to 31 March 2021:



A quarterly Patient Experience report is generated for oversight, discussion and escalation via the Trust Quality & Safety Committee.

A Patient Experience Governance report is being developed to capture themes and learning, which will be shared at the monthly Divisional Governance meetings.

Workshops with the central Complaints Team have been undertaken to ensure that themes and learning from complaints is captured and that when logging and closing complaints.

The triangulation of data and further in depth analysis of the contributing factors to the themes continues, however formal triangulation meetings have been stood down during the Covid 19 pandemic and triangulation occurs through the quarterly CLIP report and through direct interaction with Governance departments.

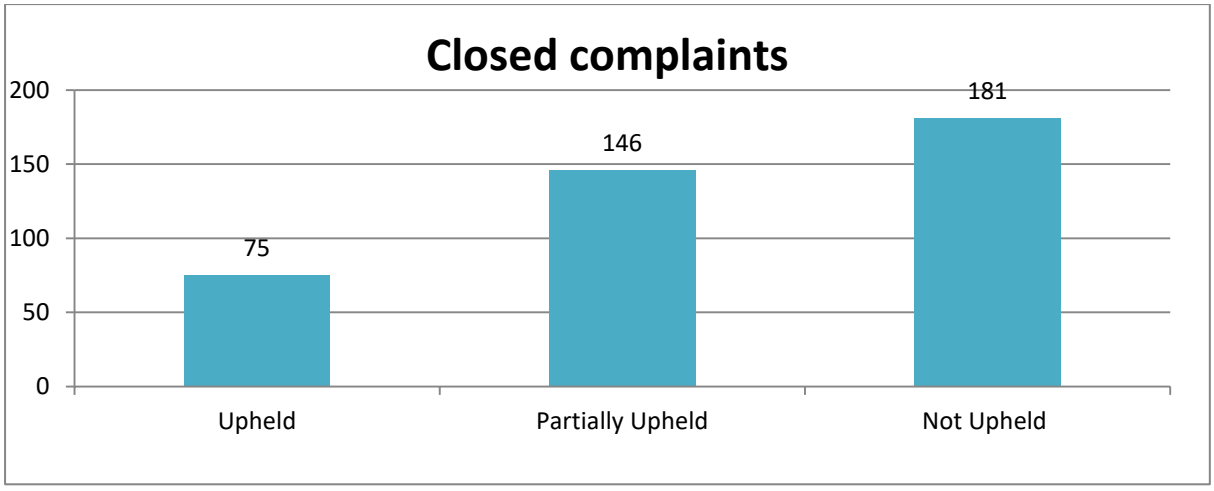
Complaints: Closed

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 removed previously stipulated response timeframes. The Trust currently aims to respond to complaints within 60 working days.

The number of complaints closed during 1 April 2020 to 31 March 2021 was 402, and reflective of the significant decrease in recorded new formal complaints

Of the complaints closed during 2020/21, there needs to be a separation of the two processes. In the period from April to November were the old process was running 21% of closed complaints were within timescale and then the remainder of the year, in the new process, it rose to 33%: and continues to rise. In the year 2020/21 37 closed complaints were re-opened compared to the 52 in the previous year 2019/20, a 29% improvement.

Of the formal complaints closed, the below graph demonstrates how many were upheld, partially upheld and not upheld.



Learning Lessons

If there is one recurrent message that patients and families share with us, it is that we need to evidence that we have learnt from their experience and make any necessary changes.
The evidence of learning is a key priority, which is embedded within in the new process.

The aim of the new complaints process is to identify learning early on in the process that this is clearly written in complaint responses and for this to be actioned by the Divisions and shared widely where appropriate. This supports demonstrating that the Trust is committed to an open, open and learning culture.

The following learning identified through the complaints process is shown below as examples:-

Concern – Patient underwent surgery in Hull and to the plan was to receive follow up care in Scunthorpe, but the referral from Hull was not receive and the patient was lost to follow up.

Learning – to prevent this happening again the two Trusts are working together to develop an electronic referral process.

Concern - Recurring Trust wide theme in complaints about communication

Learning - Multiple methods of sharing learning are currently in use, including ward newsletters, team meetings and individual conversation. The Trust Learning Lessons Newsletter will contain detailed examples of poor communication and the impact on patients and their families. Introduction of SAGE and THYME foundation level communication training for staff.

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.

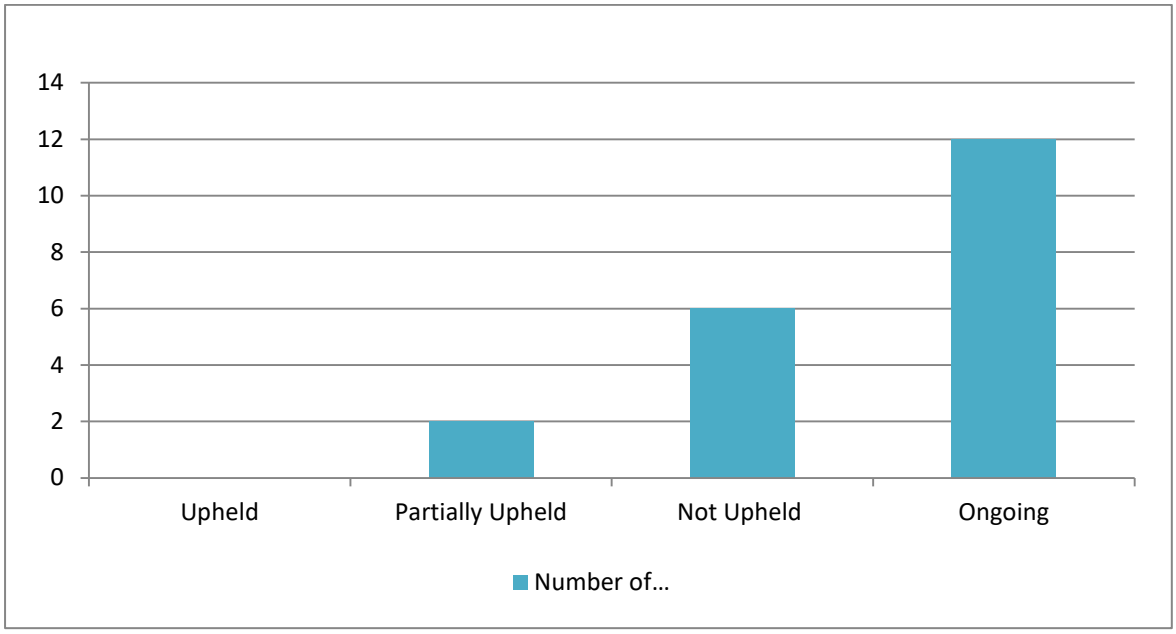
Concern – Failure of breast reconstruction (via Complaint):

Learning – Introduction of oncoloplastic MDT, and psychology involvement introduced preoperatively .This will improve the patient pathway.

Parliamentary and Health Service Ombudsman (PHSO)

“The PHSO look into complaints where someone believes there has been an injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and not put things right.”

The below graph illustrates the Trusts performance in regards to PHSO complaints during the period 1 April 2020 – 31 March 2021. Please note that the PHSO suspended their service during the Pandemic and resumed in January 2021. We currently have 12 ongoing enquires/investigations.

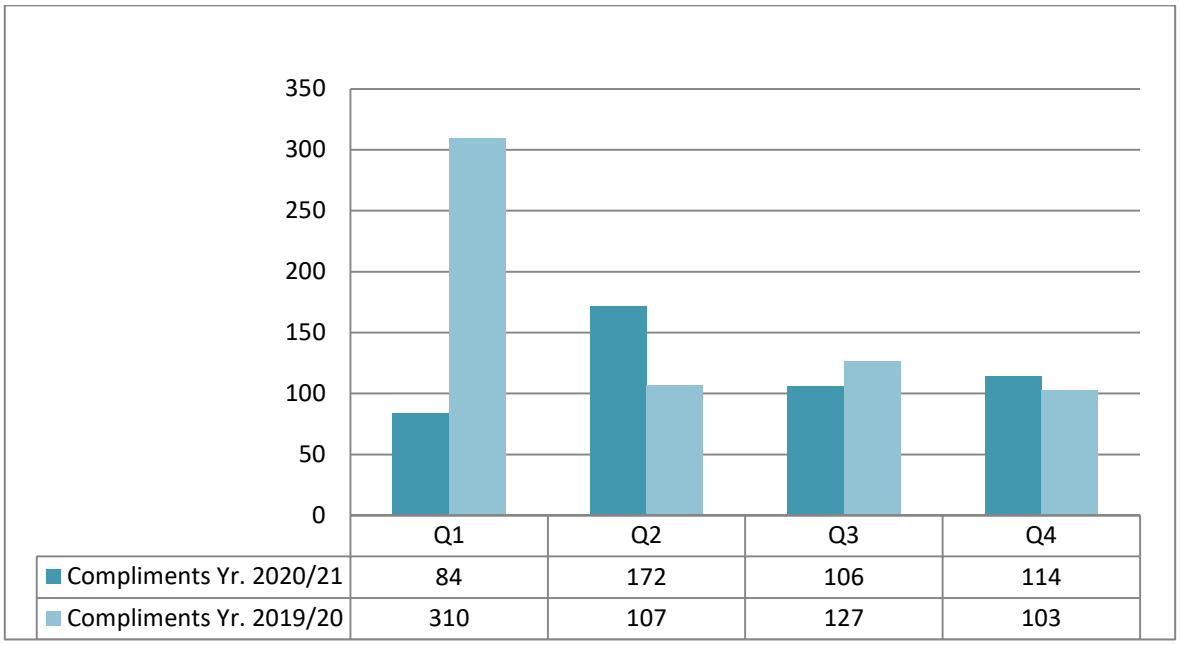


Compliments: Activity

Compliments are central to the measurement of patient experience, as are complaints and concerns. The Trust is working at ensuring these are readily captured and shared with teams.

Staff are encouraged to keep a folder with their area for their thank you cards and the compliments they receive directly. Compliments that are received through the PALS and Complaints Department are logged onto 'Survey Monkey'. Staff can also put their compliments onto the internal 'Hub'.

Below is the total number of compliments logged through Survey Monkey and the Patient Experience Hub. It is evident that there was an initial reduction of logged compliments at the first wave of the Covid 19 pandemic, this has subsequently levelled out. There is still further work to look into systems for recording positive feedback more consistently:



	Q1	Q2	Q3	Q4
Compliments Yr. 2020/21	84	172	106	114
Compliments Yr. 2019/20	310	107	127	103

Developments

There have been numerous quality improvement developments within the last twelve months, which has enabled the Trust to continue to ensure we provide a patient focused PALS and Complaints Service:

- The new complaints process was implemented across the Trust on 2 November 2020 and significant improvements in the handling of complaints, response times, learning have been noted. However, this must continue to be promoted and embedded .through continued collaboration with clinical divisions.

- Policy and Procedure for the Management of Feedback from Complaints, Concerns, Comments and Compliments (DCP071) has been approved .The policy has been amended in line with the new complaints process.

- The weekly Support and Challenge meeting for the Complaints Team has been very successful. This allows discussion of priority complaints, re-opened complaints, and any concerns that are identified during the course of the week. Senior Nurse oversight of this enables prompt escalation and action of issues.

- Complaint trackers have been developed for each member of the Complaints Team, which monitors the progress of every complaint...

- A Quality Improvement project has been undertaken to review the PALS service, which is ongoing. The aim is to look at how we can respond to PALS concerns in a timelier manner, working with Divisions to take ownership of their concerns and to provide the complainant with an appropriate response to their concerns.

- The Chief Nurse monthly PALS and Complaints report has been improved to provide accurate and more relevant data for Divisions, enabling them to have robust oversight of all their complaints and concerns.

Conclusion

This year has seen many challenges across the NHS and Northern Lincolnshire and Goole NHS Foundation Trust, in relation to the impact of the Covid 19 pandemic. Despite this the Trust successfully implemented an improved complaint process across every division, supported by its clinical and non-clinical staff.

The Trust is committed to ensuring that its patients, carers and families have a good experience of care when using its services, but for those who unfortunately have to use the complaint service the aim is to provide a service that is built on quality.

Our aim in the coming year is to build on the improvements already seen in our complaint process, not only in the response times but in the quality of those responses delivered. Through continued supportive challenge our processes will face ongoing scrutiny.

Patient feedback from our process is actively collected and reviewed to identify areas for further development.

In relation to the PALS service, we are undertaking quality improvement work, which will be ongoing over the next six months, and see the same level of scrutiny applied to our processes across Divisions to ensure that a consistent, timely and compassionate experience is delivered.

Appendix 1.

Develop a Responsive, Quality and Patient Centred Complaint Process

Central Complaints Team, Jo Loughborough & Dawn Harper

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Feedback from complainants using the Trust formal complaint process was:

The complaint process was not meeting their expectations

Aim

Our aim was to create a new complaint process that was timely, robust, compassionate and evidenced learning. Feedback obtained from complainants in the "old" complaint process was that, at times, the process was lengthy and did not always answer their questions.

Measurement

The main data measure we used was:

Complaints responded to in timescale.

However, there additional key measures as we progressed to move from the "old "complaint process to the "new" process, including the pivotal:

Complaints open greater than 120 days

Changes

Engagement; Met with patients, stakeholders, central team, & divisions

Co- designed: Mapped out a new process to address:

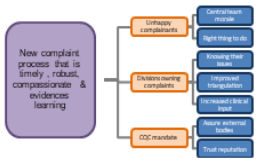
Timeliness through tracking

Compassionate meaningful responses through quality review processes

Robust investigations through a new Lead Investigator role

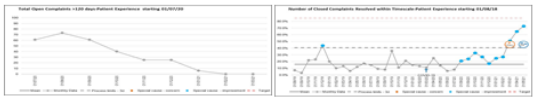
Learning evidenced in responses and on incident reporting suite

QI tools



Data

This clearly shows the improvement journey, from closing all "old" process complaints to improving timeliness against trust timescales



Learning and what's next?

We learnt that using QI processes and data helps evidence the quality journey. Everyone worked collaboratively and developed new skills and ultimately all involved can tell the same story.

Next steps are to apply same principles to our PALS service.

QI Team V.1

Our Complaints Journey

NHS Northern Lincolnshire and Goole NHS Foundation Trust

We knew our Trust complaint process needed to change: not only our review of internal data or our CQC inspection but from what our patients and families who had to unfortunately use the complaint process told us. We all agreed we wanted to create a service that made us proud to work within and that met the expectations of those accessing it. Early in the process we established a rolling feedback survey to gather insight from our complainants.

Having worked the same way for many years, changed seemed scary and we didn't quite know where to start .We began by identifying our drivers for change and checking this by asking key stakeholders what they wanted from a complaint process, including the most important people – the complainants. We then undertook some central discussions as a team about what worked well and where the areas for improvement lay, this led us to identify that we needed to change the way complaints were seen within divisions and ensure a robust investigation (ownership through the Lead Investigator role), how they were kept in timescale (visual tracking framework), quality of responses (through improved clinical input & quality reviews).

Our next step was to develop a tracking framework, by using the PDSA cycle and engaging with the central team a working version was created. Alongside this a piece of co-design with key stakeholders reviewed the whole of the complaint policy and pathways. Our Family Services division volunteered to undertake the pilot and through their feedback were able to modify the process and identify the gaps.

The central team were guided through these extensive changes through workshop style engagement sessions, which led to a bespoke caseload matrix being developed and trialled, using PDSA methodology, to support their fears over workload. The team also worked collaboratively, using a PDSA cycle to develop a learning log on the Trust incident reporting suite – which mirrored that, was evidenced in responses .Quality review of complaint responses was introduced to develop clinical oversight of final responses and standardised key elements of meaningful response writing, and this was combined with workshops with the central team.

A transition plan was developed to move from the "old" complaint process to the new one and through engaging with divisions and triumvirates the Trust all took up the challenge to roll out the new complaint process in November 2021.

What the staff engagement work revealed was there was a piece of large cultural work to undertake with the central team regarding their previous poor experiences of change management. This remains ongoing, but the team talk now is all about the "privilege of working together" and they feel they have been "listened to throughout".

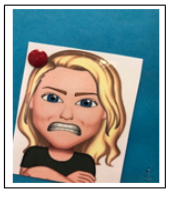
In the following 16 weeks: all complaints over 120 days were successfully closed, all old process were closed within the KPI timeframe, all divisions transitioned into new process using Lead Investigator role, development of a training package, development of learning log on Trust Incident reporting suite, sign off of new complaint policy- everyone involved was proud of the achievement, and our data could evidence the improvements.

Currently the average length of time a formal complaint is open is less than the Trust agreed timescale, all complaints have a Lead Investigator, learning is evidenced in responses and responses are person centred. We are now looking at our next steps….watch this space!

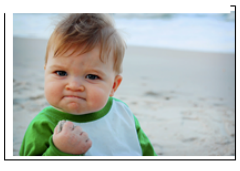
Our Team

We did a lot of writing ideas down

It wasn't all plain sailing – some days felt like this



Today we feel like this



QI Team V.1

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)179

DATE OF MEETING	03 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Michael Whitworth, NED & Chair of Workforce Committee
CONTACT OFFICER	Michael Whitworth, NED & Chair of Workforce Committee
SUBJECT	Workforce Committee Minutes from 27 April 2021
BACKGROUND DOCUMENT (if any)	Not applicable
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee – 27 July 2021
EXECUTIVE SUMMARY	Minutes of the Workforce Committee meeting held on 27 April 2021 and approved at its meeting on 27 July 2021

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients. The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday 27 April 2021 at 2.00 pm via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Christine Brereton	Director of People
Linda Jackson	Vice Chair
Claire Low	Deputy Director of People
Michael Proctor	Non-Executive Director
Peter Reading	Chief Executive
Kate Wood	Medical Director

In Attendance:

Abolfazl Abdi	Deputy Chief Operating Officer
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

The Chair informed the committee that Michael Proctor is the Deputy Chair of the Workforce Committee

1 Apologies for absence:
Ellie Monkhouse, Robert Pickersgill and Shaun Stacey

2 Declarations of Interest:
The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

3 Minutes of the previous public meeting held on Tuesday 23 February 2021:
The minutes from the previous meeting held on Tuesday 23 February 2021 were accepted as a true and accurate record.

4 Matters arising from the previous minutes:
No matters arising

5 Review of action log:
Action 72 – Internal and External Surveillance Systems Policy – use of CCTV for disciplinary purposes
Claire Low reported that originally when first discussed the proposal was for the disciplinary policy to be changed to allow CCTV footage to be used in disciplinary scenarios. The trade unions are not in agreement that CCTV can be used in any disciplinary process and the CCTV licence would need to be changed to allow that. If the need is serious enough, the police will potentially have the authority to request access to the CCTV footage, or alternatively they could try interviewing

potential security guards that have witnessed the security footage. The Chair added that this action came to the committee by means of a referral from the Audit Committee as they were concerned about violence on violence with other staff and he questioned if this is an action for this committee. Peter Reading confirmed that it cannot be included in the licence so it cannot be in the disciplinary process, if it were a criminal matter it may be able to be used in those circumstances. The Chair agreed to remove this item from the action log.

Action 79 – Update on ACPs
The Chair stated that the Chief Nurse had confirmed that she was quite happy this matter had been dealt with. The Chair agreed to remove this item from the action log.

Action 89 – Pride and Respect – add to annual workplan
It was noted that there is going to be a whole approach to the next phase of Pride and Respect and when that has been worked through that will be included in the workplan. It was agreed to remove this item from the action log.

6 Workforce Committee – Terms of Reference:
The Chair stated that the committee should be reviewing the TOR annually and undertaking an effectiveness review of the committee. Some parts in the TOR are dated as well as some of the strands. The Chairs view would be to finalise the annual workplan, then undertake a review of effectiveness and then look at the TOR later in the year. Linda Jackson added that the document presented at the NED meeting showed that reviews of effectiveness should be completed and presented to the August Trust Board. A pragmatic approach may be to keep them separate this year. Christine Brereton agreed with Linda Jackson because you cannot review if meetings are not held.

A discussion was held about the previous public and private part of the Committee. It was agreed that there should be one Committee, with highlights/issues being escalated to the Board as appropriate. Peter Reading added that this applies to all of the sub-committees and they don't need to have a private and public meeting. The Chair confirmed that the Workforce Committee would operate on that basis moving forward.

The Chair highlighted that there wasn't a Governor present at the meeting today and the TOR of the committee refer to the fact that a BAME staff representative could be invited. The Chair agreed to discuss this further and update the committee.
Action: The Chair

7 Draft Annual Workplan – April 2021:
Christine Brereton confirmed that as discussed at the previous meeting, she had produced an annual workplan for 21/22 to support delivery of the TOR, and presented this to the Committee for discussion and agreement. The annual workplan divided out strategic and operational issues. Christine confirmed that any areas of concern of workforce will be highlighted to the Workforce Committee to identify if further work was needed (which may result in a deep dive to the Committee) or further assurance. She also confirmed that this was a good opportunity to now start to present the data performance report at every meeting of the committee to assure the Trust Board it has sight of that. Data will also form part of the IPR report for the Board and confirmed that the KPIs for workforce presented will be further developed in order to also represent "softer" workforce data such as H&WB and culture and leadership. Christine confirmed that a review had also been undertaken to ensure that reports were not being duplicated by being presented to the Board, and various different sub-committees, and had communicated with the medical directorate, nursing directorate and the COO outside of the meeting and in developing the annual workplan.

Comments received on the proposed annual workplan:

- Peter Reading suggested that education and training also includes items that relate to the Medical Directors office

- Kate Wood agreed that some of the reports did previously go everywhere and there was an opportunity to streamline. She referred to the, Medical Revalidation Annual report (Annual Organisational Audit), and proposed timing of this April. KW/CB to discuss outside of the meeting.

- Kate Wood stated that line 48, The Undergraduate Report, belongs to the People directorate and not the Medical Directors directorate because Health Education England commissions that and she asked for the name on that to be changed.

Linda Jackson stated there was a formatting issue and she asked for the headings to be repeated on every page of the report. Linda suggested moving some items from April 2022 as it seemed quite heavy in that month i.e. HASR. Linda felt that the committee is tackling operational performance but NLaG still has vacancies and she went on to ask if there will be deep dives into those areas. Linda highlighted new roles and what NLaG is doing to try and do things differently, that proactive approach is missing. The Chair replied that when the committee gets the strategic section deep dive he would expect it to look at the wider workforce issues. The role of this committee is to deep dive into that particularly if it is a critical issue.

Christine Brereton added SPC charting is a different way of reporting, if the committee works within variant levels and in acceptable normal levels that should be enough assurance. Where things go off scale the committee will need to do a deep dive to identify where the issues were and to agree what should be done about them. The committee can add on deep dives as required and determine where it would see them. Where things are improving the committee may also be able to do lessons learned. Christine Brereton saw new roles being in a deep dive as part of the People Strategy to see what the trust is doing to respond. Peter Reading agreed it is right for this committee to select the deep dives as Christine described and then tell TMB it is concerned after the deep dive, take our advice away and take the appropriate action.

Michael Proctor made the same point as Linda Jackson regarding April 2022. With regard to deep dives, if the committee had a referral about risk or harm from cancer, one way to tackle this may be to do a deep dive on one cancer pathway. Deep dives do have their uses and Michael agreed with Christine and would support that.

Christine Brereton added that there may be some deliverables around the NHS People Plan and there may be some KPIs given to the trust nationally and they can also be brought to this committee, alongside the data reporting section.

The Chair confirmed the workplan had been accepted by the committee with the above amendments and removal of the word ‘Draft’. The final workplan will be presented at the next meeting for final approval

8 People Strategy – Annual Delivery Implementation Plan Sign Off:

Christine Brereton presented to the Committee the annual delivery plan 21/22 to support the delivery of the NLAG People Strategy (the strategy had been confirmed by the Trust Board in June 2020). She confirmed that she had recently presented this to the Executive Team and there are a few amendments to be made to the timescales, not reflected in this copy. Christine agreed

to update the plan and circulate it to all. The plan gives a direction of travel and priorities for the trust.

The following comments were made on the proposed annual delivery plan:

Linda Jackson asked if retention initiatives should be included. Christine Brereton agreed that retention was an emerging issue both locally and national and this would be included as part of the Culture work outlined in the plan. A discussion was held about nursing recruitment and retention and as required, and in line with the workplan, updates will be provided to the committee.

The Chair referred to actions 3 and 4 on page 3 and he asked if the directorate will be fully staffed by then and will everything have been delivered. He went on to ask if the directorate is seconding people in, because he is a little concerned it is over stretching itself. Peter Reading replied in terms of the restructure the proposals got support from Exec Team this morning to invest in some of the actions. Christine Brereton replied that some of the timelines will change; some of the delivery will be in 2022. Christine Brereton thanked the Chair for his concern and she agreed that a review of some of the objectives will be needed now that the Executives had approved the investment in the Directorate via the restructure proposals.

Kate Wood was not party to the Exec Team discussion and she stated that both Christine Brereton and herself would have some work to do around the transition from Medical Director to People Directorate for doctors in difficulty. Christine confirmed that this was in the plan and a date for transition could be determined and included in the final plan. Kate referred to the development of the future roles, such as ACPs and Physicians Associates and ICS plans and couldn't see reference to this in the plan for the next year. Christine Brereton confirmed that the plan talked about partnership working with the ICS, and through the HASR review, and it was there that she saw the development of new roles rather than at an individual trust level. Christine Brereton further confirmed that at the current time (and given it was a year 1 plan) the focus for this year needed to be HR case management and getting the basics right, and starting to develop plans for leadership development and culture change. Peter Reading stated that the debate had been had at Exec Team and he agreed and supported Christine's point of view. Firstly, there is capacity and this organisation has to sort out the basics, and the plan is about the basics for this year. It cannot divert capacity into other areas at this point. Secondly, this organisation is not mature enough to be able to handle new roles as well, it has invested in new roles in the past and the divisions do not have jobs at the end of their training. Peter agreed that development of new roles should be carried out on a wider scale.

The Chair felt that Kate Wood asked a good question and he was also keen to make progress in this area and didn't want NLaG to miss strategic opportunities.

9 Workforce Performance Report – Trust and Directorate:

The Chair asked the committee if they felt the right things have been included in the report. Christine Brereton had taken some data to Trust Board in February but that she had wanted to further work on this to provide assurance to both the Workforce Committee and the Board. As a result, Paul Bunyan and his team have started to provide some basic data from where the directorate felt assured. A lot of work has been done on cleansing the data, looking at SOPs and getting to the position where some of the metrics can be included in the wider IPR data. The data will be presented at each meeting so the committee can see the journey. Workforce data will be linked to the People Strategy and Workforce Plan and they would also like to include health and wellbeing, flexible working and temperature checks to show how staff are feeling. Work has also been looking to develop some benchmark parameters through discussions with HUTH, York and the Humber and they are quite satisfied that this is progressing in the right areas.

The Chair welcomed the work around data quality and would like to understand how the committee can be assured that the data has been cross referenced and engaged within divisions within the Trust. Abolfazl Abdi replied that from a division's perspective he felt the answer is yes, as the data had been validated. Kate Wood added she attends the PRIMs meetings and they get updates from HRBPs working in divisions. In conjunction with the divisional team, they get that data and it is produced directly with the teams themselves. Her oversight is when the teams jointly present that information that they have prepared together. Claire Low added there is an extra level of engagement with the deputy network around the workforce metrics in terms of agreement of SOPs i.e. the vacancy position and sickness, particularly around what is in and what is out when staff are on maternity leave.

Linda Jackson stated she liked the revised charts and annotations although she would like to understand further the trust turnover rate. She referred to the healthcare assistant's (HCAs) vacancy rate; last year it was at 7% and in October it was at 10%. She asked what learning was taken from that to stop that happening again. Claire Low replied that the trust had never previously struggled to recruit to HCA posts. The recruitment team and nursing directorate are manually going through the establishment versus the ledger to understand the vacancy position. A recommendation going forward is to get the establishment into ESR. There is a real disconnect, the ledger says there were twenty whole time equivalent HCAs removed from the ledger last month as they were not in ESR. They have recruited HCAs into a pool and are keeping that over established. The vacancy rate for HCAs has now significantly reduced and given the efforts of the nursing and people directorate a pipeline was now also available.

Michael Proctor asked with regard to vacancies would it be possible if there is an increase in establishments to mark that on the chart and he also asked if the committee could have a midwifery staffing chart. CB/PB will review if this is possible. He also sought clarity on whether PADR was appraisals and it was confirmed they were. He referred to mandatory training, stating that overall is looks good, 91% against a target of 90% for core training and 80% against a target of 85% for role specific training but referred to the variation between different departments and whether underperformance was being identified. Christine Brereton replied work is being done on this for the board development session next week and a deep dive would be undertaken to understand where the problem areas were. The Chair welcomed this report and looking at anomalies agreed that some further work may be needed to ensure that we were identifying any areas of underperformance.

Claire Low replied that the mandatory training identified overall, but in terms of CQC findings the data may not identify some areas of risk but work is taking place with Harriet Stephens at the Board session next week. The Chair stated that in an ideal world the committee would do a deep dive into workforce but this needs to be at a strategic level and needs to look at indicators, KPIs and what CQC are telling us. The trust wants to provide great care and people who have been appraised, trained and in the right numbers will do that. There are certain indicators that the committee needs to get underneath. Christine Brereton replied with regard to targets, for now the trust is comfortable where the data needs to be but the trust cannot answer the question, where do the targets come from. There is probably some debate to be had around targets at some point. The Chair agreed that is right, you need to be looking at comparators and what needs stretching and the targets need to be realistic.

Peter Reading added with regard to vacancies for healthcare support workers in spring 2018 the trust recruited 80 and said it would never happen again. Claire's explanation about the data was really helpful; the trust really needs to join the data up. Michael Proctor commented that obviously great progress has been made in a short space of time.

9.1 Vacancy Position
No further discussion took place

9.2 Turnover
No further discussion took place

9.3 Sickness Absence
No further discussion took place

9.4 Mandatory/ Statutory Training Completion
No further discussion took place

9.5 PADR Completion
No further discussion took place

10 Workforce Policy and Procedures:
Nothing to report

11 Trust Board Highlight Report:
It was agreed to highlight the progress made on the data and plan and that there is nothing to escalate out of that. The Chair agreed to pull this together and discuss with Christine Brereton before submission.

12 Meeting dates:
Michael Proctor stated that the dates of the meetings and work schedule will be subject to some review and he would expect Helen Harris to inform the committee if the changes from the BAF will change things for this committee.

It was confirmed that the June meeting had been cancelled and the next meeting will be held in July which gets this committee into the regular cycle with everybody else.

13 Any Other Urgent Business:
Christine Brereton confirmed that she and Claire Low will be interviewing next week for the Associate Director roles which are currently being covered on an interim basis as part of the People Directorate restructure for workforce and culture leadership. She agreed to keep the committee updated.

14 Date, time and venue of next meeting:
Tuesday, 27 July 2021 at 2.00 pm held virtually via Microsoft Teams

The meeting closed at 15:18

NLG (21) 180

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors Public
REPORT FROM	Dr Kate Wood – Medical Director
CONTACT OFFICERS	Dr Liz Evans – Guardian of Safe Working Jane Heaton – Associate Director – Strategic Medical Workforce.
SUBJECT	Guardian of Safe Working - Annual Report
BACKGROUND DOCUMENT (if any)	TCS 2016/2018 – Junior Doctors
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	This report will go to the JDF and JLNC for information once Trust Board have considered the paper.
EXECUTIVE SUMMARY	The Annual Guardian of Safe Working Report has been revised from previous years. It was felt the Board would appreciate oversight of the exception reporting and trends and work that has been done and needs to be done to make the learning experience at NLaG a good experience. In previous years, the report had focused on the vacancy position highlighting gaps in the rota's. This year, the focus is more on the areas identified through exception reporting and the trends this identifies in order to focus on areas that may needs additional support from interventions from the GoSW and the DME. Overall, the exception reporting is still low and primarily focuses on additional hours, with a small number of missed educational opportunities. The DME continues to support the educational requirements through exception reporting. There is an opportunity at Induction in August to engage with the new intake of training grade doctors to encourage exception reporting in order to be able to identify trends, particularly on hours and education, in order to work with colleagues to improve our learning environment for our doctors in training.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)					
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Annual Report

Dr Liz Evans
Guardian of Safe Working
July 2021

Contents

Executive summary

The Annual Report of the Guardian of Safe Working Hours shows the exception report information for the annual period of June 2020 to May 2021. ¼ reports continue to be generated and share at TMB, JLNC, the Junior Doctor's Forum (JDF) and with colleagues at Health Education England (HEE).

There are no trainees within the Dentistry service at NLaG and so the Annual Report applies only to doctors in training.

We are now in the fifth year of the 2016 national contract for doctors in training which aimed to encourage stronger safeguards to prevent doctors working excessive hours. Exception reporting (ER) of extra unplanned hours, missed breaks and missed education is now well established in Northern Lincolnshire and Goole NHS Foundation Trust and we continue to positively promoted exception reporting through Induction, training and the quarterly Junior Doctors' Forum for Safe Working Hours.

The Trust appointed a new Guardian of Safe Working from 24 May 2021.

The 2016 contract was subject to review in 2019 and although largely unchanged there were some notable differences which the Trust has implemented.

Exception reporting is a valuable instrument that provides frontline information regarding pressure points in the system, ensures safe working hours, improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The extra pressure of the Covid19 Pandemic particularly during 2020 and the first quarter of 2021 brought with it surge rotas that were carefully constructed in consultation with our doctors in training and their representatives. This resulted in a reduction in the number of exception reports as hours were carefully monitored and staff aware of the need to balance time at work with rest.

The safety of patients is a paramount concern for the NHS and for us as a Trust locally. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.

Fill rates for doctors in training at the Trust continues to be strong which has helped with rotas and working hours.

Rota design and co-ordination now sits within the Workforce Resource Centre. This provides regular oversight of rota design and ensure that the doctors in training terms and conditions are met within that design.

High level data – Data as of June 2021

(Please note: The figures below do not add up, this is because the reporting is a mixture of both head count and WTE – the data is extracted from two separate spreadsheets one from recruitment and one from Finance. For future reporting we will look to be able to provide a consistent approach either by head count or by WTE rather than both).

Number of training posts (total): 220

Number of doctors in training posts: 188.07

Number of LTFT trainees: 7

Number of training post vacancies 34.03

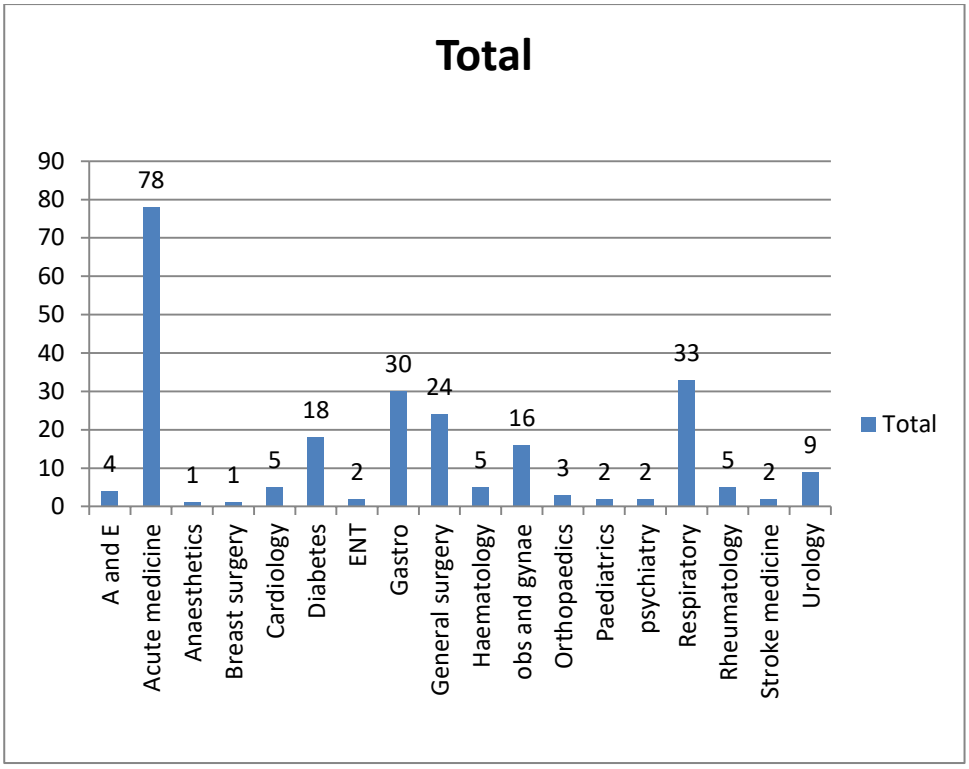
Number of Trainees by Site (shown below):

Site 1 SGH	87
Site 2 DPOW	77
Site 3 GDH	0

Source: Recruitment via establishment spreadsheets and vacancy spreadsheets.

The table below, from the Allocate software, provides a breakdown of the total number of exception reports received during the period June 2020 to May 2021.

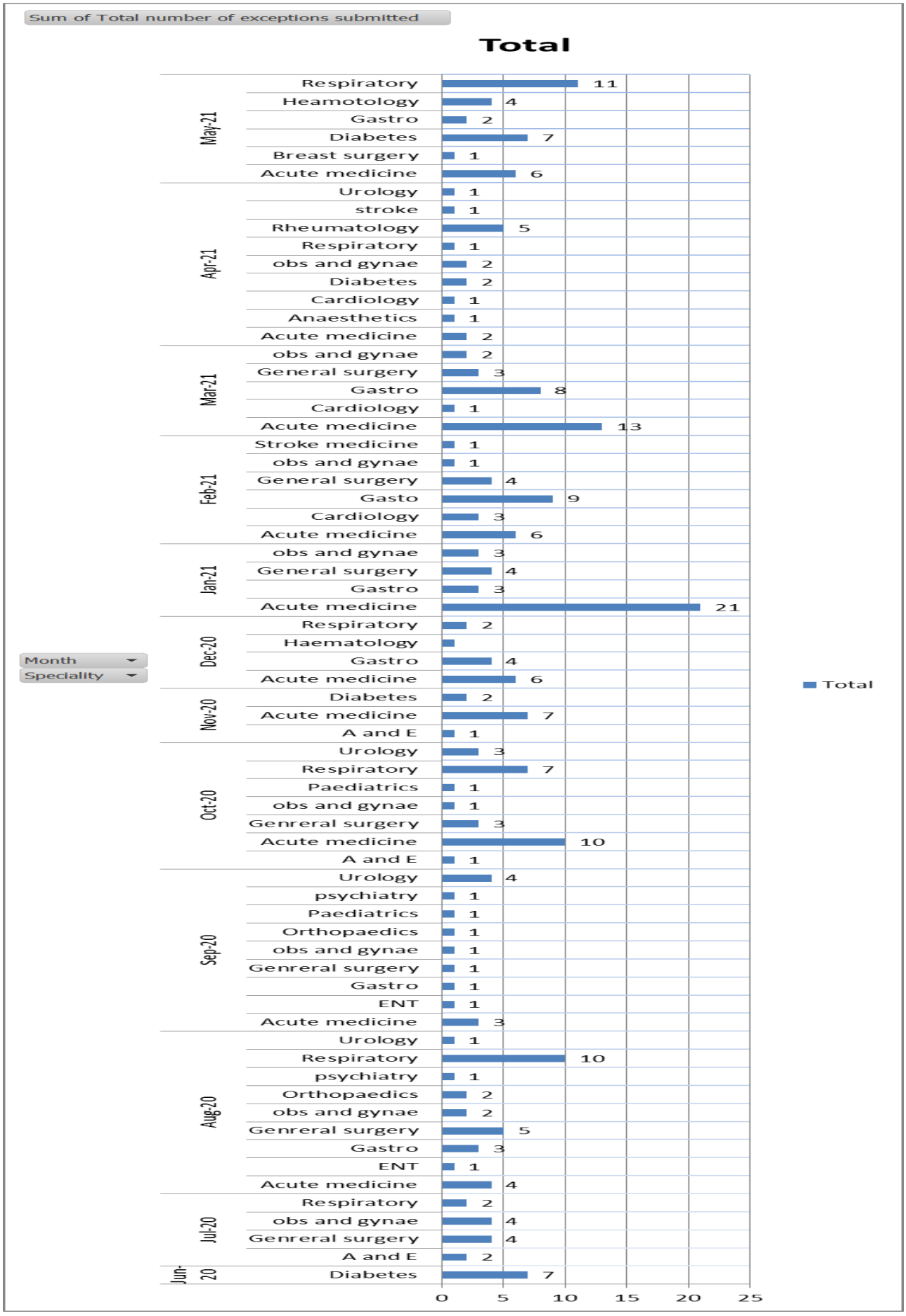
Department	Sum of Total number of exceptions submitted
A and E	4
Acute medicine	78
Anaesthetics	1
Breast surgery	1
Cardiology	5
Diabetes	18
ENT	2
Gastro	30
General surgery	24
Haematology	5
Obs and Gynae	16
Orthopaedics	3
Paediatrics	2
psychiatry	2
Respiratory	33
Rheumatology	5
Stroke medicine	2
Urology	9
Grand Total	**240**



On looking at this data, it shows the areas within the Directorates and Specialties that generate the highest number of exception reporting. This enables specific focus to be given to the areas identified in order to support the specialty in reducing exception reporting and providing a good learning environment for the doctors in training.

The table on page 6, breaks down the exception reporting further by showing the number of exceptions reported by specialty by Month between June 2020 and May 2021 and again by providing this information we are able to tease out the areas that require support. For example, we would have expected during this period to see an increase in exception reporting within Acute Medicine because of the COVID pandemic.

This report also confirms the concerns that have arisen within the Gastroenterology and Rheumatology department for doctors in training and triangulates the data from other sources, for example the GMC survey and HEE information. This allows targeted support to increase the positive experiences of our doctors.


Sum of Total number of exceptions submitted
Total
May-21
Respiratory 11
Heamotology 4
Gastro 2
Diabetes 7
Breast surgery 1
Acute medicine 6
Apr-21
Urology 1
stroke 1
Rheumatology 5
Respiratory 1
obs and gynae 2
Diabetes 2
Cardiology 1
Anaesthetics 1
Acute medicine 2
Mar-21
obs and gynae 2
General surgery 3
Gastro 8
Cardiology 1
Acute medicine 13
Feb-21
Stroke medicine 1
obs and gynae 1
General surgery 4
Gasto 9
Cardiology 3
Acute medicine 6
Jan-21
obs and gynae 3
General surgery 4
Gastro 3
Acute medicine 21
Dec-20
Respiratory 2
Haematology
Gastro 4
Acute medicine 6
Nov-20
Diabetes 2
Acute medicine 7
A and E 1
Oct-20
Urology 3
Respiratory 7
Paediatrics 1
obs and gynae 1
Genreral surgery 3
Acute medicine 10
A and E 1
Sep-20
Urology 4
psychiatry 1
Paediatrics 1
Orthopaedics 1
obs and gynae 1
Genreral surgery 1
Gastro 1
ENT 1
Acute medicine 3
Aug-20
Urology 1
Respiratory 10
psychiatry 1
Orthopaedics 2
obs and gynae 2
Genreral surgery 5
Gastro 3
ENT 1
Acute medicine 4
Jul-20
Respiratory 2
obs and gynae 4
Genreral surgery 4
A and E 2
Jun-20
Diabetes 7
0 5 10 15 20 25
Month
Speciality
Total

Summary

1. The Trust was granted £60,000 of national money to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. There are still some areas that require completion which had stalled due to COVID, however these are known and will be implemented as quickly as possible.

2. Fill rates remain strong but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

3. There have been 0 fines imposed for any breach of the doctors in training contract.

4. This past year has seen a marked improvement in the engagement with our doctors in training and we will continue to build on this during the next year.

5. The GoSW attends meetings between the Trust and HEE to monitor the learning environment. During the past year these meetings have concentrated on Medicine and Gastroenterology.

6. The GoSW holds Junior Doctor Forums every month and these are a valuable opportunity for our Doctors representatives to meet with the Guardian, MD office, DME office, BMA and LNC in one place. Issues addressed over the past year have included:

- Rota difficulties
- Continued progression on the Fatigue and Facilities Charter
- Frontline behavior at work
- Attendance at JDF by Trust staff
- Increased awareness to raise the concerns as they happen in order to resolve in a timely manner
- Trust and confidence that issues raised by the doctors are considered and reported back in a timely manner

Recommendations

1. To support and encourage the work of the Guardian and the DME in engaging Educational Supervisors and Consultants in the exception reporting system.

2. To ensure a positive regard for the education of trainee doctors recognising the importance of the medical workforce and safeguarding the balance of service provision and education.

3. To support initiatives to improve the doctors in training experience at NLaG in Medical areas removing the HEE requirement for improvement and strengthening the Trust's reputation and attractiveness as a training provider/employer.

Dr Liz Evans - Guardian of Safe Working

Date: July 2021

NLG(21)181

DATE OF MEETING	3rd August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Dr Kate Wood, Medical Director & Responsible Officer
CONTACT OFFICER	As above
SUBJECT	**Medical Appraisal & Revalidation Annual Report (AOA)** Dr Kate Wood, Medical Director
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	Workforce Committee - Approved
EXECUTIVE SUMMARY	This report is an essential requirement done on an annual basis summarising the appraisal position for doctors connected to NLAG as their Designated Body. Revalidation and medical appraisal ensures that the current medical workforce, whose RO is Dr Kate Wood, are fit to practice across 4 domains of the GMC'S *Good Medical Practice.* The appraisal process captures this information by asking doctors to provide evidence of continuing professional development, participation in quality improvement activities, reflecting upon significant events, incidents and complaints and feedback from colleagues and patients. This portfolio of evidence informs the RO whether a doctor is fit to practice and informs the GMC of this (revalidation). To ask the Board to accept the report noting it will be shared with the higher level RO at NHS England and Improvement. The Board, through the Chief Executive Officer, are required to sign the 'Statement of compliance' at the end of the report confirming that the organisation is in compliance with the RO regulations. The approved annual report and signed statement of compliance will be submitted to NHSEI by the Responsible Officer's office.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)

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 good leadership
	✓			

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		Workforce and Leadership	✓
Quality and Safety		Strategic Service Development and Improvement	
Estates, Equipment and Capital Investment		Digital	
Finance		The NHS Green Agenda	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	*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.*				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	Approval	Information	Discussion	Assurance	Review
		✓			

Annual Revalidation Report 2021

Contents

1. Purpose of the Paper

The purpose of this paper is to provide the board with information about processes in place at NLaG for medical appraisals, revalidation recommendations to the GMC, and medical governance arrangements.

The report will therefore help NLaG in its pursuit of quality improvement, provide the necessary assurance to the higher level responsible officer and can act as evidence for CQC inspections.

Furthermore the purpose of this paper is to provide assurance to the board that the organisation continues to implement and comply with the Responsible Officer Regulations and legislation; Medical Profession (Responsible Officers) (Amendment) Regulations 2013.

2. Background to appraisal and revalidation

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. It was also launched to enable a proactive system of ensuring doctors are fit to practice in the UK. Prior to the introduction of revalidation there was no consistent mechanisms of ensuring doctors are fit to practice and if there was concerns around fitness to practice, a patient had already come to some form of harm.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctor
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

All doctors are allocated to a designated body (DB) through the GMC. NLaG is the designated body for all our non-training grade doctors such as; consultants, Specialty Doctors and Trust Grade doctors. Dr Kate Wood is the Responsible Officer (RO) and Mr Ajay Chawla is the appraisal lead for the Trust.

Doctors in training are connected to the deanery and locum agency doctors are connected to the HOLT medical agency for purposes of appraisal and revalidation and therefore are not included in this report.

3. General Information

3.1 Medical appraisal and Revalidation process during COVID-19

The GMC contacted the Medical Director/Responsible Officer in June 2020 outlining the GMC's approach to revalidation. The GMC advised the RO that the GMC would be adopting a flexible approach to revalidation. Doctors due to revalidate between March 2020 and March 2021 have had their revalidation submission dates pushed back by 12 months. To date, the GMC and NLaG continue to have a flexible approach to revalidation and appraisals owing to the ongoing recovery and potential future waves of the virus.

Flexible approach includes the following;

- If a doctor misses an appraisal due to reasons relating to the pandemic, then this will not stop a doctor revalidating providing all the supporting information is available to make a recommendation of revalidation (for example 360 feedback, reflection on significant events, CPD)
- Postponing appraisals and/or deferring revalidation at the doctors' request for more time to collect supporting information. This can alleviate pressures to meet revalidation requirements.

In terms of medical appraisal, NHS England and Improvement advised NHS Trusts in England that doctors, who are due for an appraisal between March and September 2020, can have their appraisal date extended by 6 months.

NHS Trusts in England were contacted again in late August 2020 that those doctors who were extended by 6 months, should be allowed to extend by another 6 months as it was becoming evident that the situation was beginning to deteriorate and a second wave was going to be imminent.

Doctors who were due for appraisal between October 2020 and March 2021 were advised that if possible, they should have their appraisal as normal. To help alleviate pressure during the winter crisis, NLaG adopted the shortened appraisal form "Appraisal 2020" format. This was received extremely well and doctors at NLaG fully engaged with the new format.

3.2 Annual Organisational Audit report (AOA)

The Annual Organisational Audit report is an element of the Framework of Quality Assurance (FQA) and this is a standardised reporting mechanism for all Responsible Officers (RO) to complete and return to their higher level RO.

Owing to the Covid-19 pandemic last year, NHS England and Improvement advised NHS healthcare organisations in England in April 2021 that submission of the AOA will not be required for the 2020-2021 appraisal year. However, organisations were encouraged to submit AOA results for the annual report.

Item	Number of prescribed connections	Completed appraisals (1)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
Consultants	199	122	77	0	199
Staff grade, associate specialist, specialty doctor	133	68	65	0	133
Temporary or short term contract holders	84	45	39	0	84
Total of 2.1.1 - 2.1.6	**416**	**235**	**181**	**0**	**416**

There are no measure 3 doctors for 2020-2021 owing the flexible approach adopted towards medical appraisal and revalidation.

A breakdown of Measure 2 is as follows:

- 7 doctors were new arrivals to the UK and the NHS and obtained their primary medical qualification outside the UK. They started with the organisation in quarter 4
- 10 doctors started with Trust in quarter 4 from another healthcare organisation without an up to date appraisal

- 16 doctors had long term sickness during their appraisal period
- 1 doctor was on maternity leave
- 142 doctors did not do their appraisal due to NHSE/I response to the COVID-19 pandemic whereby doctors due for appraisal between March 2020-September 2020 had their appraisals extended initially by 6 months, during 1st wave, and another 6 months during the 2nd wave.
- Of the 142, 13 have completed their 20-21 appraisal. The remainder will combine 2020-2021 with 2021-2022 appraisal and will be reported in the 2021-2022.

3.3 Responsible Officer Role

Dr Kate Wood, Medical Director, is the nominated RO for this Trust. The RO has received RO training and is a licensed medical practitioner. Therefore NLaG is compliant with Regulation 5 of The Medical Profession (Responsible Officers) Regulations 2010.

The RO also attends the NHS England and NHS Improvement quarterly RO network meetings and best practice is shared with the Clinical Lead for Appraisal and the Revalidation Assistant.

3.4 Funds, capacity and resources

To date the organisation has been compliant with Regulation 14 of The Medical Profession (Responsible Officers) Regulations 2010, which states that each designated body must provide the appointed/nominated RO with sufficient funds and other resources necessary to enable the RO to discharge their responsibilities.

3.5 Records of NLaG licensed medical practitioners

The Revalidation Assistant is the Trust-wide coordinator who maintains records of NLaG licensed medical practitioners. This includes;

- GMC Connect : A database of Medical Practitioners who have a prescribed connection to NLaG
- L2P Appraisal software system. All Medical Practitioners who are on the NLaG GMC connect database will have an L2P account.

To ensure that these lists are accurately maintained, the Revalidation Assistant will run ESR starter and leaver reports at least every 2 weeks, and adjust the lists above accordingly, a standing operating procedure has been developed and adopted.

3.6 NLaG Medical Appraisal Procedure policy document

This procedure will be due for review again in February 2023.

3.7 Short-term placement and locum doctors

Short term contract holders, such as NHS locum Consultants, fixed terms speciality doctors and Trust Grade doctors, are supported in their continuing professional development (CPD), revalidation and governance in coherence with substantive medical staff, i.e., they are not considered or managed differently to permanent medical staff.

Short term contract holders are expected to maintain their CPD through the appropriate Trust processes, such as Study leave, participating in mandatory training, attending medical teaching sessions, to name a few.

They are also expected to engage with medical appraisal and revalidation. Upon appointment short term contract holders are incorporated into the local appraisal software system, L2P, are duly welcomed by the RO via email, advised of medical appraisal help sessions, signposted to the revalidation assistant and the GMC are informed that the doctor in question has a prescribed connection to NLaG.

In terms of governance all new short term contract holders are initially made aware of governance procedures, such as incident reporting, through the Trust's induction Policy as are all new starters to the Trust.

4. Ensuring Effective Appraisal

4.1 The Medical Appraisal

Doctors who have prescribed connection to NLaG use the L2P software system. Each doctor has an individual L2P account which is linked to their NHS e-mail. The doctors are required to fill their appraisal form via the L2P system and there are 3 basic elements to the appraisal.

1. Appraisal Inputs – doctor fills in each section of the L2P form and uploading supporting information/evidence which covers their scope of practice. Once completed the doctor submits form to appraiser via the L2P system.

2. Appraisal meeting – meeting between doctor and assigned appraiser.

3. Appraisal outputs – Doctor and appraiser agree a PDP for the year going forward and the appraiser writes up a summary on how the doctor meets the 4 domains of Good Medical Practice with the supporting evidence provided. The appraiser and doctor both sign off the appraisal. The appraiser then submits to the RO office for RO review and sign off.

Appraisal inputs vary among doctors however the appraisal outputs are somewhat more structured. The appraiser must confirm in the final sign off statements that:

- An appraisal has taken place that reflects the whole of a doctor's scope work and addresses the principles and values set out in Good Medical Practice
- Appropriate supporting information has been presented in accordance with the Good Medical Practice Framework for Appraisal and Revalidation and this reflects the nature and scope of the doctor's work
- A review that demonstrates appropriate progress against last year's personal development plan has taken place
- An agreement has been reached with the doctor about a new personal development plan and any associated actions for the coming year
- No information has been presented or discussed in the appraisal that raises a concern about the doctor's fitness to practise

The appraiser is not automatically obliged to confirm all the statements mentioned if they feel that one or more is not reflected in the appraisal.

All doctors at NLaG are reminded that their annual appraisal must cover their entire scope of practice, which may include charity work, private work etc. and the doctor must provide evidence that they are fit to practice every single role they carry out whether this be clinical, managerial or educational because every single role a doctor carries out in their practice, does have an impact on patient care.

Supporting information to demonstrate fitness to practice against a scope of work varies however the Trust, via the revalidation assistant, does provide clinical governance information to all doctors. This includes;

- Incidents that they have been named in the past 12 months; if a doctor is named in a significant event or incident, they must summarise the event and demonstrate reflective practice. Any doctors that are informed of significant events and/or incidents by the Revalidation Team, but upon RO review the information is not included in appraisals, the appraisal will be referred back to the

doctor to rectify. This is because it is a GMC requirement that a doctor must comply with.

- Complaints that they have been named in the past 12 months.
- Claims that that have been named in the past 12 months
- Clinical activity data (upon request)

Doctors are also encouraged to upload or provide evidence of medical indemnity/insurance.

In relation to mandatory training, it is not a mandatory requirement for appraisal and or revalidation however the revalidation team do inform doctors that mandatory training courses do attract Continuing Professional Development points (CPD) and therefore doctors do upload their mandatory training matrix as part of the support information portfolio.

GMC guidance states that consistent failure to engage with mandatory training can be a GMC referable matter and may impact on revalidation. "*Failure to meet local appraisal or contractual requirements may be discussed at your appraisal but should not influence the revalidation recommendation made about you … However; in exceptional circumstances your responsible officer may decide that significant failure to meet local requirements will impact on their recommendation. They would need to be satisfied (and satisfy us) that failure to meet local requirements means you are not engaging with revalidation and therefore failing to meet our requirements. They would need to specify which of our requirements you have not met.*"[1]
Doctors are also required to undergo 360 feedback at least once in a 5 year cycle. The RO office also actively recommends and ensures doctors complete the 360 feedback element in year 3 of their revalidation cycle which is approximately 2 years before a doctor is due to revalidate their license.

All supporting information which is presented by the doctor must be fully reflected on how they meet the 4 domains of Good Medical Practice. Reflective practice also drives quality improvements as well as professional and personal development.

All doctors are contractually and professionally obliged to engage with appraisal. Doctors are sent reminders via the L2P system and the RO office that they are due

[1] *Guidance on supporting information for appraisal and revalidation content, https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation/essential-information-to-help-you-meet-our-revalidation-requirements, paragraph 23-24, General Medical Council, accessed 09/07/2021*

for appraisal. Doctors who are late with appraisal are then supported by the RO office and the DCDs.

Consistent non-engagement with appraisal results in the RO discussing the doctor's individual case with the GMC Employment Liaison Advisor and potentially, a subsequent referral to the GMC for non –engagement. Prior to all formal non-engagement referrals, the RO requests that the GMC contact the doctor with an early warning letter. If the doctor is also eligible for pay progression this is deferred by a year.

No submissions of non-engagement have been made during 2020-2021

4.2 Medical Appraisers

Between April 2020 and March 2021, NLaG had 48 approved medical appraisers who were conducting appraisals. Each appraiser has undertaken medical appraiser training which is provided internally by the Trust.

Each Medical appraiser undergoes quality reviews. This consists of two parts; Firstly, a report which collates appraisee's feedback via the post-appraisal questionnaire (PAQ). An example of PAQ can be referred to in section 4.2.2.

Secondly, a quality assurance report on the medical outputs that the appraisers have produced. A total average of all results can be referred to in 4.2.1 but each individual appraiser would receive a report in a similar format but with their own result. The aim of these reports, which are sent to the appraisers, is to allow the appraiser to reflect on what has gone well and identify any improvements which will enhance their personal learning for medical appraisal. The revalidation team also uses the quality assurance reviews to identify and implement improvement to local process which is then picked up in the annual training sessions.

4.2.1 Quality Assurance of Medical Appraisal Outputs using EXCELLENCE tool

The Medical Appraisal Outputs consists of the PDP, appraiser comments and summary of the appraisal and provides assurances to the RO that the doctor is meeting Good Medical Practice frameworks. To quality assurance medical appraisal outputs the Trust uses the "EXCELLENCE" tool. Below is the table of results as well as headline results whereby a comparison of the 20-21 results with the 18-19 results have been made.

			overall average RAG rating
OVERALL	E	Encompass all? does the summary comment on context, including stage of revalidation cycle, and reflection on the whole of the scope of work?	1.38
	X	Exclude bias and prejudice? are all statements objective, free from bias and prejudice and based on evidence? Is it a typed, professional document?	2.00
	C	Challenge, support and encourage? Does the summary demonstrate that the appraisal was challenging, supportive and focussed on the needs of the doctor?	1.73
	E	Explain why any statements (including health and probity) have not been agreed? DOES APPROPRIATE COMMENTARY EXPLAIN ANY 'NO' OR 'DISAGREE' ANSWERS?	2.00
REVIEWING	L	Look at supporting information, lessons learned and changes made? does the summary drive quality improvements by reflecting what has been learned and what needs to be changed as a result?	1.64
	L	Look at last year's PDP and reflect on each objective? if any objectives have not been achieved, have the reasons been discussed and documented?	1.70
	E	Encourage excellence, celebrate accomplishments and record aspirations? does the summary capture examples of good practice and record aspirations (some of which may have a timescale over one year)?	1.62
PLANNING AHEAD	N	Note any gaps/no gaps in the requirements for revalidation and how they will be addressed? what supporting information is outstanding for each role?	1.32
	C	Contain SMART PDP Objectives? Are they Specific, Measurable, Achievable, Relevant and Timely? Do they challenge the doctor to make quality improvements?	1.90
	E	Explain the new PDP items? does the summary show how the PDP objectives are relevant and derive from the supporting information and appraisal discussion?	1.48

The headline results are the following:

Areas requiring improvement:

- Appraisers need to improve on commenting on a doctor's revalidation cycle i.e. where they are in the cycle and what needs to be done to ensure timely revalidation of licence. This was an area of improvement when the last quality assurance exercise was conducted and therefore this is an area of concern. However this does not reflect whether an individual doctor is to fit to practice or not and therefore it is an area of minor concern which will be addressed in the upcoming medical appraiser training sessions.

- Need to drive reflective practice more robustly and consistently to ensure lessons learned and quality improvement. Again, this will be addressed through medical appraiser training modules
- Appraisers should encourage excellence and celebrate achievements more.
- Address gaps in evidence which support revalidation requirements and Good Medical Practice framework.

The next medical appraiser training session is looking to be held in September or October 2021. The above areas of improvement will be considered as modules for this training session. To measure success, a comparison of 20-21 results will be made against 21-22 results.

Areas that appraisers excel in and have improved on since the last quality assurance exercise;

- All appraisals are free from bias and prejudice. This infers that all our appraisers have high regards for equality and ensure this is applied to their role in a professional manner
- Ensuring PDPs are SMART and why the final PDP has been developed. This means that doctors at NLaG can be assured that their personal development will be meaningful and help them in their professional and personal lives. This has a positive impact on our local services and quality of care
- Since the last quality assurance exercise, Appraisers have improved on challenging doctors. This means that appraisers are submitting appraisals in the full knowledge that the doctor they are appraising is practicing within the GMC 4 domains of Good Medical Practice and therefore fit to practice
- Our appraisers conduct the necessary probity and health checks which is one of the key cornerstones of the medical profession in the UK, maintaining registration and medical UK licensing which is considered the ‘Gold Standard’ within medical profession on the whole

4.2.2 Medical Appraisal Post Appraisal Questionnaire (PAQ) results

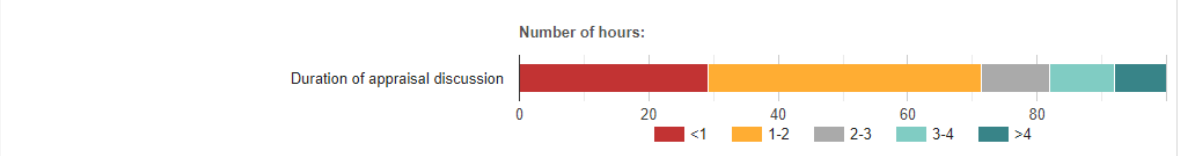
Process Overview

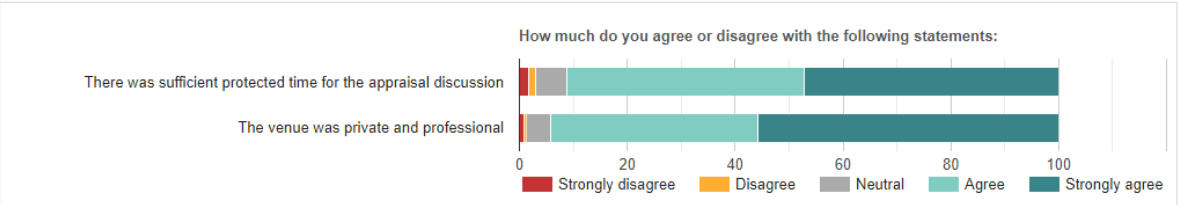
For appraisal months from the start of April 2020 to the end of March 2021 Set period

Number of completed responses for this period: 237

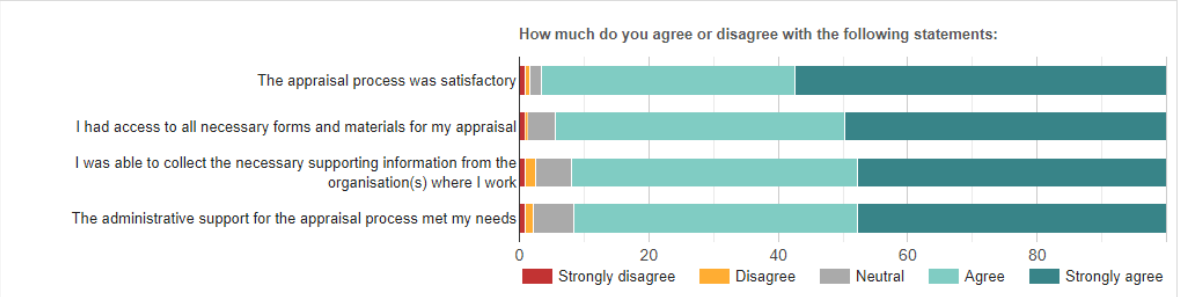
Show charts and data | **Show charts only** | Show data only

Environment and timing





Administration and management of the appraisal system



The headline result for 'Process Overview' is that doctors had less time to complete their appraisals during 2020-2021 however this is entirely expected and not a cause for concern. 44% of doctors agreed that they had sufficient time to complete their appraisal with a further 47% strongly agreeing. Despite the pressures for the pandemic, doctors agreed that they still had plenty of time to complete their appraisal.

In terms of administrative and management support for medical appraisal, majority of doctors agreed that they were supported and were able to collect the necessary support information from the Trust

Appraiser Overview

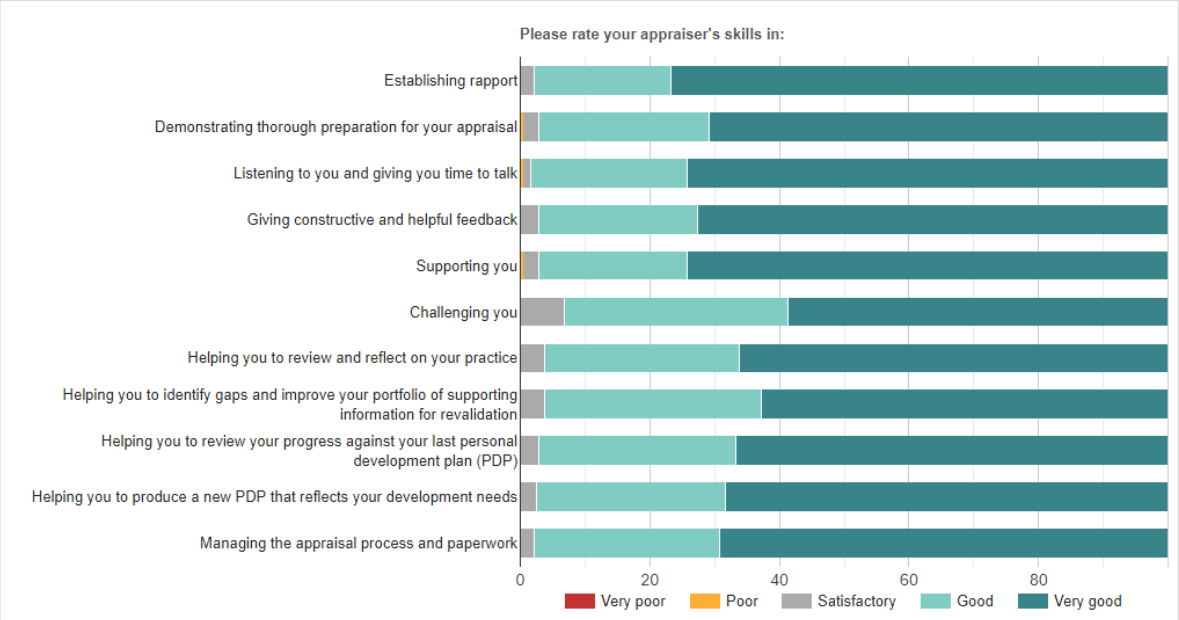
For appraisal months from the start of April 2020 to the end of March 2021 Set period

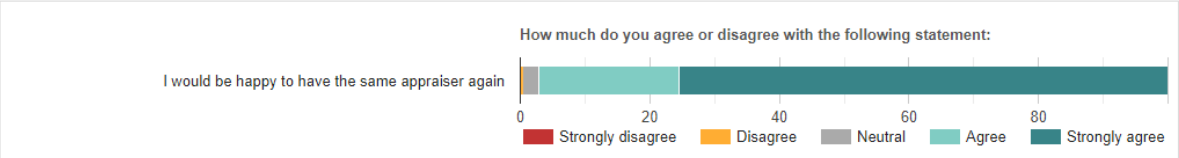
Number of completed responses for this period: 237

Show charts and data | **Show charts only** | Show data only

Your appraiser

Please give your appraiser feedback for their personal development

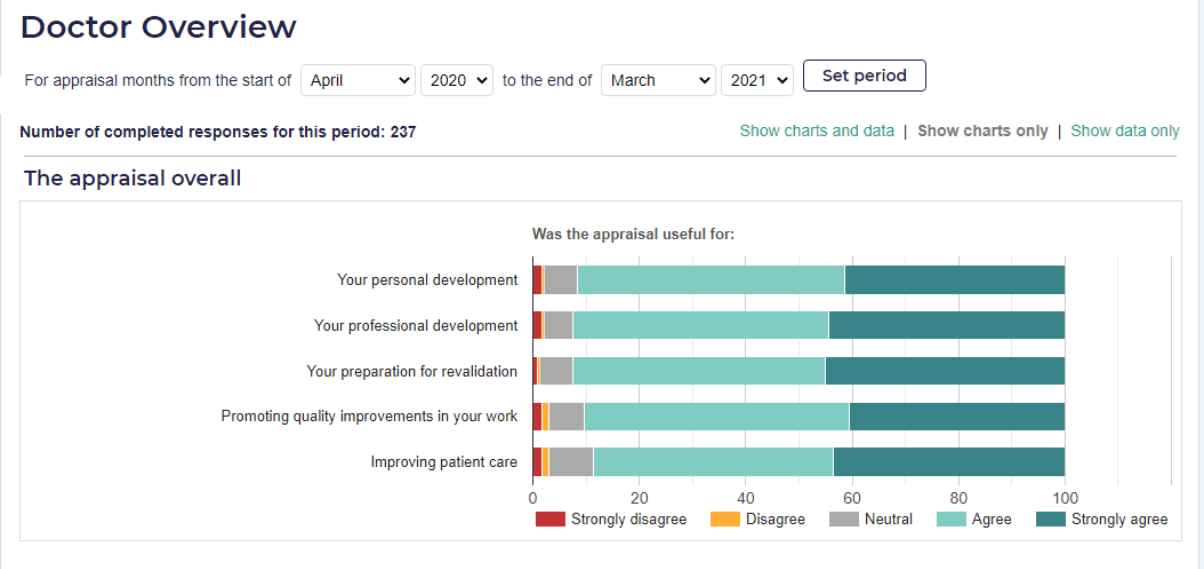




88% of doctors would be happy to have the same appraiser again which is a reflection on the quality of appraisers the Trust has. At least 95% of doctors reported the following;

- That they were able to establish a good rapport
- That their appraiser had clearly prepared for the appraisal meetings
- That they were listened to
- Received helpful feedback
- Felt challenged and supported
- Were able to review and reflect on their practice
- Were able to identify gaps in their appraisal portfolio
- Were able to review progression again their last PDP
- Develop a new PDP for their development needs
- That their appraiser had a good handle on the appraisal paperwork

All of the above is an excellent and positive reflection of the skill, knowledge and experience of the Trust's appraisers and that continued investment in the appraiser role is clearly in the Trust's best interest, whether through off site training or the 0.25 PA allocation, but it is clearly returning its investment through high quality appraisals and a medical workforce that feels supported through the appraisal process.



Furthermore, not only are the doctors benefiting on an individual/personal basis, but the benefits have the potential to impact on the organisation as a whole, for example 85% doctors believed that their appraisal was useful for improving patient care and promoting quality improvement.

4.3 L2P appraisal software

The Trust procured L2P in November 2015. All medical appraisal documentation is stored electronically on the system and only the Revalidation Assistant has full administration rights whilst the RO has full viewing rights for appraisals.

Access and use of data adheres to the requirements of the Data Protection Act (1998). L2P is registered with the Information Commissioner's Office: Registration number. z2384214

In the event that external individuals require a doctor's appraisal, then the requester is required to approach the doctor concerned in writing. The request must be reasonable and clearly stated. On rare occasions this may not be possible particularly in police, legal or GMC matters whereby appraisal information can be released without consent depending on the severity of the issue and what level of

patient harm has occurred. These cases should they arise are judged case by case in relation to releasing appraisal information and in line with internal Trust polices.

There are clear guidelines regarding access arrangements for medical appraisal documentation for medical staff in the Medical Appraisal Procedure.

With regards to maintaining patient confidentiality, doctors are notified that supporting information that has patient identifiable data must be removed or redacted before uploading documents to the L2P form.

For the Board's information there have been no breaches of patient data to date in relation to medical appraisal.

L2P also has a number of reporting mechanisms. This includes;

- NHS England quarterly compliance
- NHS England annual compliance
- Past appraisal performance by grade
- Past appraisal performance by department
- Resource forecast by month
- Resource forecast by department
- Late appraisals by department
- Late appraisals by month
- Appraiser activity
- Appraisals with appraiser
- Appraisal completion by department
- Agreed PDP learning/development needs
- Medical educators
- Medical educators CPD

The contract with L2P is due to expire in November 2021. At the time of writing this report, the Medical Director's Office is currently undergoing a competitive tendering process, in line with NLaG policies and procedures and with the assistance of the Sourcing and Contracting team, to acquire a new contract for medical appraisal software which is value for money.

4.4 Quality Assurance measures

Current quality assurance measures, as well as planned measures which are included in the action plan, are outlined below:

- Appraisee feedback on the overall process and their appraiser.
- EXCELLENCE quality assurance tool. Every appraiser has 2 appraisals quality assured per appraisal year. This equates to approximately 100 appraisals being quality assured per year.
- Monthly revalidation meetings between the revalidation assistant and the Responsible Officer
- Responsible Officer occasionally facilitates the RO network meetings, in partnership with NHSE/I. This ensures sharing of best practice and new process development.
- Annual Training events for medical appraisers and all medical staff who wish to learn more about local process
- Medical Appraisal Induction sessions for new starters although primarily aimed at new starters from abroad.
- Annual Audit to NHS England and Improvement
- Annual revalidation report
- Statement of compliance signed by the CEO, which is then submitted to NHSE/I
- Revalidation team and RO attends the NHS England appraisal networking events
- Quality visits from NHS England and NHS Improvement
- Fortnightly meetings between Clinical lead for appraisal and revalidation assistant.

4.5 Compliance Reporting

Quarterly reporting directly to the Divisional Clinical Directors and the Chief Operating Officer commenced in July 2021.

This is a new and more consistent way of reporting directly to the divisions.

4.6 NHS England Quality visits

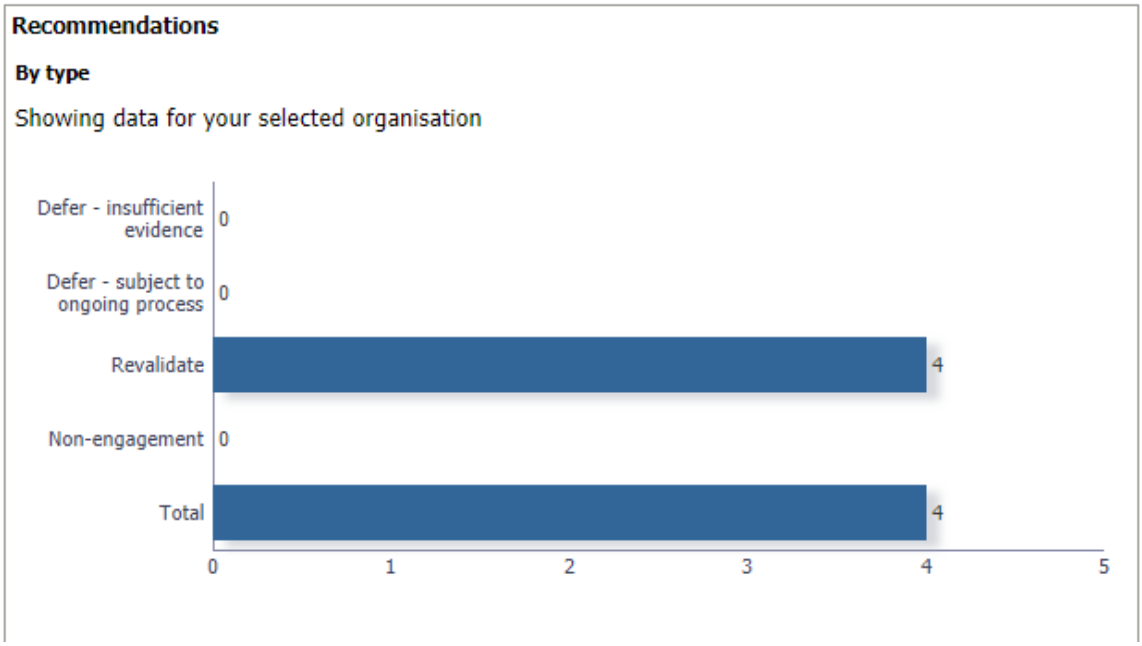
There have been no visits from NHS England & Improvement since July 2019

5. Recommendations of Revalidation to the GMC

5.1 Revalidation submission data

Between 01/04/2020 and 31/03/2021

What would you like to view? My selected organisation / Average for my organisation type



Between April 2020 and March 2021, only 4 doctors were revalidated. There were no deferrals or non -engagement submissions made to the GMC by NLaG.

As highlighted in point 3.1, doctors who were due to revalidate between March 2020 and March 2021 have had their revalidation submission dates pushed back by 12 months by the GMC.

Since April 2021, the revalidation process has since reverted back to usual operations.

5.2 The recommendation process

There is currently a 3 stage sign off to assess whether a doctor has met the criteria to successfully revalidate using the revalidation checklist.

Firstly the revalidation assistant pulls a GMC report of all doctors who are under notice for revalidation and assesses each doctor's appraisal portfolio on L2P against the revalidation checklist. This is the first stage sign off.

Once completed the revalidation assistant meets with the Clinical lead for Appraisal who then completes second stage sign off by reviewing the medical appraisal outputs.

Stage 3 is RO level. In the revalidation meetings the revalidation assistant will present the revalidation checklist portfolios for final review and decision.

All documentation and decisions are documented and filed. Doctors who are revalidated or deferred are duly notified of the decision.

Currently, the RO office is looking at introducing a further sign off stage, prior to RO level sign off. The new sign off stage will incorporate the Divisional Clinical Directors. The exact format of this sign off process is to be determined and become operational. An update will be provided in next year's report.

Doctors who are considered for non-engagement, which could ultimately mean that their license is withdrawn by the GMC, would have gone through the stages of the non-participation outlined below

6 Medical Governance

6.1 Local Medical Governance arrangements for medical appraisal

The revalidation assistant provides timely governance information to all doctors for their appraisal which includes; Datix incidents and serious events, complaints and claims that occurred in the previous 12 months from date of requesting the information from the appropriate teams; Datix team, Complaints team and the Claims/Legal team.

Currently we inform every doctor if they have been named in any of the above, whether this is in a managerial capacity, direct clinical input or part of a wider team, and if so that they must summarise and demonstrate reflective practice which encourages quality improvement ideas.

Although the doctor is directly provided with clinical governance data, it still maintains the doctor responsibility to upload to the L2P form and reflect. If it has been found that a doctor has not included this information, despite being named, then the revalidation assistant will refer the appraisal back and outline the omission.

In line with GMC requirements, doctors must include all incidents and SUIs that they have been named in by their employer(s) in their appraisal for purposes of reflective practice.

If a doctor consistently omits incidents or SUIs despite repeated assistance and support from the revalidation team, then this could be considered as a probity issues which opens the possibility for the doctor to be referred to the GMC for non-engagement with appraisal and revalidation processes and consideration of internal MHPS procedure being undertaken. To date there has been no incidents of probity issues relating to clinical governance data.

6.2 Monitoring conduct and performance

Medical staff performance and conduct is managed through regular supervision, through annual appraisal and participating in regular audits, case reviews, SJRs, all but to name a few, as part of quality improvements processes which is captured via the appraisal and revalidation process.

During appraisal discussions the doctor is encouraged to discuss aspirations and challenges and to review the progress of PDP objectives. The doctor is also required to reflect meaningfully on when things have gone wrong and demonstrate how changes and learning needs have been identified and actioned.

We also train appraisers to challenge doctors In relation to participating in quality improvement activities, especially if there is a lack of.

The “Doctor’s in Difficulty” (DiD) group has been operational since April 2018. The purpose of DiD is to ensure those required to attend are sighted on issues and concerns in relation to “Doctors in Difficulty”. Doctors are classified as being in difficulty if they meet one or more of the criteria below;

- Known through internal referrals to/from the General Medical Council and NHS Resolution and/or have restrictions on clinical practice
- Going through an MHPS investigations
- On or recently returned from long term sickness absence
- recent sickness absence relating to stress, anxiety and/or other mental health issues
- Have had 4+ sickness episodes in over 12 months (rolling)
- Involved in a confirmed serious incident
- Training issues

- "Other" – this covers a range of issues that would not sit in the above categories, for example, employment tribunals.

The attendees of the group, which has senior HR representation, also ensure those doctors sighted on issues outlined above, are receiving the required support from the operational divisions and the HRBPs, and challenge where there is a deficiency in pastoral support and/or general support altogether (such as return to work).]

Other processes include the local Maintaining High Professional Standards policy and procedure, ensuring private practice is declared in the appraisal form and that doctors provide evidence of adequate and appropriate insurance and/or indemnity cover, whilst further ensuring that NHS and private practice do not conflict, and job planning.

6.3 Responding to Concerns

The Trust has a specific Maintaining High Professional Standards Policy/Procedure (MHPS) which supports in dealing with responding to concerns. In addition the Doctors in Difficulty Group ensure those required are sighted on issues and concerns known through recruitment of doctors with restrictions on their practice, internal referrals to/from the General Medical Council and NHS Resolution or those that have previously or are due to commence employment at Northern Lincolnshire and Goole NHS Foundation Trust.

Our Trust Board is sighted on all cases going through the formal MHPS process, for example the number of suspensions and this is provided by our People and Organisational Effectiveness Directorate. In addition the Doctors in Difficulty Group provide a written update annually for the Trust Board which is presented by the Medical Director

6.4 Transfer of Information between ROs

When a doctor joins NLaG and has come from another UK healthcare organisation whether this is another NHS Trust, Locum agency or training, then the Revalidation Assistant invokes the Medical Practice Information Transfer process (MPIT).

The revalidation assistant will formally contact the doctor's previous designated body with a MPIT form, which is prepopulated with the doctor's name, GMC number and NLaG's RO details, and requests that the designated body and its RO, or authorised delegate, fills in the form.

The MPIT form requests the following information;

- Date when Doctor left previous organisation
- Date of last ARCP/appraisal
- To inform the new RO any of additional information or concerns relating to the doctor's practice

7. Employment checks

Systems to ensure that appropriate pre-employment background checks are undertaken to confirm doctors who are starting with the Trust, have qualifications and are suitably skilled and knowledgably to under their professional duties, are covered by the Recruitment and Selection Policy and the "Recruitment and Selection – A Best Practice Guide".

For Agency Locum doctors who are identified as potential candidates to fill a shift which is live on the Locum Management System, the CV of potential candidate is sent to the Clinical Leads to review that the qualification, skills and training competencies of the candidate are suitable for the shift.

After the quality visit review in July 2019, it was advised by NHS England & Improvement that the Trust should look to obtain appraisal information at the point of recruitment and/or interview. This is so that doctors who do not have an up to date appraisal, can be appropriately accommodated for to have an appraisal as soon as possible if they are successful.

In summary, appraisal information can be captured at point of application dependant on which online platform the doctor uses to apply for a clinical role.

A suggestion has been put forward to NHS jobs to include this information on the application forms and this is due to be discussed and negotiated within the NHS jobs national negotiation process.

8. Conclusion

8.1 Review of actions from last year's annual revalidation report

Appraisal Compliance Reporting

The Revalidation Team produce reports which are sent to the Division Clinical Directors and Chief Operating Officer on a quarterly basis.

Short term contract holders and appraisal

The Medical Appraisal Induction sessions, aimed at new starters, continues to be operational.

NHS England Action Plan

This action plan has been completed.

Ensuring Trust meets the 4 principle of effective medical governance

A gap analysis exercise is currently ongoing which is being led by the Associate Director for Strategic Medical Workforce.

8.2 Current issues and new actions

- To continue and enhance the support for new doctors from abroad
- Continue to work with GMC in terms of workshops being hosted at NLaG
- Ensure that Mandatory Training is reviewed in a supportive way at medical appraisal
- Trust to continue to work towards the 4 principles of effective medical governance
- Continue to train and retrain medical appraisers
- Ensure NHS locum consultants who are doing CESR are including this in their appraisal and PDP
-
- Define a new process for the new sign off stage for Divisional Clinical Directors
- To ensure appraisal of paediatric work for medical staff who primarily see and treat adults. This would include Surgeons, Anaesthetists and Emergency Medicine medical staff.

8.3 Action from the Board

To ask the Board to accept the report noting it will be shared with the higher level RO at NHS England and Improvement.

The Board, through the Chief Executive, are required to sign the ‘Statement of compliance’ at the end of the report confirming that the organisation is in compliance with the RO regulations.

The approved annual report and signed statement of compliance will be submitted to NHSEI by the Responsible Officer’s office.

Feedback and recommendations from the Board are also welcomed.

8.4 Statement of compliance

The Board of Northern Lincolnshire and Goole NHS Foundation Trust have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief Executive

Official name of designated body: **Northern Lincolnshire and Goole NHS Foundation Trust**

Name: Signed:

Role:

Date:

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(21)182

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Andrew Smith, NED / Chair of ARG Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	Audit, Risk & Governance Committee Minutes from 23 April 2021.
BACKGROUND DOCUMENT (if any)	-
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	ARG Committee – 3 June 2021
EXECUTIVE SUMMARY	Minutes of the Audit, Risk & Governance Committee held on 23 April and approved at its meeting on 3 June 2021.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
				✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety	✓	**Strategic Service Development and Improvement**	✓
Estates, Equipment and Capital Investment		**Digital**	
Finance	✓	**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	Oversight of entire BAF process, completion and achievement.				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

MINUTES

MEETING: Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**

DATE: **22 April 2021** via MS Teams

PRESENT:	Andrew Smith	Chair of ARG Committee / Non-Executive Director
	Michael Whitworth	Non-Executive Director
	Neil Gammon	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Helen Harris	Director of Corporate Governance
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Nicki Foley	Local Counter Fraud Specialist
	Helen Kemp-Taylor	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Tom Watson	Internal Audit Manager (Audit Yorkshire)
	Mike Norman	External Audit – Senior Manager (Mazars)
	Rob Pickersgill	Deputy Lead Governor
	Nicola Parker	Assistant Director of Finance – Planning & Control (For Items 4.1 and 5.2)
	Simon Tighe	Deputy Director of Estates & Facilities (For Item 11.1)
	Dr Kate Wood	Medical Director (For Item 9.3)
	Angie Legge	Associate Director – Quality Governance (For item 11.2)
	Alison Hurley	Membership Manager / Assistant Trust Secretary (For item 12.1)
	Sue Meakin	Data Protection Officer / Information Governance Lead (For Item 12.2)
	Ivan Pannell	Head of Procurement (For Items 12.3; 12.4 and 12.5)
	Anne Barker	Finance Directorate Administration Manager / PA to CFO

Item 1 04/21 **Apologies for Absence**

Apologies for absence were noted for Stuart Hall.

Item 2 04/21 **Declarations of Interests**

There were no declarations of interest made.

Due to the need for Tom Watson to attend another meeting it was agreed to take the next items out of sequence.

Item 7 04/21 **Internal Audit (Audit Yorkshire)**

7.1 Internal Audit Progress Report

The report was taken as read and Tom Watson was invited to highlight additional items to note. Tom Watson highlighted that good progress had been made since the January 2021 ARG Committee meeting with six audits completed, four with significant assurance ratings and two with limited assurance. A number of audit reports were still in draft form and were due to be finalised shortly. Requests had been made to amend the audit plan i.e. Seven Day Services to be replaced with a review of the Register of

External Agency Visits and approval was sought from the Committee for those changes.

Tom Watson also highlighted the actual audit days for 2020/21 which, at the time of writing the report stood at 195 against the planned days of 229.

Andrew Smith sought approval from the Committee members of the changes to the audit plan, which were agreed.

Neil Gammon asked how many of the six draft reports had been completed since the completion of the progress report. Tom Watson confirmed that one further report had been finalised leaving five still to be finalised and also confirmed to Neil Gammon's query that the Internal Auditors work extends into the new financial year slightly to cover year-end timeframes and deadlines, so their work could run until the end of April which would still allow time for audit reviews to be finalised.

Andrew Smith noted the Procurement Compliance report where limited assurance had been given; referencing the external audit report which refers to the importance of the ARG Committee and Trust Board with respect to procurement processes. Andrew Smith asked what the concerns of Internal Audit were to give limited assurance and if there was anything that the Finance Directorate should be looking at specifically and also whether there could be an impact on statutory audit.

Tom Watson responded by advising that it was essentially what Ivan Pannell has been regularly reporting to the ARG Committee i.e. the position with the Contracts Database, with a number of contracts due to expire or already having expired necessitating a single tender procurement process, etc. Also issues around purchase order (PO) compliance, resulting in a need to ensure these are reported back to divisional level and Procurement needing to focus on that as well as the roll out of e-requisitioning. It was agreed that this will be picked up under the External Audit report update later on the agenda.

Andrew Smith asked Lee Bond if there were any problems at the year-end regarding procurement and Lee Bond confirmed that no problems had been encountered.

Lee Bond added that he was not surprised with the limited assurance rating for the Procurement Compliance Audit given the historic issues with capacity and staffing and explained that major development is required in the Procurement team which he anticipated would be commenced in 2021/22.

Neil Gammon asked if the Procurement team was now up to establishment or if a co-ordinated procurement exercise was to be carried out with HUTH. Lee Bond explained that he was hoping to get approval from York shortly to advertise for a Director of Procurement to coordinate the ICS procurement function of Hull, York and NLAG. Harrogate already buy in services from West Yorkshire so already have an ICS wide function so this is a longer term plan which will provide leadership and create a development plan. The NLAG Procurement team will carry on with day to day operational work and move forward with catalogues etc. in the meantime.

Andrew Smith referred to the Mental Health Act report (page 8 of summary) and asked if this should be highlighted to Quality & Safety Committee (Q&SC). Tom Watson confirmed that this was discussed at Q&SC and Mike Proctor as Chair is aware of the report. Andrew Smith proposed cross referencing to Q&S.

Action: Andrew Smith

The BAF review had been given significant assurance and Andrew Smith stated that this was pleasing to see but asked what the significant assurance was on. Tom Watson explained that there is clear national guidance on what should be included within the BAF which was all found to be in place so was based on that. Andrew Smith concluded that in process terms it was in a good place, but in development terms there was work to do. Tom Watson confirmed this assessment as correct, and added that the opinion is based on looking back over the previous year, acknowledging that the previous BAF document is currently in a state of change.

Andrew Smith referred to page 5 and the follow-up of limited assurance review, specifically Recruitment files and asked if there was anything that the Committee should be aware of in terms of progress. Tom Watson confirmed that this piece of work is finalised and would be tracked through the follow-up process. It had been given limited assurance the previous year and significant progress had not been seen and would be picked up later on the agenda in the Head of Internal Audit Opinion (HoIAO) section.

7.2 Internal Audit Recommendations Follow-up – Status Report

Tom Watson highlighted that good progress had been made and referred to the last ARG Committee meeting where it was requested that he catch up with Execs responsible for the long outstanding recommendations. Since the writing of this paper, Shaun Stacey had confirmed completion of the Operations Directorate recommendations. Tom Watson also highlighted that the last remaining recommendation from 2017/18 was now closed so reporting a slightly better position since the writing of the report. Tom Watson also noted that the HoIAO reflected slightly different follow-up information, as the HoIAO reflected recommendations that had been given revised target dates, which was not included in this report.

Lee Bond observed that there appeared to be a significant number of recommendations overdue prior to 2020 which was not an acceptable position. Lee Bond advised the Committee that the Execs with overdue recommendations were aware and working on them.

In terms of the medical recruitment files Lee Bond confirmed that he had spoken at length with Christine Brereton and was confident that these are included within the People Directorate's work programme over the next 12 months and anticipated a number, if not all, would be closed down. Lee Bond added that although he was not comfortable with the position he was getting more confident that overdue recommendations were being addressed.

Andrew Smith commented that he was in agreement with Lee bond and would like to see the numbers continue to decrease and will continue to track overdue recommendations at this Committee.

7.3 Insight Technical Updates Report

The report had been provided for information and was also circulated to all NEDs so nothing further to highlight. Andrew Smith commented that it was a really good read and a useful document.

7.4 Draft Internal Audit Plan

Andrew Smith noted that this was a good clear plan and asked for any comments from the Committee.

Neil Gammon queried the absence of system working, in terms of the ICS, within the Audit Plan and asked if this was something that should be addressed as the ICS is the direction of travel. Lee Bond suggested that he was not entirely sure that they were ready for that yet as he was unsure of what would be audited at this time. He added that the risk area is with the HASR process but with the creation of a Committee in Common felt that the governance processes were being strengthened. Neil Gammon acknowledged this but suggested in 18-month's time it could be felt that something was missed and asked if an audit of our deployment of resource to ensure that the Trust gets it right is required. Andrew Smith stated that he had pondered this area too, and accepted Lee Bond's point that timing is important but also felt that Neil Gammon made a good point so suggested that this should be kept under review.

Tom Watson explained that the draft plan had been reviewed by the Executive Directors and approval was being sought. Rob Pickersgill offered an observation that in Appendix C he noted that waiting list management was not included within the plan for 2021/22. Tom Watson explained that it was on the original ideas list but other audits were given priority when finalising the plan. Andrew Smith agreed with Rob Pickersgill and suggested that the question should be asked again about adding this back on the plan for 2021/22. Tom Watson suggested using the contingency days for this review, but Lee Bond proposed taking back to the Executive Team with a request from the ARG Committee that the waiting list audit is reintroduced into the plan and exchanged for something else, as he did not want to use contingency days just yet. Following the discussion the plan was approved subject to the possible changes discussed.

Action: Lee Bond

Neil Gammon commented that he had been at a meeting the previous day where it appeared that the Trust has a better grip on waiting list management and any clock stops are picked up straight away and suggested that it was going in the right direction and maybe that was why it was not felt to be a priority for inclusion in the 2020/21 audit plan. Lee Bond posed the question as to what assurance the Committee were after from such a review as it covers a multitude of areas, adding that it was a fundamental part of the organisation and recovery plans were in place. Andrew Smith agreed but would prefer to have that assurance evidenced that the grip is in place and suggested that the Committee would be looking for clarity on the risk of patient harm and how that is managed and also the size of the waiting list and recovery.

Tom Watson left the meeting.

Helen Kemp-Taylor concluded the discussion on the plan by commenting that they will be watching progress with the ICS closely and will talk to Lee Bond about some audit work in this area in due course, and bring this back to the Committee in due course.

5.4 Head of Internal Audit Opinion (HOIAO) - Draft

Helen Kemp-Taylor presented the draft Head of Internal Audit Opinion (HOIAO) and explained that the assessment was the same as last year but the context this year had been quite different and Internal Audit have worked with the Trust to reprioritise in-year. They had defined audits as 'must do's' and 'should do's' and had also completed two pieces of work around Covid-19. Helen Kemp-Taylor highlighted that whilst there were still three or four pieces of work to complete she felt that it should be recognised the work that had been completed, and that it was testament to both the Trust and to Tom Watson and his team to get the plan done given events of the last year. Significant Assurance had been given in the draft HoIAO that governance arrangements and internal control processes are fit for purpose.

Helen Kemp-Taylor noted that nine significant assurance opinions had been made with a further four reviews receiving limited assurance. The Data Security & Protection Toolkit stage one report was an advisory piece of work only. Procurement Compliance had already been referred to earlier on the agenda. The Mental Health Act audit, which Shaun Stacey had requested, would be reflected in the final HoIAO.

The final HOIA Opinion would be presented at the ARG Committee in June 2021 and Internal Audit will ensure that work with Executive Directors continues to address outstanding recommendations, including a number for the HR team which Christine Brereton is sighted on.

Andrew Smith commented that the document usefully pulled together all threads and issues discussed with Tom Watson earlier in the meeting. Andrew Smith asked how concerned should the ARG Committee be on the Data Security & Protection Toolkit review and Helen Kemp-Taylor advised that it was being completed in two stages, with stage one being to identify gaps, etc.

Following the discussion the draft HOIA Opinion was noted.

The Committee returned to the planned agenda running order at this point.

Item 3 04/21 **Minutes of the previous meeting**

The minutes from the public meeting held on 21 January 2021 were reviewed. Rob Pickersgill noted that his title stated that he was Lead Governor and should read Deputy Lead Governor. Subject to this amendment the minutes were accepted as a true record. Andrew Smith noted that an executive had raised a concern with him that previous minutes which correctly noted delays in the internal audit process appeared unduly negative towards executives; he sought confirmation that this was not the intention and was more a reflection of the unprecedented impact of Covid, no counter views were expressed.

The Highlight report for the Trust Board was also noted.

Item 4 04/21 **Matters Arising / Review of the Action Log**

The action log was reviewed as follows:

7.1 (15 06 20) – A&E: 4 Hour Wait Performance – Helen Kemp-Taylor to refer back to Tom Watson for further details, as he had left the meeting at this point. It was agreed to leave this action open until the next meeting.

6.8 (21 01 21) – Standards of Business Conduct Policy – Helen Harris advised that this was in progress. Andrew Smith asked when this would be completed and Helen Harris stated that it would be completed by the end of the following week and therefore should be completed by the next meeting.

8 (21 01 21) – Losses and Compensation Report:

- Reported Fridge losses – Lee Bond advised that this was still to be followed up with the Chief Pharmacist
- Doctors Travel Payment – Following the receipt of further information, this action to be closed.

9 (21.1.21) – BAF / SRR – Risk 3: Andrew Smith confirmed that this action had been completed and it was moving to the Finance and Performance Committee. Action to be closed.

Following the review the action log was noted.

4.1 Balance Sheet Control Accounts

Nicola Parker attended the meeting to present the paper following a question raised by Rob Pickersgill at a previous ARG Committee meeting. Andrew Smith commented that it was a really good paper and he had no questions. Rob Pickersgill confirmed that the paper answered his question and noted that reference is also made within the Internal Audit Report and thanked Nicola Parker for providing the update.

The paper was noted.

4.2 Amvale Contract Update

Ivan Pannell had provided a brief update on the Amvale Contract and Andrew Smith noted that the issues previously raised looked like they would be resolved with the provision of this contract. Lee Bond stated that it was disappointing that it had taken so long but there was now clarity of thought and anticipated that the contract would be in place by the end of October 2021. The Committee were content to close this item from the Action Log.

Item 5 04/21 Annual Governance Issues

5.1 Going Concern Report 2020/21

Andrew Smith commented that the document was very good and clear, and helped him understand the position. Lee Bond stated that whilst there are no problems envisaged over the next 6 months the following 6 months is an unknown, but added that as NHSE/I have issued a letter about continuity of service the annual accounts have been prepared on a going concern basis. Lee Bond asked if the External Auditors were in agreement with this.

Mike Norman stated that he was in absolute agreement with this, and added that it was a statutory instruction to prepare on a going concern basis, so no concerns.

5.2 Draft Annual Accounts 2020/21

Nicola Parker attended the meeting to present the draft Annual Accounts and had provided, for ease of reference, a summary at the beginning of the paper which listed key details to note contained within the accounts.

Nicola Parker took the Committee through the highlights of the Annual Accounts.

Andrew Smith thanked Nicola Parker for taking the Committee through the draft accounts and asked Lee Bond if he had anything to add. Lee Bond stated that the team had done a lot of work in pulling the draft accounts together and also added that confirmation from the Centre is still awaited around income.

Andrew Smith queried the bad debt provision for overseas charges and Nicola Parker explained that historically this had been a significant outstanding debt but the recovery rate is increasing. She explained that provision had been made within the accounts for those outstanding debts over 360 days and work will continue with recovery agencies and whilst they would not be written off, there remained a need to provide for them in the accounts.

Andrew Smith proposed including in the review of the Draft Annual Accounts in the highlight report to the Trust Board and Lee Bond agreed that this item and the Going Concern item should be highlighted.

Action: Highlight Report to Trust Board

5.3 Annual Governance Statement 2020/21

Helen Harris presented the draft document and advised that it had been reviewed by the Executive Directors and CEO with additional information still to be included i.e. Head of Internal Audit Opinion once finalised. Helen Harris added that there had been some additional changes since the draft document was issued for the ARG Committee papers and these would also be included in the final version.

Andrew Smith noted therefore, that the report had been brought to the Committee for information and challenge and sought comments from the Committee.

Neil Gammon advised that due to the late provision of the paper and still being in draft form he had not had time to read it and would pass on any comments to Helen Harris outside of the meeting.

Sally Stevenson noted that on page 22 i.e. systems and processes, the narrative was the same as the previous year which stated that *an independent review of RTT report was expected in May 2020* and asked if that should be amended. Sally Stevenson also highlighted on page 25 RTT follow ups which stated that *during the year this had improved* and asked if that was correct. Helen Harris advised that Shaun Stacey had provided further updates since the paper was circulated. There were other amendments/typos and Sally Stevenson agreed to feedback to Helen Harris via email.

Mike Norman also stated that Mazars would review the document and feedback any comments.

Andrew Smith advised that he had reviewed the HOIA Opinion and those issues from the External Audit progress report and took comfort that it had been cross referenced. The draft AGS was noted subject to other ARG Committee colleagues reviewing and feeding back to Helen Harris with any comments/concerns after the meeting.

Action: All

Item 6 04/21 **External Audit (Mazars)**

6.1 Progress Report

Mike Norman introduced himself as the new External Audit manager for the Trust following a shuffle at Mazars. Mike Norman presented the report and highlighted key messages including that there were no fundamental changes to the risks identified and the auditors were in a good place to start their detailed work and present the final report to the June 2021 ARG Committee meeting. Discussions had been held around the accounting issues, some of which were highlighted by Nicola Parker and Mike Norman confirmed that they were entirely consistent with the national picture.

Mike Norman referred to the reference to the procurement compliance report made earlier by Internal Audit and the limited assurance rating, but he did not envisage this would impact directly on their audit of the draft accounts.

Andrew Smith commented that the report was very useful and asked if they were happy with the submission deadlines. Mike Norman confirmed that the deadlines would be met and they would not be seeking an extension, adding that they are only granted on very limited grounds, and also confirmed that the year-end inventory would remain immaterial.

Lee Bond asked if the timescales for the audit were sufficient given the number of clients that Mazars have. Mike Norman confirmed that work had already commenced with a resourced plan in place including an interim visit on site, with around three weeks' worth of work which would take them towards the end of May with the formal reporting through to June 2021. Unlike last year, remote working is not an issue as they are well experienced in this now and therefore did not need to flag any concerns around achieving the timescales.

Item 8 04/21 **Counter Fraud**

8.1 LCFS Progress Report

Nicki Foley presented the report which was taken as read and she highlighted specific items to note.

The new Government Counter Fraud Functional Standard came into effect in April 2021 which requires a review for compliance against the new standards and an assessment against the previous year, even though they have not been in place throughout 2020/21. The Functional Standard return, which is a self-assessment exercise similar to the old Self-Review Tool (SRT) exercise, is due for submission to the NHSCFA at the end of May 2021. Nicki Foley advised that given this is a transitional year, there is an expectation from the NHSCFA that there would be some red and amber areas within the return where the Trust is not wholly compliant with the new standards. The May 2021 submission would still require sign off by the Chief Financial Officer and the ARG Committee Chair, in line with the former SRT process.

Nicki Foley explained that an action from the previous meeting in January 2021 was to reflect on the impact of Covid-19 on counter fraud at a local level, stating that this was documented on page 8 of the report. Nicki Foley commented on the obvious changes in terms of working from home and potential problems liaising with people, but this had not proved overly problematic. Nicki Foley also advised that she had managed to still conduct an interview under caution, applying all necessary Humberside Police Covid-19 guidance, etc. Nicki Foley stated that there had been an avalanche of intelligence and awareness received during the pandemic, and she had liaised with the relevant teams where there was the potential for heightened fraud risks.

On a final note, Nick Foley informed the Committee that at the outset of the pandemic there was an expectation that fraud referrals may increase, but that did not materialise, although she added that there was still the potential for fraud issues to come to light.

Following the update the report was noted.

8.2 Counter Fraud Operational Plan 2021/22

Nicki Foley presented the Counter Fraud Operational Plan for 2021/22, with suggested actions being worked on over the coming year, and noted that it is aligned to the new Functional Standards. It had been signed off the Chief Financial Officer and the Assistant Director of Finance – Compliance and Counter Fraud.

Nicki Foley highlighted that the value of fraud prevented would now be captured going forward following the introduction of the new national case management system, CLUE.

Andrew Smith queried if there was any relevance to the colours assigned to the different sections of the operational plan and Nicki Foley confirmed that there was not, it was simply presentational.

Andrew Smith asked if any support was required from the Committee to ensure traction and progress is made on the new standards. Nicki Foley advised that all actions are included in the routine quarterly progress reports to the Committee and therefore all requirements for the standards should be covered, along with monitoring by her.

Following review the report was noted.

8.3 Local Counter Fraud, Bribery and Corruption Policy and Response Plan

Nicki Foley informed the Committee that the policy document had been subject to its annual review and as a result had been updated with only minor changes made i.e. job titles, change made from NHS Provider Standards with the new Functional Standard and some links updated. Following review the Policy was approved.

Item 9 04/21 Review of Board Assurance Framework (BAF) and Strategic Risk Register

9.1 Review of BAF and Strategic Risk Register – Risk Appetite Statement – Current Position

Andrew Smith noted that the draft BAF report was much more succinct and suggested taking both items 9.1 and 9.2 together.

Helen Harris presented the reports and explained that the first report (9.1) gave an overview from May 2019 to March 2021 and where the current risks were and are now and is based on the previous BAF.

Helen Harris highlighted specifically that there were two strategic risks that achieved the target risk scoring i.e. Risk of Ineffective Relationships with Stakeholders (Strategic Objective 4); and Risk of Insufficient Investment and Development of the Trust's Leadership (Strategic Objective 5). In Appendix A of the report there were eight strategic risks that would remain high due to Covid-19 and therefore no particular movement in those.

Helen Harris also noted that the BAF is reviewed through other Board sub-committees but had had different oversight over the last couple of months due to the significant amount of work revising the document.

9.2 Review of BAF and Strategic Risk Register - The Future

Helen Harris advised that following the review of the strategic objectives, scoring and risk appetite at the Trust Board she was now in the process, with all Directors and Deputies, of working up the detail behind each strategic risk. This will then be reported to the Trust Board and brought back to each sub-committee, probably on a quarterly basis, and reported regularly to ARG Committee. Whilst the BAF document is currently a work in progress Helen Harris thanked the Trust Board, as a tremendous amount of work had been done to get it to its current state, and hoped that it would provide a level of assurance in terms of the progress made.

11.20am Sue Meakin joined the meeting.

Neil Gammon commented that there had been a huge amount of work, learning and re-adjustment and referred to the first document (9.1) and the achievement of the two strategic risks as described by Helen Harris, stating that he could only find one and questioned the scoring on Appendix A. Andrew Smith queried the strategic objective 5 risk appetite score on item 9.2 and Helen Harris advised that she had updated this since the paper was produced. A discussion ensued on the challenge of identifying risks and issues as the BAF is revised.

Andrew Smith agreed that significant progress has been made in defining the strategic appetite and range but as discussed at the Finance & Performance Committee the meaning of giving a rating of 20 needs to be considered carefully. Andrew Smith also noted on page 2 of item 9.1 scores of 15 and above and asked that consideration be given going forward if these are risks or issues.

It was suggested that it should be highlighted to the Trust Board that the ARG Committee were interested in the evolution of the risk scoring and keeping this under review.

11.25am Dr Kate Wood joined the meeting.

Lee Bond commented that he was not sure if he was on the same page as Andrew Smith's comments, adding that he had sat on provider Trust Boards for 15 years and when he sees a BAF at the Audit Committee he asks himself what is it doing there. Lee Bond went on to say that an Audit Committee's terms of reference say that the Committee's responsibility is to oversee the system of control/governance, and the BAF is a useful tool in this process, but he was interested in the Chair's view of the BAF at the ARG Committee. Andrew Smith responded by stating that the Committee need to keep an oversight of it as it evolves to ensure that it does the job it needs to do. Andrew Smith asked if not here in terms of governance where else would it have the oversight.

Rob Pickersgill stated that the BAF has been a source of frustration as it is not clear and is clogged up. He agreed with earlier comments that risks and issues are confused and suggested that some of the risks should emerge from the project reports in what they are going to do, giving an example of scanners. Lee Bond did not entirely agree with the example given stating that it is a risk if the service fails as well as the financial risks as equipment is kept longer than its usual life-span. Rob Pickersgill stated that he felt that objectives were not drawn out and that issues were masking risks, questioning what scope there was for changing the format. He suggested that maybe this should be at the Finance & Performance Committee, adding there was a need to analyse resilience and it needed more emphasis given the last year

Michael Whitworth, whilst acknowledging Lee Bond's point but also agreeing with Rob Pickersgill, did think there were issues and informed the Committee that the Workforce Committee do perform deep dives into areas of the BAF which relate to that Committee. He added that the role of the ARG Committee is to have oversight of what other sub-committees are doing.

9.3 Progress Against the Risk Strategy

Dr Kate Wood attended the meeting along with Angie Legge to present the report.

Angie Legge advised that some progress had been made but had subsequently stalled due to Covid-19 but this was now being progressed again. She briefly outlined the work that the Divisions had been doing and how this was now being progressed with the support of NHSE/I who did a piece of work which had been incorporated into the report. Angie Legge went on to explain that they were now running risk clinics supported by NHSE/I, as well as providing facilitated risk identification sessions. Training sessions have now been rebooked which will widen the basic understanding of risk across the Trust, and they will also be looking to see if more training is needed at a deeper level. Workshops are planned using the Manchester Patient Safety Framework, which Angie Legge stated are a great way to look at risk maturity and along with the Internal Audit report will identify the areas of revision required within the Risk Management Strategy.

Angie Legge confirmed to Andrew Smith that corporate functions are included in the Risk Clinics and not just Divisions.

Andrew Smith stated that he was surprised that it was a five year plan and queried if it would really take that long. Angie Legge stated that the original Risk Strategy was approved for a five year period and that it was designed to be a five year plan and reviewed after the three year point, but acknowledged that it should have been a three year plan at the outset. Dr Wood added that they were given a very clear steer when they took over responsibility for the strategy that it should be for the five years. Andrew Smith asked who gave this steer, and Dr Wood confirmed that it was the Director of Strategy at that time.

Andrew Smith queried if it needed a further refresh now given the Trust's new risk appetite statement and Angie Legge agreed that she would be happy to do that in terms of overarching refresh and rewrite but would like the Internal Audit report and Manchester Patient Safety Framework done first to help inform those changes. Dr Wood agreed that given the changes to timescales as a result of Covid-19 and the discussions with Internal Audit it would be more sensible to wait for those results. Helen Harris supported this approach and suggested waiting at least six months before making the changes and bringing it back to the Committee.

Andrew Smith suggested adding progress on the Risk Strategy on the ARG Committee agenda and Neil Gammon commented that bearing in mind the fundamental nature of risk, this could be included as a standing agenda item on the Committee's work plan to monitor that progress remains on track.

Dr Wood advised that, for the avoidance of any doubt, there is already a comprehensive Risk Strategy in place and the development plan presented to the Committee today was to improve understanding and use of risk management within the organisation. Angie Legge agreed to provide Andrew Smith with the current Risk Strategy.

Action: Angie Legge

It was also agreed to add to the work plan for ongoing monitoring purposes and to add to the highlight report for the Trust Board.

Action: Sally Stevenson

11.2 CQC Statement of Purpose

Angie Legge presented the report and highlighted that the Statement of Purpose is annually refreshed, but had been done early to now include reference to the Trust's Covid-19 vaccination hubs as advised by CQC but no other changes have been made. Angie Legge confirmed that the updated document had been approved for submission by Tony Bramley as the ARG Committee Chair at the time. The Statement of Purpose remains under constant review.

Andrew Smith asked Angie Legge to explain the purpose of the document and Angie Legge advised that it was a set template for providing details of what services the Trust provides on each of its sites.

Lee Bond questioned the rationale for this being brought to the ARG Committee as he suggested it was Trust business. Sally Stevenson explained that it was a document previously taken to the Trust Governance and Assurance Committee for review and approval, but when that Committee was abolished a mapping exercise was performed by the then Trust Secretary and this item came across to the ARG Committee. Lee Bond commented that he had never seen this item at another Audit Committee, although he was not saying it was necessarily wrong, just that it seemed an operational form filling task.

The Statement of Purpose was approved, but with a question as to the need for it to be brought to ARG Committee.

Post meeting note: Angie Legge, Dr Wood and Helen Harris discussed this on email following the meeting and it was agreed that it would in future go to the Trust Management Board for sign off and then to the Trust Board. Helen Harris agreed to document this on the Annual Cycle of Business.

Dr Wood and Angie Legge left the meeting.

Item 10 04/21 Losses and Compensations Report

Lee Bond presented the report and highlighted specific points to note, including:

- Sustained improvement in losses, compensation and special payments over the last three years and now amounted to £54.4k.
- £22k attributed to Pharmacy waste and the organisation is very diligent how it reports this.
- £12.5k attributed to bad debts relating to overseas visitors. A national system is in place to try and identify overseas visitors before they arrive into hospitals but some are emergencies and therefore costs are difficult to recover.
- Overpayment of salaries referred to two cases where recovery of the costs had been unsuccessful amounting to £5.8k.

Lee Bond added that the report is brought to the Committee for information and suggested that the financial controls and procedures are operating effectively.

Item 11 04/21 Management Reports for Assurance – Items for Approval

11.1 Annual Health and Safety Policy Statement

There were no comments raised and the Policy Statement was approved.

11.2 Annual Review of CQC Statement of Purpose

Discussed and approved earlier on the agenda.

Item 12 04/21 Management Reports for Assurance

12.1 Quarterly Document Control Report

Alison Hurley had joined the meeting to present the report and highlighted an improved position with overdue documents now at 102 from 293 in January 2021. There were 146 documents coming up for review in the next three months. The report also included risk stratification in terms of patient safety, clinical risk or other risk.

The report was provided for information and was noted.

12.2 IG Steering Group Highlight Report

Sue Meakin attended the meeting to present the report which was taken as read and she highlighted specific areas to note. The Data Security & Protection Toolkit Improvement Plan had been shared with NHS Digital in February 2021 and once feedback is received will share with the ARG Committee. Sue Meakin also advised the Committee that there had been a new ICO referral the previous week and would update the Committee in due course.

The report included the various ongoing Information Governance workstreams undertaken by the team.

Andrew Smith queried if the new ICO referral featured in the AGS, which Helen Harris agreed to check.

Action: Helen Harris

Lee Bond queried if Freedom of Information came under the IG Steering Group's remit. Sue Meakin advised that she is having conversations with Ade Beddow, who is responsible for FOI requests within the Trust, as historically a report was taken to the Steering Group and she is looking to reinstate that so that the information is captured.

Lee Bond asked whether there was a risk assessment process for incidents before they are reported to the ICO. . Sue Meakin confirmed that there was and explained that there is a matrix designed to work out the impact and risk to an individual, and that there is a specific one for data incidents that are referred to ICO. Lee Bond then asked who conducted the risk assessment process and Sue Meakin confirmed that it was her as the Trust's Data Protection Officer, following which it goes to Shauna McMahon as the Trust's SIRO and then to the CEO.

Following review the report was noted.

12.3 Waiving of Standing Orders

Ivan Pannell presented the report which showed a significant amount of activity in the last quarter given the need to spend capital before the end of March 2021. A full procurement process had not been undertaken due to time constraints but had gone through correct waiver processes. There were two waivers rejected i.e. items already on site and in use before Procurement were made aware, with a retrospective waiver subsequently rejected as this was a breach of SFIs. The division in question were made aware of their responsibilities of complying with the process. The other rejected waiver was also as a result of paperwork not received by Procurement until the day

before the service was due to finish and the necessary sign-off of the waiver and the requisition had been completed.

Lee Bond stated that Ivan Pannell chases diligently to ensure the timely sign off of waivers by him, adding that the waiver process works.

Following the update and review the report was noted.

12.4 Invoices without Purchase Orders Report

Ivan Pannell presented the report and apologised that the data for March 2021 was not available at the time of report submission and therefore the figures for January and February 2021 were provided. He went on to report that whilst the number of invoices coming through is on an even track, there was no huge progress in the position of the outliers as detailed at the last meeting and will need to set some priorities and targets for these.

In March 2021 there was significant spend on capital with all activity going through on a purchase order i.e. £43m which is usually around £10m-£13m, so a significant increase, and Ivan Pannell confirmed that all were processed with the right governance arrangements.

12.5 Contract Progress Report

Ivan Pannell reported that some small progress had been made in the last quarter with the MRI / CT provision being significant pieces of work at rapid pace. The new contract for car parking and security services scheduled to commence on 1 July 2021 was also another significant piece of work undertaken by the team jointly with Estates and Facilities.

Ivan Pannell advised that there are 89 contracts due for renewal over the coming year with some of those of high value which is a concern in terms of capacity. Mitigation plans are in place for those.

Andrew Smith thanked Ivan Pannell for the clear reports presented and they were duly noted.

12.6 Salary Overpayments Report

Sally Stevenson presented the report and highlighted that there had been a £15k decrease in the value of overpayments for Q4 from £90k in Q3 to £75k in Q4 2020/21.

Sally Stevenson noted that it was disappointing to note the annual figure of £455k was the highest value for several years and whilst the annual figures were decreasing in recent years, had now increased and there are still issues with late termination forms. Internal Audit recommendations suggested more publicity around the late forms being submitted, and this has been done in the past and is about to be done again. Currently there is a mix of issues with ESR manager self-service and paper copies of forms.

Sally Stevenson also highlighted the number of advances made due to the lack of bank account details on ESR manager self-service and discussions are taking place with the Bank office / HR colleagues to address those.

Lee Bond commented that there is a good track record of recovering money when an overpayment has been made, with low levels of associated write-offs, but there is an impact on the organisation and should be avoided where possible.

The report was noted.

12.7 Hospitality and Sponsorship Declarations

Helen Harris presented the report which detailed all hospitality, sponsorship and gifts declared by staff for 2020/21. Helen Harris advised that the development of the new electronic system is progressing and will be rolled out across the Trust once finalised.

There were no questions and the report was noted.

12.8 LSMS Annual Work Plan

The LSMS Annual Work Plan was brought to the Committee for information only and was therefore noted.

Item 13 04/21 Action Logs & Highlight Reports from other Board Sub-Committees

The action logs and highlight reports from the following Board Sub-Committees were provided:

13.1 Finance & Performance Committee
13.2 Quality & Safety Committee
13.3 Workforce Committee
13.4 Health Tree Foundation Committee
13.5 RATS Committee
13.6 Ethics Committee

There was nothing further to add from the individual Committee Chairs and the papers were noted.

Item 14 04/21 Any Other Business

14.1 There was no urgent business raised.

Item 15 04/21 Matters for Escalation to the Trust Board

The following items were agreed to highlight to the Trust Board:

- Draft Annual Accounts 2020/21
- Going Concern Report 2020/21
- Risk Strategy

Item 16 04/21 Matters to Highlight to other Trust Board Assurance Committees

Andrew Smith to cross reference the Mental Health Act with Quality & Safety Committee.

Action: Andrew Smith

Item 17 04/21 Review of ARG Committee Workplan

It had been agreed to include monitoring of the Risk Strategy development plan on the work plan.

Action: Sally Stevenson

As all sub-committees work plans would be reviewed in July/August 2021 the ARG Committee work plan was noted.

At this point Auditors from both Internal Audit and External Audit left the meeting in order to discuss the next item in private.

The following items were discussed following the Private agenda item

Item 18 04/21 **Review of the Meeting**

Andrew Smith, as Chair of the ARG Committee for the first time, thanked everyone for their clear and useful papers. He asked that if anyone had any feedback for him to please let him know.

Lee Bond commented, using the CQC paper as an example that the Trust needs to challenge why we do things and equally ask if we are missing things at meetings. He added that in terms of the four pillars of governance think the assurances are there so hopefully NEDs can conclude that everything is operating effectively.

Andrew Smith agreed with Lee Bond's comments and said that this challenge would be performed at the agenda setting meetings.

Rob Pickersgill noted that in terms of the earlier item relating to Internal Audit assurance ratings he was surprised to see the CQC compliance was now green noting the last time this was looked at by Governors it was not, so assumed there had been progress over the last year.

Andrew Smith, before closing the meeting advised that this would be Neil Gammon's last ARG Committee meeting and wished to place on record his thanks for everything that Neil Gammon had done for the Committee, adding that his wise and calm ways would be missed.

Item 21 04/21 **Date and Time of the next meeting**

Thursday, 3 June 2021 (Final Accounts only) – 2.00pm-3.30pm – via Teams Meeting

NLG(20)183

Northern Lincolnshire and Goole NHS Foundation Trust

DATE	3rd August 2021
REPORT FOR	Trust Board of Directors – Public
REPORT FROM	Andrew Smith, Chair of Audit, Risk and Governance Committee
CONTACT OFFICER	Lee Bond, Chief Financial Officer
SUBJECT	**Audit, Risk and Governance Committee Annual Report 2020-21**
BACKGROUND DOCUMENT (if any)	HFMA Handbook 2018
PURPOSE OF REPORT	For Noting 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 annual report summarises the key work of the Audit, Risk and Governance Committee during 2020/21. It contains details of membership and attendance at each meeting throughout the year, the principal areas of review undertaken by the Committee in terms of governance, risk management and internal control. It also summarises the impact of Covid-19 on the Committee's business during 2020/21. Appendix 1 details attendees at meetings, either members, regular attendees or ad-hoc attendees. Appendix 2 is the Committee's annual rolling work plan for 2021/22. This report is presented to both the Trust Board and the Council of Governors for information.

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)	
TRUST BOARD ACTION REQUIRED	**The Trust Board is asked to note the annual report from the Audit, Risk and Governance Committee.**

Northern Lincolnshire and Goole NHS Foundation Trust

AUDIT, RISK AND GOVERNANCE COMMITTEE

ANNUAL REPORT

FOR THE YEAR ENDED 31ST MARCH 2021

Andrew Smith – Non-Executive Director
Chair of Audit, Risk and Governance Committee

3rd June 2021

1. Introduction and Purpose of the Report

The Audit, Risk and Governance Committee of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is established under Trust Board delegation with approved terms of reference that are aligned with the latest Audit Committee Handbook (2018), as published by the Healthcare Financial Management Association (HFMA) in association with the Department of Health. The Audit, Risk and Governance Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes.

This report sets out how the Committee has satisfied its terms of reference during 2020/21 and seeks to provide the Board with evidence relevant to its responsibilities for the Annual Governance Statement (AGS).

2. Terms of Reference

The Membership and Terms of Reference for the Committee are subject to regular review and revision as necessary, most recently in January 2021 for limited minor updates. The February 2021 Trust Board subsequently ratified the revised terms of reference for a further year. The terms of reference will be reviewed again during 2021/22 in line with the Committee's annual work plan to consider whether they remain fit for purpose. The Committee also revisited and re-approved adjustments to its rolling 2020/21 annual work plan during the year.

In terms of the impact of Covid-19 on the Committee's business, additions were made to the terms of reference of the Committee in April 2020 in order to: reduce attendance at meetings; make the frequency of meetings flexible and responsive; add to its responsibilities the oversight of the new temporary governance arrangements proposed for the Trust; manage the relationship with both the External and Internal Audit services appropriately; increase the emphasis on counter fraud and anti-theft preparedness; focus on the changing risks in the Board Assurance Framework; and undertake a risk-based review of the Committee's Work Plan. Additionally, appropriate adjustments were made to the format and content of the Committee's agenda along with the introduction of a specific 'Discussion and Decision Log During C-19 Governance' (adopted by all Board Sub-Committees). The additional provisions were included as an annex to the existing terms of reference, and remain within the current document to enable them to be invoked with the explicit discretion of the Trust Board as necessary going forward.

As part of the Committee's regular review of its own governance arrangements, it undertook a self-assessment exercise in January 2021 using the latest HFMA NHS Audit Committee Handbook self-assessment checklist. This exercise did not identify any significant gaps in the Committee's processes or terms of reference. The results of this latest exercise were submitted to the Trust Board for information in February 2021.

3. Membership and Attendance

The Committee consists of three non-executive directors (NEDs), of which two must be present at a meeting of the Committee for it to be quorate. The Committee has been chaired by Andrew Smith, NED, since February 2021, having previously been chaired by Tony Bramley, NED, from July 2019 to January 2021. NED members during the year were Michael Whitworth (Vice Chair) and Neil Gammon (who ended his current term at the April 2021 meeting). An Associate NED, Stuart Hall (Vice Chair at Hull University Teaching Hospitals NHS Trust), also attends the Committee. There is cross NED membership with other Trust Board sub-committees.

The Committee continued to meet, albeit virtually, during the Covid-19 pandemic throughout 2020/21. The virtual meetings format has worked well, with ad-hoc attendees dialling in only for their item in line with their allocated time slot.

The Committee met on five occasions (four full meetings plus an additional meeting for the audited accounts to be approved) during 2020/21 and has discharged its responsibilities for scrutinising risks and controls that affect all aspects of the Trust's business.

A record of attendance by Committee members and regular attendees is provided at **Appendix 1**. The record shows excellent attendance from both core members and regular attendees, with a good cross section of other managers attending on an ad-hoc basis to provide assurance to the Committee on various matters as and when necessary.

4. Principal Review Areas

3.1 Governance, Risk Management and Internal Control

During 2020/21 the Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS), the Head of Internal Audit Opinion (HoIAO), External Audit opinion and other appropriate independent assurances. The Committee considers that the AGS for 2020/21 is consistent with the Committee's view on the Trust's system of internal control.

The Committee received regular reports during the year on the Trust's Board Assurance Framework and Strategic Risk Register (BAF/SRR). As well as being informed that the BAF/SRR was being subject to a full review with a view to streamlining it, the Committee also reviewed and commented on certain risks and their associated scores contained within it.

3.2 Internal Audit

The Trust's internal audit service is provided by Audit Yorkshire, who replaced KPMG on the 1st June 2018, following a competitive procurement exercise in early 2018. The contract for the internal audit service is for a period of three years, with the option to extend for a fourth and final year. The extension option was discussed and approved at the October 2020 meeting of the Committee, meaning that 2021/22 will be the fourth and final year of the contract. An agreed Internal Audit Charter is in place with Audit Yorkshire.

The Committee received the Annual Internal Audit Report for 2019/20 from its internal auditors at its June 2020 meeting.

An internal audit plan was considered and agreed for 2020/21 at the January 2020 meeting of the Committee. As in previous years, the Committee has sought to work effectively with Internal Audit throughout the year to review, assess and develop internal control processes as necessary. The Committee reviewed progress against the agreed internal audit work plan for 2020/21 via routine written progress reports from its internal auditor at each meeting, at which an internal audit representative was always present. Written progress reports outline the status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate.

Clearly the Covid-19 pandemic caused some issues for the internal audit team, in terms of delays to certain planned audits, increased operational pressures on Trust staff providing

information/data for audits and Audit Yorkshire also having to adapt their working practices to remote working and virtual meetings. During the year Audit Yorkshire reviewed all remaining planned audits and considered them in terms of 'must do' and 'should do' audits to ensure that a meaningful Head of Internal Audit Opinion could be achieved at the end of 2020/21. Despite the difficulties of the pandemic, at the time of preparing this report the internal audit plan for the year was substantially complete.

During 2020/21 Internal Audit completed 20 reviews (19 reports, as one report combined two linked reviews), of which 3 were pieces of advisory work and an assurance rating not applied. Assurance ratings, as to the adequacy and effectiveness of control arrangements in place, for the remaining 17 reviews were as follows:

- 0 reviews with High Assurance rating;
- 12 reviews with Significant Assurance rating;
- 5 reviews with Limited Assurance rating;
- 0 with Low Assurance rating;

The 2020/21 Head of Internal Audit Opinion was also received by the Committee which gave an overall opinion as follows: ***Significant assurance*** *can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently*. The 2020/21 HoIAO is included within the AGS, which forms part of the Trust's Annual Report.

The Trust also formulated its annual internal audit plan for 2021/22. The Executive Team provided suggestions for the plan and these were then discussed further between them and refined into a programme of audits for the forthcoming year. The proposed internal audit plan for 2021/22 was presented to the April 2021 meeting of the Committee for consideration and approval.

Audit Yorkshire operates an electronic follow-up process for all recommendations made, which involves the relevant managers providing periodic updates and evidence, via the electronic system, in support of all recommendations considered to be closed. Details of overdue recommendations were also provided to the relevant Executive Directors with a view to addressing these as appropriate. A routine report is prepared by Audit Yorkshire to show the status of recommendations made, and this is presented to each meeting of the Committee for assurance or the consideration of action as appropriate.

3.3 Counter Fraud

The Audit, Risk and Governance Committee continued to receive regular written progress reports from the Trust's Local Counter Fraud Specialist (LCFS) throughout the year. Additionally the Annual Counter Fraud Report for 2019/20 and the Annual Counter Fraud Operational Plan for 2020/21 were also submitted to the Committee during the reporting year.

The Committee noted the heightened efforts of the LCFS during the year to promote awareness of counter-fraud issues resulting from the increased risk of fraud relating to Covid-19. Such awareness was undertaken both generally throughout the organisation and also by employing targeted awareness at those areas/teams at greater risk during the pandemic. The Counter Fraud Operational Plan for 2020/21 and the local Fraud Risk Assessment were both revisited in light of the increased risk of fraud threats emerging from the pandemic.

The LCFS continues to develop a strong anti-fraud culture, whilst at the same time investigating allegations of fraud to a criminal standard. The LCFS also continued to liaise effectively with the Trust's Human Resources team with a view to applying appropriate internal disciplinary and sanctions as necessary. A staff fraud awareness survey is being performed in May 2021 to assess awareness and understanding of NHS fraud issues and the results, and any associated action plan, will be received by the Committee.

The Trust continues to host and manage an in-house counter fraud collaborative, known as Counter Fraud Plus (CFP) between itself, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust. This collaborative arrangement commenced in July 2013 under a formal SLA arrangement. It is designed to provide a more resilient counter fraud service between the organisations involved. In September 2020 the collaborative arrangement expanded to include two other Lincolnshire Trusts, namely Lincolnshire Partnership NHS Foundation Trust and Lincolnshire Community Health Services NHS Trust, after they expressed a desire to join the collaborative. The Committee has received reports that the collaborative continues to work effectively and successfully across all five local organisations.

3.4 External Audit

The Trust appointed its current External Auditor, Mazars, in September 2019 following a tendering exercise. Mazars took over from PwC, who had been the Trust's External Auditors since 2012 (having been re-appointed in September 2016, again following a mini-tendering exercise). The Committee once again duly supported the Council of Governors with this latest appointment process. The existing contract is for a term of three years, with the option to extend for a further year, and commenced with the audit of the Trust's financial statements for 2019/20. The Trust's External Auditor attended all meetings of the Committee during 2020/21. Oral or written progress reports are received from the Trust's External Auditor at Committee meetings, including the audit opinion on the Trust's annual financial statements.

In line with Regulator guidance, the Trust has a '*Policy for Engagement of External Auditors for Non-Audit Work*' to avoid any potential conflicts of interest, either real or perceived, in terms of the objectivity of their opinion on the financial statements of the Trust. The policy, which can be found on the documents section of the Trust intranet, is subject to annual review and revisions were duly considered by the Committee at its January 2021 meeting and submitted to the Trust Board for information at its February 2021 meeting. The value of non-audit services is routinely disclosed in the Trust's accounts, however there was no such work performed by Mazars during 2020/21.

During the year a private meeting with both the external and internal auditors took place before the May 2020 meeting of the Committee. In this private meeting the auditors expressed satisfaction with the level of cooperation received from the Trust, and no matters of concern have been raised. However in line with its Terms of Reference, there is an open offer to all parties (the Trust, external auditors and internal auditors) to request a private meeting at any time.

The Committee also formally considered the performance of the Trust's External Auditor at its July 2020 meeting following the conclusion of their year end accounts work. No issues of concern were identified as part of the evaluation, and this was particularly notable given the emerging and significant impact of Covid-19 on the year end accounts and audit process.

5. Financial Reporting

At its April and June 2020 meetings the Committee reviewed the draft and audited annual financial statements for 2019/20 before submission to the External Auditor, the Trust Board and NHS England / Improvement (NHSE/I), and we understand these were in agreement with our accounting records and the current Regulatory requirements.

Prior to the preparation of the 2020/21 financial statements, the Committee reviewed and agreed the detailed accounting principles at its January 2021 meeting. The Committee also reviewed the draft and audited annual financial statements for 2020/21 prior to the anticipated submission of this report to the August 2021 Trust Board meeting. The Committee approved the 2020/21 financial statements on behalf of the Trust Board (in line with formal delegated authority given by the Board in February 2021), which are due for submission to NHSE/I by the national deadline of noon on Tuesday 15th June 2021.

At the April 2021 Committee meeting the issue of 'Going Concern' status was discussed with the External Auditor. As a result the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise, and this was agreed by the External Auditor.

6. Management Reports

The Committee has requested and reviewed various management assurance reports from a range of directors and managers within the organisation in relation to relevant areas of enquiry during the financial year 2020/21. We thank all those who have assisted the Committee in these matters, particularly given the operational pressures arising from the Covid-19 pandemic.

7. Other Matters Worthy of Note

The Committee followed its agreed annual work plan throughout the year and received regular reports covering Waiving of Standing Orders; Losses and Compensations; Hospitality and Sponsorship declarations; Orders placed with and without Purchase Orders; Salary Overpayments; and Document Control. Additional information is called for as appropriate.

The Committee once again received the Local Security Management Specialist (LSMS) work plan and annual report for information and assurance.

Throughout the year the Committee also received the highlight reports and action logs from the Trust's main assurance Trust Board sub-committees in order to assess the effectiveness of the Trust's governance arrangements.

Minutes of the Committee's meetings and a Chair's Highlight Report of matters to be escalated are submitted to the Trust Board for information, assurance or decision as necessary.

The Committee members would like to place on record their thanks to the Trust's external auditors (Mazars), internal auditors (Audit Yorkshire), and our in-house counter-fraud service. All have provided a professional and effective service throughout an unprecedented and challenging 2020/21.

8. Conclusion and Plans for 2021/22

The Audit, Risk and Governance Committee's refreshed work plan for 2021/22 is attached at **Appendix 2**.

The Council of Governors will also receive a copy of this annual report and work plan.

The Committee will remain active in reviewing the risks, internal controls, reports of auditors and audit recommendations and will continue to press for action and improvements where required throughout the coming year.

Appendix 1 - Schedule of Attendance at Audit Committee meetings during 2020/21

Member / Attendee	Apr-20	Jun-20	Jul-20	Oct-20	Jan-21
Members:					
Tony Bramley – NED / Chair (up to and inc. Jan21)	Y	Y	Y	Y	Y
Michael Whitworth – NED / Deputy Chair	Y	Y	Y	Y	Y
Neil Gammon – NED	Y	Y	N	N	Y
Associate Members (not forming part of quorum):					
Stuart Hall – Associate NED, NLAG / Vice Chair, HUTH	-	Y	Y	Y	Y
Andrew Smith – Associate NED	-	-	-	Y	Y
Regular Attendees:					
Jim Hayburn – Interim Director of Finance (to Sept20)	Y	Y	Y	-	-
Lee Bond – Chief Financial Officer (from Oct20)	-	-	-	N[3]	Y
Wendy Booth –Trust Secretary (to May20)	Y	-	-	-	-
Helen Harris – Trust Secretary (from Jun20)	-	Y	Y	Y	Y
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	N	Y	Y	Y	Y
Nicki Foley – Local Counter Fraud Specialist	Y	N/A[2]	Y	Y	Y
Data Protection Officer and Lead for IT (SM)	N[1]	N/A[2]	Y	Y	Y
Head of Procurement (IP)	N[1]	N/A[2]	Y	Y	Y
Internal Audit	Y	Y	Y	Y	Y
External Audit	Y	Y	Y	Y	Y
Ad-hoc Attendees:					
Asst. DoF – Process & Control (NP)	Y	Y	-	-	Y
CEO (PR)	-	Y	-	-	
EPR & Business Continuity Manager (GJ)	-	-	Y	-	-
Associate Director of Quality Governance (AL)	-	-	Y	-	-
Deputy Director Director of Estates & Facilities (ST)	-	-	Y	-	-

Member / Attendee	Apr-20	Jun-20	Jul-20	Oct-20	Jan-21
Membership Manager (AH)	-	-	**Y**	**Y**	**Y**
Freedom to Speak Up Guardian (LH)	-	-	-	**Y**	-
Deputy Director of Finance (BS)	-	-	-	**Y**	-
Chief Information Officer (SM)	-	-	-	-	**Y**
Associate Director of IM&T (SM)	-	-	-	-	**Y**
IT Data Security Manager (TF)	-	-	-	-	**Y**
Lead Governor (RP)	-	-	-	-	**Y**

Notes:
[1]Not required to attend due to Covid-19
[2]Not required to attend, Final Accounts meeting only
[3]Brian Shipley, Deputy Director of Finance, attended in the absence of Lee Bond, Chief Financial Officer

APPENDIX 2 - AUDIT, RISK AND GOVERNANCE COMMITTEE - 12 MONTH ROLLING WORK PLAN

Item of Business	3 Jun 21 (Public Disclosure Statements meeting)	22 Jul 21	21 Oct 21	Jan 22	Apr 22
Audit Committee - Annual Review of Terms of Reference				X	
Audit Committee - Annual Review of Work Plan				X	
Audit Committee - Annual Self-Assessment Exercise & Results				X	
Audit Committee - Annual Report to Trust Board / CoG	X				
Audit Committee - Annual meeting dates/times/locations			X		
Audit Committee - Annual Review of External Auditor Performance		X			
Private Discussion with Auditors (internal and external)	X	as needed	as needed	as needed	as needed
Receive highlight reports & action logs from other Board sub-committees		X	X	X	X
External Audit - Annual External Audit Plan / Timetable / Fees				X	
External Audit - Routine Progress Reports	X	X	X	X	X
External Audit - Year End Report & Letter of Representation	X				
External Audit - Report on Trust's Quality Account (*if required*)	X				
Internal Audit - Annual Internal Audit Plan				X	
Internal Audit - Routine Progress Report / Technical Updates		X	X	X	X
Internal Audit - Head of Internal Audit Opinion	X (Final)				X (Draft)
Internal Audit - Annual Report (inc. client feedback survey results)	X				
Internal Audit - IA Plan strategic workshop results				X	
Receive Status Report on Implementation of IA Recommendations		X	X	X	X
Annual Governance Statement	X (Final)				X (Draft)
Public Disclosure Statements: Review changes to Accounting Policies				X	
Draft annual accounts, quality accounts and VFM conclusion					X
Audited annual accounts	X				
New from April 2020 – Any Covid-19 ARGC Related Business	as needed	as needed	as needed	as needed	as needed

Item of Business	3 June 21	22 Jul 21	21 Oct 21	Jan 22	Apr 22
LCFS - Annual Counter Fraud Report		X			
LCFS - Annual Counter Fraud Work Plan					X
LCFS - Written Progress Reports		X	X	X	X
LCFS - Concluding investigation reports / related issues		as needed	as needed	as needed	as needed
LCFS - Annual review of Fraud and Corruption Policy					X
LCFS - Results of Annual Staff Fraud Awareness Survey		X			
LSMS - Annual Security Management Report		X			
LSMS - Annual Security Management Work Plan					X
LSMS - Ad-hoc reports and updates		as needed	as needed	as needed	as needed
Review of Waiving of Standing Orders		X	X	X	X
Review of Losses and Compensations - quarterly		X	X	X	X
Review of Hospitality and Sponsorship		X	X	X	X
Review of Salary Overpayments & Underpayments - quarterly		X	X	X	X
Review of data re: Invoices without Purchase Orders		X	X	X	X
Review of finance related policies (SFIs / Standing Orders / Scheme of Delegation, Recovery of Salary Overpayments Policy, Standards of Business Conduct Policy, etc.)		as needed	as needed	as needed	as needed
Annual Review of Policy for Engagement of External Auditors for Non-Audit Work				X	
Board Assurance Framework (BAF) and Risk Register report - quarterly		X	X	X	X
Review of Assurance Sub-Committees' Conduct of Risk Oversight		X	X	X	X
Annual Review of Risk Management Strategy / Development Plan Progress Report		X	X	X	X
Annual Review of Trust's freedom to speak up arrangements			X		
Freedom to Speak Up Guardian			X		
Annual IG Toolkit Return		X			
IG Steering Group Highlight reports - quarterly		X	X	X	X
Document Control report - quarterly		X	X	X	X

Item of Business		3 Jun 21	22 Jul 21	21 Oct 21	Jan 22	Apr 22
Annual Fire Report			X			
Annual Health and Safety Policy statement						X
Annual Emergency Preparedness, Resilience and Business Continuity Report			X			
Clinical Audit Annual Work Plan			X			
Review of Data Quality Dimensions (*new item from HFMA checklist 2018*)		as needed	as needed	as needed	as needed	as needed
New HFMA NHS Audit Committee Handbook Items – July 2018						
Cyber security – Review the Trust's information governance and cyber security arrangements annually.		as needed	X	as needed	as needed	as needed
Mergers and acquisitions – review new arrangements		as needed	as needed	as needed	as needed	as needed
Working with regulators - oversee action plans relating to regulatory requirements (e.g. single oversight framework; use of resources)		as needed	as needed	as needed	as needed	as needed
Working at Scale – oversee developing partnership arrangements (e.g. accountable care organisations)		as needed	as needed	as needed	as needed	as needed

NLG(21)184

DATE OF MEETING	03/08/21
REPORT FOR	Trust Board of Directors Public
REPORT FROM	Adrian Beddow, Associate Director of Communications
CONTACT OFFICER	Charlie Grinhaff, Communications Manager
SUBJECT	Communications Update
BACKGROUND DOCUMENT (if any)	
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	
EXECUTIVE SUMMARY	This report covers Quarter 1 of 2021/22 and highlights key activity of the Communications team in relation to internal and external communications activity.

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	✓
Estates, Equipment and Capital Investment	✓	**Digital**	
Finance		**The NHS Green Agenda**	✓
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)					
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

July 2021

Kindness • Courage • Respect

July update 2021 (covering Quarter 1: April to June)

The team continue to give communications support to the Trust priorities, including:
Pandemic response: Strategic meetings have been reinstated and the all staff COVID-19 emails reintroduced on Tuesdays and Fridays as required
Quality priorities: ePMA – celebration of the completion of the inpatient ward rollout. Infographic produced
Quality Improvements: new campaign with its own look and feel highlighting quality improvements across the Trust launched. A week-long special saw 11 quality improvements highlighted.
Strategic service development and improvement: The internal staff focused communications campaign for Humber Acute Services has started with weekly emails on a Monday going out to all NLaG and HUTH staff. A number or virtual engagement sessions have been held and the staff survey is live.
Estates, equipment and capital investment:
The official MRI opening with Strictly star Joanne Clifton was a success. Working with the Health Tree Foundation we have launched a ‘Can you Spare 10p for our ED’ campaign.
Other projects: During June and July (and likely, as at the time of writing, into August too) the team has been supporting the Trust on an ongoing legal issue which has taken up around 15 days.

Continued…

Other projects: During June and July (and likely, as at the time of writing, into August too) the team has been supporting the Trust on an ongoing legal issue which has taken up around 15 days.

General Enquiries: The team spend a great deal of time dealing with general enquiries from the public via the email address nlg-tr.enquiries@nhs.net. Until now these have never been tracked but as part of the website redevelopment project this has been looked at to identify common requests. These can be anything from a quick signposting to another department to something more complex and time consuming. Examples include work experience/clinical attachment/placement requests, patient complaints and compliments, parking queries, lost property, test results, invoices and contact detail requests. Between April and June 296 were received and dealt with.

Internal Communications

Ask Peter: These are steadily increasing with more than 100 coming in every month and 328 in total during Quarter 1. Hot topics include COVID-19 related questions, parking, pay and estates and facilities related questions.

Senior Leadership Briefings
Topics covered have included:
CQC prep, operational performance and finance updates,
Humber Acute Services and our plans for improving our digital capabilities.
91 staff attended the April session, 84 in May and 61 in June.

Staff Facebook Group
There were 1,147 posts between April and June.
Posts with the most engagement:
- Grateful for extra annual leave day
- Big thank you prize draw results
- NRC patients able to watch the football

Monday Message topics include:
Discharge to Assess
Connecting for Health
Amanda Pritchard visit
Our Green agenda plans

External Communications

Proactive media releases have increased with 21 issued between April and June compared to 6 in the same period last year. Media enquires have fallen to 71 for the same period, down from 153 (although it should be noted that the team have proactively been sending inpatient stats to the Grimsby and Scunthorpe telegraph). The Trust appeared in 203 new articles/stories, and 97% of these were positive or neutral.

National media coverage: The story of a man facing jail for a false £1.5million compensation claim attracted national media attention including the Independent, Daily Mail and The Times
Press release with the most coverage: Charity match in memory of patient who died of coronavirus to raise funds for ICU

Recent media interviews
Shaun Stacey on operational pressures
Maurice Madeo and Graham Jaques on infection control
Toni Newlove on the support given to women who have lost a baby

Top media releases views on website
Walk in COVID-19 vaccinations
Visiting restrictions eased - appointments only
Blue badge holders can register

71
Media enquiries dealt with (90% within deadline)

21
Proactive media releases issued

97%
Of media coverage was positive or neutral

Social Media and Website

Social media is one of the key channels we use for celebrating staff.

Highlights:
- Our top tweet and top Facebook post was ‘Tracey and Lee tie the knot’ – a celebration of a patient wedding organised at Grimsby hospital.
- A single post on Facebook highlighting high attendances at our Emergency departments reached more than 40,000 people
- We posted more than 60 #ThumbsUpFriday posts in Quarter 1.

Twitter stats: 392 tweets, 1,700 engagements, 2,400 clicks.
Facebook stats: 450 posts, 38,000 engagements, 4,100 clicks
We have 15,000 followers/fans on Twitter and Facebook combined for the corporate NHSNLaG profiles

Website stats:
119,086 website users
430,111 page views

Top visited pages:
Staff portal
Staff guidance
Grimsby hospital home page

5
#ThumbsUp Friday posts every week on average

430,000
Page views on our website

38,000
Engagements on one post alone on Facebook

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(21)185

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors - Public
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	As above
SUBJECT	Documents Signed Under Seal
BACKGROUND DOCUMENT (if any)	N/A
OTHER GROUPS WHO HAVE CONSIDERED PAPER (where applicable) AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report below provides details of documents signed under Seal since the date of the last report (June 2021 – NLG(21)137).

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 tick ✓)			
Pandemic Response		**Workforce and Leadership**	
Quality and Safety		**Strategic Service Development and Improvement**	
Estates, Equipment and Capital Investment		**Digital**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	N/A				
BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
		✓			

Use of Trust Seal – August 2021

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
-	-	-

Action Required

The Trust Board is asked to note the report.

NLG(21)186

DATE OF MEETING	3 August 2021
REPORT FOR	Trust Board of Directors – Public Meeting
REPORT FROM	Helen Harris, Director of Corporate Governance
CONTACT OFFICER	Alison Hurley, Membership Manager & Assistant Trust Secretary
SUBJECT	Updated Register of Directors' Interests
BACKGROUND DOCUMENT (if any)	Trust Constitution (Paragraph 33)
OTHER GROUPS WHO HAVE CONSIDERED PAPER AND OUTCOME	N/A
EXECUTIVE SUMMARY	The report provides the updated Register of Directors' Interests as at July 2021

LINK TO STRATEGIC OBJECTIVES - which does this link to? (please tick ✓)				
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 good leadership**
				✓

TRUST PRIORITIES - which Trust Priority does this link to? (please tick ✓)			
Pandemic Response		**Workforce and Leadership**	✓
Quality and Safety		**Digital**	
Estates, Equipment and Capital Investment		**Strategic Service Development and Improvement**	
Finance		**The NHS Green Agenda**	
Partnership & System Working			

BOARD ASSURANCE FRAMEWORK (explain which risks this relates to within the BAF or state not applicable (N/A)	11 - Risk of insufficient investment and development of the Trust's leadership (including clinical leadership) – capacity and capability.

BOARD / COMMITTEE ACTION REQUIRED (please tick ✓)	**Approval**	**Information**	**Discussion**	**Assurance**	**Review**
				✓	

REGISTER OF DIRECTORS' INTERESTS
Updated as at July 2021 (v3)

NAME & POSITION	INTERESTS	DATE
Terry Moran, Chair	➢ Chair, Hull University Teaching Hospitals NHS Trust ➢ Chair, SLP College Charity ➢ Trustee, Cat Zero Charity	05.11.2020
Linda Jackson, Vice Chair	➢ Associate NED at Hull University Teaching Hospitals NHS Trust ➢ Both Sister and Sister-in-law works at DPoW (in Women's and Children division)	30.11.2020
Dr Peter Reading, Chief Executive	➢ Spouse of Dr Catherine Reading, Director, Catherine Reading Limited ➢ Company Secretary of spouses company, Catherine Reading Limited ➢ Director ex officio as Trust CEO of WebV Solutions Ltd ➢ Director ex officio as Trust CEO Together Plc ➢ Co-Chair Disabled NHS Directors Network	13.04.2021
Lee Bond, Interim Director of Finance	➢ Chief Finance Officer and Deputy Chief Executive Officer at Hull University Teaching Hospitals ➢ Trustee of WISHH Charity ➢ Vice President, Healthcare Financial Management Association (HFMA)	29.10.2020
Ellie Monkhouse, Chief Nurse	➢ Husband is foot and ankle Consultant Orthopedic Surgeon at Leeds Teaching Hospitals	16.11.2020
Shaun Stacey, Director of Operations	➢ None	04.11.2020
Dr Kate Wood, Medical Director	➢ Husband is Trust employee (Theatre Manager, DPoWH)	04.11.2020
Christine Brereton, Director of People (non-voting director)	➢ Partner is currently working in the Humber Coast and Vale as the Integrated Care System Finance Lead and working with the Trust's Chief Financial Officer	26.01.2021
Helen Harris, Director of Corporate Governance	➢ Member of Patient Participation Group, central Surgery, Barton-upon-Humber (NLCCG)	04.11.2020
Jug Johal, Director of Estates & Facilities (non-voting director)	➢ Chairman, Asian Sports Foundation	05.11.2020
Ivan McConnell, Director Of Strategic Development (non-voting director)	➢ None	16.11.2020

NAME & POSITION	INTERESTS	DATE
Shauna McMahan, Chief Information Officer	➢ None	22.10.2020
Stuart Hall, Associate Non-Executive Director	➢ Non –Executive/Vice Chair, Hull University Teaching Hospitals NHS Trust	16.11.2020
Gillian Ponder, Non-Executive Director	➢ Employed by Openreach Ltd in role responsible for large scale recruitment, supply chain and logistics	25.06.2021
Michael Proctor, Non-Executive Director	➢ Non-Executive Chair of Conclusion (Health Care Consultancy).	21.01.2021
Andrew Smith, Associate Non-Executive Director	➢ 100% shareholder and sole Director of First Advisory Services Ltd my personal service company – no NHS involvement ➢ Non-Executive Director for Harris Financial Planning Limited	15.07.2021
Maneesh Singh, Associate Non-Executive Director	➢ None	06.05.2021
Michael Whitworth, Non-Executive Director	➢ Interim Chief Executive Officer of Barnet Federated GPs (part-time) ➢ Owner/Director of Michael Whitworth Consultancy Ltd – this has been inactive since the summer of 2019 and is currently inactive and in the process of being wound up ➢ I have been asked by NHSE/I to be a part-time advisor to the Finance Workstream of the Flu and COVID-19 Vaccination Programme. The expectation is that this role will be remunerated	16.10.2020
Ade Beddow, Associate Director of Communications	➢ None	17.11.2020